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**Emory Family Medicine
Residency Program
Handbook
2006 - 2007**

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I. Introduction

A. Background

The Emory Family Medicine Residency Program (EFMRP) is committed to training excellent family physicians, capable of practicing full spectrum family medicine in the 21st century. We accomplish this by carefully incorporating clinical activity, education, and scholarly activity within the clinical and academic setting of Emory University School of Medicine.

Our Family Medicine Centers (FMC) comprise the Section of Family Medicine, an organization passionately committed to patients' health through sharing of knowledge and the discovery of breakthrough healthcare. We believe in training our residents to educate themselves, their patients, and each other as we deliver healthcare. We believe in educating our residents as adult learners. It is therefore incumbent on residents to do self-evaluation to assess their goals, needs and progress. With the help of their family physician faculty advisors, residents learn to set objectives based on these goals, decide what experiences are needed to achieve them, and learn how to seek out knowledge as part of their continuing medical education. In turn, the residents, while caring for their patients, are taught to educate them about their healthcare and guide them as the patients make decisions regarding their own healthcare. As the residents progress through their training, they are taught and encouraged to educate each other, other healthcare providers, and the community through conferences, lectures, and community talks.

Family physicians actively lead the teaching of the residents in formal settings such as precepting, lectures, and on ward rounds. However, we believe that one of the most important methods of teaching is by being role models for the residents. The family medicine faculty set the standard as faculty members are providers of comprehensive care to the individual and the family. Faculty members see patients in the Family Medicine Centers, the hospital, perform procedures, and continue to deliver maternity services. Behavioral medicine faculty, well versed in family systems, family theory, and counseling, assist by providing additional role modeling and teaching in behavioral medicine and mental health. Nursing and administrative personal also participate in the education of residents by guiding them through the process of seeing patients in the FMC, and by modeling how the FMC attends to individual patient and family needs.

The family physician faculty also guide the residents in how to be part of the healthcare team, demonstrating and teaching how to interact with consultants in other specialties, social services, nutrition services, physical and occupational therapy, and community resources.

The residency exists within the Department of Family and Preventive Medicine, part of the Emory University School of Medicine. As a new addition to this academic tradition, the Family Medicine Residency strives to make contributions to the discipline of family practice and to other disciplines, through research and other scholarly activities, and through participating in the education of other members of the medical community.

It is through the careful combination of clinical care and academic endeavors that our enthusiastic faculty train Emory Family Medicine residents for practice in the 21st century.

B. Mission Statement

1. Our mission is to facilitate each resident's growth as an individual and as a family physician.
2. Guiding Values and Principles:
 - a. To commit to lifelong learning.
 - b. To practice medicine with integrity.
 - c. To advocate for patients at all times.
 - d. To promote autonomy while encouraging teamwork.
 - e. To participate actively in the community.
 - f. To respect diversity of culture and spirituality.
 - g. To balance personal and professional lives.

C. Structural Framework

1. The EFMRP exists within the context of several administrative organizations. The organizational diagram is located in the Appendix section (Appendix A).

D. Principles of Family Medicine

1. Continuity of care
2. Comprehensive and holistic service
3. Cultural sensitivity
4. Community orientation
5. Cost-effectiveness
6. Highest quality of care possible
7. Patient Advocacy

II. Curriculum Design

A. Overview

1. General **GOALS** in residency training for EFMRP:
 - a. Learning to provide comprehensive, family-oriented primary care.
 - b. Providing family-oriented maternity care.
 - c. Training in procedural skills that allow the patient to stay with their primary physician.
 - d. Learning behavioral medicine skills and resources for patient counseling and education.
 - e. Practicing preventive medicine.
 - f. Coordinating the health care team including other specialty physicians, allied health care providers, and community resources.
 - g. Practicing evidence-based medicine.
 - h. Learning community-oriented primary care.
 - i. Learning practice management and administrative skills necessary in today's changing healthcare systems.
 - j. Learning to be an educator of patients, families, communities, other trainees, and self.
 - k. Beginning the process of lifelong learning, including self-assessment.
 - l. Providing an environment for residents to grow as physicians, individuals, and as a cohesive team.

2. Specific Rotation Goals and Objectives
 - a. See individual rotation curricular descriptions (Appendix B).
3. Rotation Outline
 - a. See Curricular Outline (Appendix B)

B. Morning Report

1. Weekdays 7:30-8:00 a.m.
2. Weekends 8:30-9:00 a.m.
3. Residents taking call for the service are required to be at Morning Report post-call.
4. Weekend attendance is required of the resident group going off call and coming on call.
5. If there are no admissions on call, it is the expectation that the team on call will present a learning topic.
6. We emphasize teaching during morning report.

C. Conferences

1. Residency didactic sessions are held Thursday from 8:30 a.m. to 12:30 p.m.
2. Attendance at these sessions is required of all residents during all but specified rotations (Appendix C).
3. It is the resident's responsibility to turn in evaluation forms after each didactic session.
4. Didactic attendance is a mandatory component of the EFMRP.
5. After Clinic Conference (ACC) is held from 12:00-12:30 p.m. and 5:00-5:30 p.m. after clinic every day except Friday afternoons (5:00 – 5:30). All residents are expected to attend when in clinic and not on call.
6. Numerous other didactic conferences are available from all the departments at Emory. Attendance may be required when on certain rotations (Appendix C).
7. EFMRP places high emphasis on the quality of the didactics program. Our expectation is that residents who are scheduled to speak/present will do so in a professional and timely fashion. In the unfortunate situation in which a resident foresees that they will not be able to present (on vacation/CME/etc...), they will contact the Chief Residents (Drs Kim and Shahryar) and the Residency Didactics Coordinator (Theresa Berry, MD) to reschedule and make sure that their time will be covered with another well-prepared lecture. If the involved resident does not do this, the Program Director will institute a disciplinary measure to help the involved residents be aware of their breach of professionalism and common courtesy. This measure may take the form of:
 - a. Extra call
 - b. Forfeiture of book money
 - c. Forfeiture of CME money/time
 - d. Official letter of reprimand from the PD
 - e. Probation for repetitive occurrences and a letter of reprimand.Professionalism is one of the ACGME six core competencies.

D. Scholarly Project

1. A scholarly project is required of each resident prior to completion of the residency. Residents will not be approved for graduation without the project being received in an acceptable manner.

2. The goal of the scholarly project is to create a lifelong interest in scholarship and the skills needed to accomplish it. Such skills include:
 - a. Ability to conduct a literature review
 - b. Ability to design a research study
 - c. Ability to critically evaluate research articles
 - d. Ability to apply evidence-based medicine to the practice of medicine
 - e. Ability to synthesize information
 - f. Ability to communicate information to others
3. Research or scholarship is a systematic attempt to test or develop knowledge. The audience for scholarly activity on the part of residents may be faculty, peers, medical students or the public.
4. Scholarly projects may take any of the following forms:
 - a. Structured literature review
 - b. Book chapter
 - c. Case report with literature review
 - d. Actual implementation or participation in research
 - e. Scholarship of teaching or learning
 - i. Curriculum development
 - ii. Patient education development
 - iii. Evaluation studies
5. The Residency Research Coordinator (RRC, Ashley Owen, PhD) will review each scholarly project at its inception to determine if it meets the requirement for the scholarly project. A project will be judged to be appropriately scholarly if it is suitable for submission to a peer-reviewed journal, or if it meets the following criteria (Glassick's):
 - a. Clear goals
 - b. Adequate preparation
 - c. Appropriate methods
 - d. Significant results (does not imply statistical significance)
 - e. Effective presentation
 - f. Reflective critique
6. Posters, presentations and other projects must be approved as scholarly projects by the RC *prior* to his/her presentation, in order to satisfy the residency requirement.
7. For each project, a research advisor must be identified. The research advisor will monitor and document the resident's progress using the *Scholarly Project Checklist* shown in Attachment N). The resident will provide an updated copy of this form to the faculty advisor and the RC prior to each resident quarterly review.
8. Scholarly project documents are to be electronically submitted to the Residency Program Director, Residency Research Coordinators (Drs. Dunlop and Owen), Residency Program Coordinator, and the resident's Research Advisor by the following deadlines:

PGY2 January 1.....Letter of intent
 PGY2 April 1.....Scholarly project proposal
 PGY3 December 1..... Completed analysis of data or literature review
 PGY3 February 1..... First draft of project
 PGY3 March 1..... Second draft
 PGY3 May 1.....*Final written project

9. For each missed deadline, the resident, his or her research advisor, and the Chief Resident/s will be electronically notified of the need for an extra call assignment. If the resident obtains an excuse for the missed deadline from his or her Research Advisor and communicates this to the chief resident within two weeks, he or she may have the extra call assignment removed. **Failure to turn the project in by this May 1st date may cause delay in completing the residency and disqualification from sitting for the Board Exam.**
10. For extenuating circumstances beyond the Resident's control, the Residency Director may grant an extension of 30 days. The final due date for all extensions and revisions is June 1. The extension request must be in writing, be received by the Residency Director before April 23 and detail the extenuating circumstances.

E. Videotaping

1. Videotaping is felt to be an integral part of residency education and all residents are expected to participate in this curricular aspect.
2. The goal of videotaping is to provide an effective method of learning and practicing progressively more refined patient interviewing techniques and communication skills. This instructional method and feedback system ensures competency in medical interviewing and professional communication skills.
3. Each resident is assigned to videotape patient encounters and then meet with faculty members to review the tapes. There will be two videotaping review cycles each academic year. The specifics of each assignment will be determined by the resident's demonstrated level of proficiency and outlined on the Videotaping/Communication Skills Progress Report form at each videotape review session. The Resident will be provided a copy of this progress report and one will be placed in the Resident's folder. Resident's progress in medical interviewing, presentations, documentation and other communication skills will be discussed at Resident Quarterly review.
4. The resident is responsible for:
 - a. Obtaining the patient's written consent to be videotaped on the appropriate form.
 - b. Completing the assigned videotaping of patient interviews and/or other learning experiences in the designated time frame. **(Unless otherwise specified, each resident should have three videotaped patient interviews ready for review each cycle.)**
 - c. Maintaining and having available the resident's own VHS-C tape (provided by the program) to do the videotaping and bringing it to review sessions.
 - d. Knowing how to access and operate the camera and ensuring that it is charged prior to use.
 - e. Capturing both the residents face and the patient's face (or other persons in the dialogue) during the videotaping experience.
 - f. Previewing the videotaped interviews ahead of time and coming to the review sessions prepared to offer meaningful self-assessment prior to reviewing the tapes with faculty.
 - g. Setting up and putting away the VCR monitor before and after the video review sessions.

5. Residents should complete videotaped assignments well in advance, as technical or logistical difficulties are **not** acceptable excuse for incompleteness. If it is necessary for a resident or the faculty to reschedule the review session for any reason (other than a dire emergency), this needs to be arranged at least one week in advance. In case of emergency, the people scheduled to meet should be phoned or paged as soon as a delay is anticipated.
6. **No shows, inadequate notice of cancellation, tardiness at reviews, or incomplete assignments may result in additional number of videotaped assignments, a written report of unprofessional conduct, and/or additional call. *Additional written self-assessment will be required of anyone failing to complete the assignment on time. Failure to complete the assignment and review within the assigned quarter may result in academic probation.***

F. Balint/Support Group

1. Each Post Graduate Year (PGY) level has a balint/support group led by the family medicine faculty or their designee.
2. Members of that PGY level are required to attend their meetings.
3. The group will set its own agenda for the meetings. The content of these meetings is considered confidential.
4. Rotations are notified about the meetings to facilitate resident attendance.
5. **These meetings are mandatory** as part of the behavioral medicine curriculum.

G. Maternity Care

1. Maternity patients are managed by their primary care provider.
2. **All OB patients must be precepted with the clinic attending at the time of the OB visit.**
3. Residents are expected to be present during labor and delivery of their patients unless they have made clear alternative arrangements (OB "Buddies").
4. Labor and delivery (L&D) contacts the resident on call who notifies the primary resident or his/her arranged covering resident on arrival of the patient in L&D.
5. Upper level residents should actively encourage interns to participate in continuity deliveries.
6. Back up for urgent problems is the resident on call and ultimately the faculty on call.
7. Residents should NEVER be in the position of delivering a patient without an attending present at the bedside.
8. The faculty on call must be notified of the admission and is expected to be in-house for all patients in active labor, and for patients being induced, augmented, or placed on MgSO₄. The attending must be kept informed of changes in the patient's status.
9. Faculty must be notified of all maternity patients who are seen in L&D triage whether admitted or not.
10. If a resident will be out-of-town during his/her patient's 36 to 42 week gestation period, knows he/she will have required call nights at another hospital during that time, or prefers to share obstetric call with a colleague or his/her family medicine center team, he/she should inform the patient and the covering colleagues and have the patient see other physicians covering the patient during the prenatal period.
11. **Residents must document all deliveries performed, both continuity and other, on the residency's inpatient procedure cards.** Residents should also contact the Residency OB Coordinator (Dr. Nwosu) within 1 week to update the OB database.

12. **In the FMC, the preceptor must sign off all prenatal charts prior to the patient leaving the clinic.**
13. **New OB visits must have a preceptor verify the resident's dating exam and firmly establish the EDC or pursue methods to do so.**
14. New OB patients and outcomes for current OB patients must be reported to the faculty responsible for tracking OB (Dr. Nwosu).

H. Didactic Policy

1. Thursday Didactic attendance is a mandatory component of the EFPRP.
2. Each resident will be responsible for signing in to didactics. Chief residents oversee attendance every didactic session and note hourly attendance, so that for a given Thursday didactic, attendance will be taken for 4 separate didactic hours. To get credit for attending a given didactic hour, the resident should be present for at least 75% (roughly) of that session. Residents are expected to be in their seats within 5 minutes of the start of a lecture in order to receive credit.
3. **For the first session, sign in is from 8:15 – 8:30.**
4. Residents are required to attend a minimum of 80% of didactics, averaged monthly.
5. The cut-off of 80% didactic attendance should be based on the total number of didactic sessions that a particular resident is able to attend during a given month, rather than 80% of the total number didactics given that month (i.e., a resident who is on a rotation in which they are unable to attend didactics should have their 80% attendance figured from the number of didactics given during their other rotations in the month in which they are able to attend).
6. At the end of every month, a percent attendance should be calculated for each resident and a published report should be given to the resident, their advisor, the residency Program Director, and the chief residents. This will be reviewed at Quarterly Evaluation.
7. For those residents falling below the 80% cut-off for the preceding month, the chief residents will assign that resident more hospital call in the next quarter. Residents not attending 80% of didactics will be given a warning followed by academic probation if the absenteeism behavior persists.

III. Policies and Procedures

A. Leave

1. Leave Benefits: Emory University School of Medicine allows for the following amounts of time away (see *GME House Staff Policies and Orientation Manual* in Appendix E and at <http://www.emory.edu/WHSC/MED/GME/HousestaffPolicies10-22-03.html>).
 - a. 3 weeks paid vacation/holiday leave (unused leave does not transfer).
 - b. 12 days paid sick leave (unused leave does not transfer)
 - c. 5 days paid funeral leave
 - d. 6 weeks paid disability leave (using all paid sick leave and 2 of 3 weeks paid vacation leave). Residents must request this leave in writing to the Program Director.
 - e. 12 weeks of family leave (up to six weeks paid leave and the remainder unpaid)
 - i. Only certain criteria meet family leave. Residents must request this leave in writing to the Program Director.
 - ii. Benefits continue through time of leave as outlined in *House Staff Policies and Orientation Manual*.

2. Unpaid Personal Leave of Absence is also available
 - a. These are at the discretion of the Program Director.
 - b. The resident must pay for benefits coverage.
 - c. In the event that a resident leaves the program emergently on a LOA, the program director must be notified in writing within one week of the resident's status and expected return to work date. If the Program Director has not received anything in writing within two weeks of the resident's absence, the resident will be placed on administrative probation for lack of professionalism and dereliction of duty and the program director will notify the resident in writing at their last known legal address and by e-mail that they are in danger of being terminated from the program. After one month away from the program without any written contact from the resident, the Program Director will proceed with terminating the resident's contract.
3. Effect of leave on ABFM Board Eligibility
 - a. In order to qualify to sit for Board Exams, the ABFM allows:
 - i. **Absence from the program for vacation or illness not exceeding a combined total of one month (30 calendar days or 21 work days) per academic year.**
 - ii. Leaves of absence (exclusive of the vacation/sick time) for a maximum of three months per academic year. Time away may be divided but any two leaves of absence may not be separated by less than two months.
 - iii. Time exceeding one month away must be made up before advancing to the next academic level.
 - iv. Specifics from the ABFM can be found on their website at:
<http://www.theabfm.org/>
 - b. To meet the training requirements of the American Board of Family Medicine (ABFM), it may be necessary for a resident/fellow to spend additional time in training to make up for time lost while on a prolonged leave of absence.
 - c. The program will do whatever possible within the above guidelines to see that the resident's personal needs are met. However, the program cannot bypass the Board requirements. Residents may be asked to give up vacation days in order to stay on schedule.
4. Vacations
 - a. Leave Request Forms (Attachment C) for time away can be obtained from the program coordinator and returned to the chief resident. Forms must be completely filled out or will be returned to the resident.
 - b. All vacation/leave requests must be submitted a minimum of 60 days prior to the vacation, and preferably 90 days prior.
 - c. Vacations must be taken in one-week blocks at the beginning or end of a rotation, except in unusual circumstances. A period of two weeks will only be considered if extenuating circumstances exist, the time spans the end of one rotation and beginning of the next rotation and the chief resident has determined that the call schedule for other residents would not be adversely affected.
 - d. No vacations are permitted during the last two weeks of June (or the month of graduation) for graduating PGY 3's. This allows for appropriate check out procedures.

5. Sick leave
 - a. If you call in sick during a working day:
 - i. Notify the Program Coordinator, Chief Resident or the Residency Program Director directly.
 - ii. Notify your rotation.
 - iii. Notify the FMC if you are scheduled for clinic.
 - iv. Complete a time away form and submit to the Program Coordinator or the staff assistant.
 - b. Any Hospital Service which requires 24/7/365 onsite coverage will require coverage prior to leaving the site. Continuity of patient care and onsite physician coverage must be maintained. **This includes onsite Labor and Delivery Suite rotations.**
 - c. If you are sick and need to leave a 24/7/365 site because of illness:
 - i. Notify the Program Coordinator or the Residency Program Director directly.
 - ii. Notify the Chief Resident directly.
 - iii. Notify your rotation.
 - iv. Notify the FMC if you are scheduled for clinic.
 - v. Wait until your replacement physician arrives.
 - vi. Complete a time away form and submit to the Program Coordinator or the staff assistant.
 - d. If you leave from your rotation or FMC due to illness:
 - i. Notify the Program Coordinator or the Residency Program Director directly.
 - ii. Notify your rotation as early as possible that you need to leave.
 - iii. Notify the FMC as early as possible that you need to leave.
 - iv. Complete a time away form and submit to the Program Coordinator or the staff assistant.
 - e. **Failure to follow these procedures may result in probation and possible dismissal.**
6. Interview Days
 - a. As part of EFMRP's Practice Management curriculum, each resident is allowed up to a total 5 days away during the PGY 3 year to interview or assess other medical practices. This time is not used nor counted for sick or other leave time.
 - b. A time away form must be completed as far in advance as possible. As part of this time away request, the practice name and location must be included, with the interview offer.
 - c. Every effort must be made not to interfere with scheduled FMC patients. **Last minute requests may be denied if it interferes with patient care.**
7. Inclement Weather Leave
 - a. Residents are deemed "essential" employees as they perform vital services during their educational experiences. Even in the event of life-threatening weather conditions, residents must report to duty.
 - b. In the event that a resident is unable to report to duty, the sick call schedule will be used to replace the absent resident. However, if this is done, the absent resident must "pay back" the pulled sick call resident at some point. The chief residents will monitor this.
 - c. In the event that no resident is able to report to duty, residents already on duty may be required to stay at the hospital but will be given compensatory time off.

B. CME

1. Emory School of Medicine residents are permitted to register for Emory-sponsored CMEs with no registration fee.
2. As many residents as possible will be sent to the GAFP annual meeting in Atlanta.
3. Each resident is allowed \$200 reimbursement for book money. Book money may be used to purchase a PDA/Palm Pilot or on-line resources such as Up-to-Date[®] subject to the approval of the Program Director.
4. A mandatory didactic attendance policy is in effect (Appendix C).
5. A letter stating that Emory is tax-exempt should accompany reimbursable purchases, as taxes are not reimbursed. (Attachment D).
6. Each PGY-2 and PGY-3 resident is allowed 5 days for CME leave and up to \$1000 reimbursement for expenses for CME course work.
7. During the PGY 3 year, the last \$500 of CME reimbursement will be directly linked to resident clinic performance and professionalism during the last months in the program. Specifically, the program will reimburse the resident the first \$500 of CME spent as soon as the bill is submitted. The last \$500 of CME reimbursement will be disbursed immediately after graduation. The purpose of this policy is to stimulate graduating PGY 3 residents to continue to maintain a high degree of professionalism and leadership until they graduate.
 Ways to lose this money (the last \$500 of CME reimbursement):
 - A. Chronically late to clinic
 - B. Poor didactics attendance
 - C. Poor clinic staff relations - arguing with faculty in clinic, poor nurse relations, etc...
 - D. Asking other residents to see your patients because you're not going to be in on time.
 The reimbursement of this remaining \$500 of CME funds will be determined by the program director based on input from the faculty and staff.
8. Funds not used for CME may be used for other educational resources (textbooks, CD-ROM, etc). CME funds are subject to the approval of the Program Director.
9. CME approval is based on adequate didactic conference attendance and general academic standing.
10. When requesting time away for CME, a leave request form (Appendix C) must be completed and turned in. A copy of the CME brochure must be attached.
11. Upon completion of the CME, the resident must turn in the number of CME hours completed prior to being reimbursed for the CME activity. This mimics what is required for CME credit after graduation and gets the resident in the habit of recording/reporting CME activity.

C. ABFM Policies

1. Attached is a copy of American Board of Family Medicine policies for qualifying for the Board Exam (Appendix F).

D. ACGME-Residency Review Committee (RRC) Requirements

1. Attached is a copy of the ACGME-RRC Program Requirements (Appendix G) and Institutional Requirements (Appendix H).
2. Attached is a copy of the ACGME outcomes project.

E. Moonlighting

1. Residents are prohibited from providing patient care services that are outside the scope of the residency training program (moonlighting) unless they receive *prior written approval* of the Department Chair and Program Director. Approval to moonlight is effective for only six-month periods.
2. If permission is granted to moonlight, the resident must:
 - a. Provide the training program with a copy of the resident's permanent Georgia medical license and DEA number.
 - b. Complete and pass Advanced Trauma Life Support (ATLS) if moonlighting in an Emergency Department outside of the Grady System.
 - c. Be in good academic standing without probationary status during the preceding year. The resident's faculty advisor must verify this in writing to the Program Director.
 - d. Be above the PGY1 level and NOT be in training on a J-1 visa.
 - e. Provide the Training Program with evidence of malpractice coverage, which is not provided by Emory University School of Medicine.
 - f. Not wear a name badge or white coat that identifies her/him as an Emory University School of Medicine House Staff Officer.
 - g. Submit an Emory Request to Moonlight form (Appendix E) to the program for signature by the Program Director and the Department Chair. Copies of this form are available in the *GME House Staff Policies and Orientation Manual* (Appendix E)
 - h. <http://med.emory.edu/GME/HousestaffPolicies7-05.htm>
3. Regarding hours of moonlighting, residents must:
 - a. Not moonlight during hours they have Training Program responsibilities or are on-call for the Training Program.
 - b. Not work more than a total (training plus moonlighting) of 80 hours per week.
 - c. Have (on average) 1 day (24 hours) out of 7 off from training and moonlighting.
 - d. Not work more than 36 hours continuously (training plus moonlighting) without a 10-hour off-period.
 - e. Provide the Training Program with the times, dates, and total hours spent in a moonlighting position. In addition, the resident must be able to verify these numbers if requested.
4. Additional information regarding moonlighting is available in the *House Staff Policies and Orientation Manual* (Appendix E).

F. Probation, Suspension, and Dismissal

1. Probation and Suspension
 - a. Probationary status can be recommended by the faculty and instituted by the Program Director for failure to comply with academic, administrative, or standards of the program. Reasons for this recommendation will be stated in writing through the Educational Prescription and the Program Director's letter.
 - b. A period of one to four months is established for re-evaluation and acceptable standards for continuation in the program are defined for the resident.
 - c. These conditions will be reviewed by the resident, his/her advisor, and the Program Director with documentation of the resident's understanding of the conditions
 - d. At the end of the period the Program Director and Residency Committee have several options for action. If no improvement has occurred and if the behavior or academic

performance has continued and is irremediable, the resident may have his or her contract terminated. If some progress is seen, but it is insufficient to meet criteria set for removal of probation, the probationary period may be extended with revision of the criteria and time period for expected improvement. If progress meets the standards established by the committee, probation may be discontinued.

- e. If at any time, the resident's behavior or performance may endanger patient care, the resident may be required to take a leave of absence from the program until the resident has improved to the satisfaction of the committee to resume patient care and provided an outside agent is able to certify that the resident is fit to continue or return to his/her duties.
- f. Suspension is an alternative course of action and may be utilized as outlined in the *House Staff Policies and Orientation Manual* (Appendix E).

2. Dismissal or Non-renewal of Contract

- a. This may result if the resident fails to comply with an educational prescription, fails to meet goals of probation as established by the Residency Committee, or does not satisfy program requirements.
- b. The resident will be informed of the possibility of dismissal at the time that probation is begun.
- c. Dismissal without warning may occur if the resident's performance or behavior violates legal or ethical standards.
- d. The resident may alternatively be placed on leave of absence without pay pending investigation and determination of the complaint.
- e. A resident's contract is in effect for one year. The program will give warning to the resident by March 1 and notice to the resident by April 1 of the academic year if the resident's contract will not be renewed for continuing residency training.
- f. Level of postgraduate training and term of contracts should not be confused. If a resident has not shown sufficient progress to be advanced to the next postgraduate training level, a contract may be continued at the current level of training.
- g. Disputes regarding academic discipline and resident complaints or grievances are dealt with according to the Graduate Medical Education Guidelines for Grievance and Due Process as included in the *House Staff Policies and Orientation Manual* (Appendix E).

G. Due Process and Appeal/Grievances

- 1. In the instance that a resident feels that a grievance has occurred, he/she can use the following resources to address the grievance:
 - a. Fellow residents
 - b. Balint group
 - c. Chief Residents
 - d. Resident Advisor
 - e. Program Director
 - f. Division Chief
 - g. Department Chair
 - h. Office of Graduate Medical Education

2. The resident is encouraged to discuss this with the parties involved. If resolution is not forthcoming, the resident is encouraged to discuss the grievance with the Program Director. If the grievance is still not resolved, the Program Director will abide by the Emory HouseStaff Policies manual section 33 online at:

http://www.med.emory.edu/GME/HousestaffPolicies10-22-03.html#_SECTION_33:_GRIEVANCE

3. See *House Staff Policies and Orientation Manual* (Appendix E) for further discussion.

H. Supervision

1. Supervision of residents by faculty within a residency serves several purposes.
2. Supervision should be considered an opportunity to teach. At times, it may be also be used for evaluation, which when then used as feedback, becomes another opportunity for learning and growth. Faculty may be required to supervise residents in certain circumstances and to varying degrees.
3. Supervision in various circumstances is described elsewhere in this document.

I. Resident Support

1. It is one of the goals of the Emory Family Medicine Residency to provide whatever support possible to its residents as individuals and as a group.
2. While this goal is important to EFMRP, it must be remembered that, at times, the Program Director and faculty may need to balance the needs of individuals and the needs of the group/residency and in doing so, each and every need may not be able to be met.
3. Sources of support include:
 - a. Faculty Advisor
 - b. Program Director
 - c. Resident Balint/Support Group
 - d. Residency Behavioral Medicine Faculty
 - e. Emory Employee Assistance Program
 - f. Fellow residents
 - g. Chief Residents

J. Dress Code

1. Physicians are expected to dress professionally for patient care in the FMC.
2. IDs should be worn and visible at all times.
3. **Scrubs are appropriate for hospital call, NOT for patient care in the FMC or other offices unless doing procedures.**
4. Residents are expected to be neat, clean, and orderly at all times during the performance of training program activities. Residents are expected to dress according to generally accepted professional standards appropriate for the resident's particular program. Where safety is a factor, residents should use common sense in choosing clothing and shoes for training activities. Jewelry, clothes, and hairstyle should be appropriate for the performance of duties in the hospitals. Program directors may require a particular, reasonable dress code for their residents, depending on the needs of the service, for public image, and safety. Photo identification tags must be worn at all times while on duty.
5. Some specific details:
 - No open-toe shoes (OSHA guidelines)

No bare midriffs

Skirts generally of knee length

Jewelry to be worn in traditional locations: ear lobes, neck, wrists, fingers.

6. Dress and jewelry should not be distracting and unprofessional. The resident's appearance should positively reflect upon the program.
7. Additional guidelines are available in Appendix D.

K. Consultations and Referrals

1. EFMRP believes that care of patients in the residency training setting should be directed by the residents.
2. Residents are expected to be responsible for considering the need for consultation and referral for patient problems in the FMC and in the hospital setting.
3. Once consultation or referral is considered, the resident is also responsible to discuss this with the FMC preceptor or hospital attending. **Each consultation mandates a precepting encounter with the attending.** This serves several purposes. While precepting, the faculty:
 - a. May be aware of someone within the EFMRP who may provide the same services or information and the consultation/referral may not be needed.
 - b. May help the resident formulate a more directed question for the consultant to answer.
 - c. May be aware of a particular consultant who would be particularly appropriate for the question.
 - d. As the billing physician and physician of record, should be aware of all consultations.

L. Resident Selection and Eligibility

1. Applications are accepted only through the Electronic Residency Application Service (ERAS). This service is available to all US Medical Graduates through their Dean's Office. Canadian medical school graduates should contact the Canadian Resident Matching Service. International Medical Graduates should contact the Education Commission for Foreign Medical Graduates (ECFMG).
2. Completed applications are reviewed periodically and candidates are notified when we have sufficient information to decide upon an interview. Interview dates are granted to qualified candidates. Application deadline is November 30.
3. A United States Medical Licensing Exam (USMLE) transcript must be included as part of the application.
4. International Medical Graduates must include an ECFMG certificate (including a current Test of English as Foreign Language (TOEFL)) and a copy of a translated medical school diploma.
5. All candidates must take USMLE Part I and are strongly encouraged to take Part II and forward their scores to the Emory Family Medicine Residency Program prior to February when the Rank List is finalized and submitted to the NRMP.
6. International Medical Graduates applying for an H1B VISA must provide documentation of successful completion of all three USMLE steps by December 31st of the year of application prior to being considered for a position in the match.

7. International Medical Graduates applying for a J1 VISA must provide documentation of successful completion of USMLE steps I and II by December 31st of the year of application prior to being considered for a position in the match.
8. First year positions are offered through the National Residents Matching Program and recruiting is in compliance with NRMP guidelines. All applicants through the NRMP are expected to be able to begin the residency no later than July 1 of that recruitment year. Failure to be able to begin on that date may result in dismissal from the program.
9. Second year applicants or applicants with a minimum of 10 months of advanced placement credit (per ABFP guidelines and application) will be considered if openings occur in this year. These PGY2 applicants will be interviewed and considered outside of the NRMP.
10. Academic records, letters of recommendation, (at least one of which must be from a Family Physician), USMLE (or Comprehensive Osteopathic Medical Licensing Exam (COMLEX), Federal Licensing Exam (FLEX) or National Board of Medical Exams (NBME)) scores, honors, and applicant's personal statement and future plans are considered in choosing to interview an applicant.
11. The interview, compatibility of the applicant with program philosophy and goals, academic record, letters of recommendation, and evidence of involvement in and commitment to family medicine weigh in the acceptance and ranking of applicants.
12. All candidates must have documented clinical experience in the United States or Canada and the majority of recommendations must come from physicians who can attest to this clinical experience.
13. Per Emory's graduate medical education guidelines, international medical graduates may only be enrolled with a J-1 or H-1 visa, or permanent resident status.
14. Emory School of Medicine and the Department of Family and Preventive Medicine does not discriminate in recruiting on the basis of race, national origin, color, religion, sex, sexual orientation, age, veteran's status, or disability. We value diversity and individuality in our candidates.

M. Advisor/Advisee System

1. Each resident is assigned an academic advisor and will meet at least every four months; ideally this should occur within 2 weeks of the quarterly reviews (held in October, February, and June).
2. The advisor is responsible for reviewing resident self-assessments, rotation evaluations, and resident summary evaluations from the faculty meeting, conference attendance, Family Medicine Center performance, scholarly activity progress, conference attendance, scheduling requests, and use of elective time.
3. The advisor is also responsible for monitoring progress of a resident's performance if the resident is on probation.
4. The resident advisor and the residency director will be responsible for notifying residents of probation, conditions for removal of probationary status, non-renewal of contracts, or actions of the program resulting in non-promotion of a resident at the expected time.
5. The advisor and residency director must both be informed of personal leave needs that will result in restructuring or extension of the resident's training program.

N. USMLE Requirements

1. All USMLE examination sittings must be reported within 14 days to the Emory Family Medicine Residency Program Director.
2. All USMLE scores and transcripts must be reported within 14 days of notification to the Emory Family Medicine Residency Program Director.
3. It is the goal of the EFMRP to train Board-Certified Family Physicians. In order to achieve Board Certification, USMLE Parts I, II, and III must be successfully completed and the resident must be licensed to practice medicine.
4. In general, residents in the EFMRP must have successfully completed USMLE Part I and should have successfully completed Part II prior to beginning the residency. Those residents not completing USMLE Part II prior to beginning the residency will be required to take and successfully pass the exam prior to the end of PGYI. Failure to initially pass USMLE Part II may be grounds for probation. USMLE Part II must be successfully completed prior to the end of PGYI. Failure to successfully complete USMLE Part II prior to the end of PGYI will be grounds for dismissal. Emory does not reimburse residents for taking USMLE Part II. Emory policy requires that residents pass USMLE Part II prior to being promoted to PGY2.
5. Residents must take USMLE Part III in the fall of the PGY-2 year. See the *House Staff Policies and Orientation Manual* (Appendix E) for details.
6. Failure to initially pass USMLE Part III may be grounds for probation. USMLE Part III must be successfully completed prior to the end of PGYII. Failure to successfully complete USMLE Part III prior to the end of PGYII may be grounds for dismissal.
7. International medical graduates may be required to take the examination out of state if they are not eligible to take the exam in Georgia.
8. These requirements are stricter than Emory's GME USMLE Policy (see the *House Staff Policies and Orientation Manual* Appendix E) due to our Board Certification Requirements.
9. Georgia now uses a Permit system which allows IMGs in the PGY 3 year to continue in residency without a state license.

O. GA Licensure

1. The Emory Office of Graduate Medical Education is on a permit system wherein each resident applies for a permit to practice medicine as a resident in the state of Georgia for each academic year. This was implemented July 1, 2004.
2. In order to sit for the ABFM Exam, the resident must hold a true medical license, not a permit.
3. Applications for a GA medical license can be requested by writing the Composite State Board of Medical Examiners, 166 Pryor Street, SW, Atlanta, GA 30303 or by calling 404-656-3913.

P. Medical Records

1. Medical records are used to document patient care and, in a residency program, may be used to document resident's provision of care and be a part of the evaluation process.
2. FMC records should be legible and ideally completed at the time of the patient visit. All records must be completed within 24 hours of the patient visit. **Prenatal records must be completed and reviewed and signed off by faculty prior to the patient leaving the clinic that day.** Residents not adhering to this policy will be given one warning. After a second violation, the resident may be placed on probation. A third violation may result in suspension or termination from the residency.

3. Hospital progress notes and orders must include a legible printed name and contact number (PIC pager number) after each signature.
4. Hospital discharge summaries must be completed within 24 hours of discharge and, ideally, are completed at the time of discharge. Hospital discharge summaries should generally be dictated by the resident completing the discharge orders and sheets. Incomplete records may result in warnings, extra call, probation, or suspension/termination.

Q. Medical Library/Informatics

1. The Emory Hospital System has excellent Medical Libraries and Informatics systems, including Internet access readily available on all nursing units.
2. Residents are expected to avail themselves of these resources to aid in patient care and enhance learning.
3. Computers with Internet access are located at both clinics and can be used for literature searches.
4. Up-to-Date[®] is available on the computer in the medical records room at Emory Dunwoody Medical Center where residents take call for the Family Medicine Inpatient Service.

R. Off-service Residents/Medical Students/Physician's Assistant (PA) Students

1. As part of its' teaching mission, EFMRP engages in the teaching of residents from other Emory departments, and medical students and physician assistant students from Emory and other schools. Such teaching occurs in the classroom, in the FMC's and on the wards.
2. Residents are expected to take an active part in the teaching and evaluation of other learners.

S. Release of Information

1. Prior to any release of information for recommendations, verification of training, letters of reference, or confirmation of competence for clinical privileging, the resident must supply the EFMRP with a signed release form.
2. Such forms are available from the Program Coordinator or through the credentialing office of the institution to which an application is made (Attachment F).

T. Promotion

1. Determined yearly by the program director with input by the faculty.
2. Evaluations must show adequate performance on each rotation and the faculty must confirm that the resident has demonstrated the ability to advance to the next level of responsibility. Evaluations must be completed and received for each residency rotation.
3. Year-to-year advancement is based on the following standards:
 - a. Must exhibit clinical performance and competence consistent with the level of training undergone.
 - b. Must satisfactorily complete all assigned rotations (supported by evaluation documentation) in each postgraduate year.
 - c. Must satisfactorily complete all assigned courses, projects, and educational prescriptions given by supervisors/preceptors and advisors.
 - d. Must satisfactorily attend family medicine conference series, didactics, and morning report.

- e. Must demonstrate a professional attitude and behavior in patient care and work with colleagues.
- f. Must achieve a satisfactory score on examinations required to obtain credit for specific required programs.
- g. Must show progressive scholarship and professional growth.
- h. Additional standards as outlined in The Special Requirements of Family Medicine Residency Training as established by the ACGME, and the ACGME Outcomes Project.
- i. Residents may fail up to two rotations in a year and still be considered for advancement to the next PGY year on cycle. However, this is not guaranteed. The resident's overall performance will be evaluated by the Program Director and the faculty, in addition to giving consideration to which rotations were failed. The Program Director and faculty may elect to continue the resident in the program but still put the resident off cycle.
- j. Residents who fail more than two rotations in a year are automatically off cycle. They may also be considered for probation or termination depending on their performance.

U. Graduation

- 1. Residents are able to graduate from the residency only after completion of all residency requirements, including but not limited to the Scholarly Projects, remedial rotations (when applicable), videotape assignments, and rotation assignments.
- 2. Certificates of completion are awarded to all graduating residents at the end of the PGY3 year.

V. Chief Resident Selection

- 1. Two chief residents from the PGYII class will be selected yearly in March or April by vote of the resident group. May and June will be chief resident-elect months with progressive assumption of chief resident duties.
- 2. Nominee selection will be according to resident established guidelines and nominees must be willing to serve the residents in that capacity. The nominees are subject to approval from the faculty and must be in good academic standing without a history of probation during their PGYII year.
- 3. Chief residents serve as role models for other residents and students, exemplifying the mission and goals of the residency program and of Family Medicine. They work with the program director in providing guidance and leadership for the program.
- 4. Leadership skills essential to performance are:
 - a. Team building
 - b. Relating to multiple stake holders
 - c. Handling transitions
 - d. Motivating and inspiring
 - e. Knowing how and with whom to plan and problem-solve
 - f. Knowing one's own style and limitations
 - g. Encouraging and appreciating differences
 - h. Managing conflict
 - i. Able to give and receive effective feedback

- j. Rewarding and recognizing others
 - k. Expecting occasional failures in others and self
 - l. Timely, clear and decisive decision-making when necessary
 - m. Money management
5. Chief resident responsibilities include:
- a. Liaison between faculty and residents
 - b. Assisting the Program Director in monitoring residents with problems and in giving feedback regarding progress or continued performance difficulties.
 - c. Assisting residents in contacting professionals for help with stress, personal problems, substance abuse, or other similar issues.
 - d. Advocating for resident needs and monitor resident stress.
 - e. Constructing an equitable call schedule.
 - f. Constructing an equitable rotation schedule subject to the approval of the Program Director.
 - g. Review and approve/deny resident vacation and elective requests prior to forwarding them to the Program Director.
 - h. Serving as a primary contact for residents with personal illness or emergencies and negotiating coverage of responsibilities with the family medicine residents.
 - i. Maintaining contact with other chief residents at Emory to coordinate schedules and communicate regarding issues of Graduate Medical Education and primary care residency training.
 - j. Represent the residents at faculty meeting and FMC providers meetings.
 - k. Serving on or delegating to residents committee assignments relevant to the Residency, Family Medicine Center, Hospital, and Medical School.
 - l. Chairing the Joint Faculty-Resident meetings and Resident Group meetings
 - m. Eliciting yearly evaluations of faculty by the residents and compiling comments to guarantee anonymity of residents
 - n. Investigating complaints regarding hospital patient care directed at the residents
 - o. Leading the family medicine service during the PGYI orientation in July.
 - p. Participating in setting recruiting goals and strategies for the program
 - q. Designating appropriate residents for use in the interviewing process
 - r. Sharing responsibility for interviewing all residency applicants
 - s. Providing each applicant with a resident contact for questions about the program
 - t. Identifying residents for lunches and dinners associated with recruiting.
 - u. Coordinating the Chief's Conference Series, Journal Club, and Mortality and Morbidity Rounds, including identifying residents and cases for presentation.
 - v. Training upcoming chief residents in assuming duties.
 - w. Assisting program director in getting scheduling requests and in running the yearly schedule.
 - x. Managing funds raised by the residents for resident activities.

W. Documentation

1. The ABFM requires residency training programs to document diagnoses made and procedures performed during training. This is necessary to address individual resident's deficits, allow modifications of the training program for all residents, and to support application for hospital privileges after completion of the residency.

2. A report of diagnoses and procedures will be compiled upon the completion of your training.
3. You should review your diagnosis/procedure list after each yearly printout to discuss areas where you need additional training or experience for your practice interests.
4. It is the ultimate responsibility of the resident to document diagnoses and procedures. Failure to do so may result in failure to recommend you for certain clinical privileges after graduation.
5. In order to document your diagnoses and procedures, you must do the following:
 - a. Diagnoses/Procedures within the FMC
 - i. During the routine of seeing patients at the FMC, you are responsible for correctly recording on the Encounter Form all diagnoses made and procedures performed on your patients.
 - ii. The office computer system will track all diagnoses and procedures at FMC.
 - iii. In order to document competence in a procedure, you must have your preceptor complete a procedure form (Attachments G-J) and this form must be turned in to the Program Coordinator.
 - b. Diagnoses/Procedures at Sites other than the FMC
 - i. Record diagnoses and procedures for all inpatients and outpatients seen in settings other than Emory Family Health on the diagnosis and procedure cards (Attachment K). This includes Crawford Long Hospital, Emory Dunwoody Medical Center, Emory Hospital and Clinics, Grady Hospital and Clinics, private physicians' offices and any other sites.
 - ii. The card must have the supervising physician's initials and patient's name and demographics.
 - iii. **Return these cards to the program coordinator monthly so they may be entered into your permanent diagnosis/procedure database.**
 - c. Moonlighting
 - i. You may record diagnoses/procedures during moonlighting activities.
 - ii. These diagnoses/procedures, however, must be under the supervision of another physician in order to be entered into your resident database.
 - iii. Procedures that have not been supervised may not be added to your resident database, but should be recorded by you for future privileging documentation.
 - d. Dictations
 - i. Dictated admission notes and discharge summaries are an additional source of documentation.
 - ii. Keep copies of these as backup documentation.

X. Electives

1. Electives must be selected with the advice and approval of the resident advisor.
2. An elective request form (Attachment L) must be completed **three months** prior to the elective or the resident will be assigned to a rotation by the Program Director.
3. Last minute changes of electives may be made, but FMC time will not be changed.
4. Only two months of elective time per year may be used to remediate a failed rotation.

5. If a resident desires doing an elective rotation that has not been done before, the resident **must write goals and objectives and a possible implementation strategy** and submit this to his/her advisor.
6. Overseas and out of state electives are possible as per Emory University GME policy. These rotations require a large amount of time to plan and the *resident is personally responsible for securing the funding for the rotation* and the continuance of benefits during this rotation.

Y. In-Training Exam (ITE)

1. It is the responsibility of the EFMRP to ensure the educational rigor of its academic program. Our goal is that 100% of our residency graduates score at the 50th percentile or greater on their initial Board Certification Exam (BCE) upon completion of the program.
2. The ITE is the most important measuring tool allowing personal and programmatic improvement to ensure ultimate universal success of the EFMRP on the ABFM Boards.
3. The design of the academic program will ensure adequate exposure is given to all possible examination topics in preparations for the board exam.
4. Selection of candidates for the EFMRP will be made utilizing prior test taking abilities as one of the academic indicators of future success on examinations. Such scores will not be considered the only indicator of success, however.
5. All EFMRP residents will take the ITE administered in November of each year.
6. All residents will review the answers to questions immediately following the administration of the examination, self-scoring themselves. Those residents who feel they need additional study will discuss this with the appropriate advisor in order to develop and document the plan in writing in the resident's training record.
7. Upon receipt of the ITE scores from the ABFM, the Program Director will analyze the weak areas. Residency-wide, corrective actions in curriculum will be recommended and implemented.
8. Upon receipt of the ITE scores from the ABFM, the faculty will meet with each resident with an analysis of personal scores. This data will be implemented into the normal periodic residency evaluations; objectives for excellence will be developed.
9. Residents who have achieved scores greater than the 20th percentile overall in each of the individual categories will be strongly encouraged to continue their present study habits and provided with methodologies to improve their examination scores to greater than 50th percentile.
10. Residents who have achieved scores greater than the 20th percentile overall but have achieved a score of less than the 20th percentile in any category will need to meet with their faculty advisor to construct a mandatory plan for additional experience, study and practice for the applicable topic(s). Residents with three areas less than the 20th percentile will be considered for academic probation.
11. Residents failing to achieve an overall score of greater than the 20th percentile will require a special academic plan and be considered for academic probation. This plan will be put in place for remediation. This plan may include: mandatory board review sessions, directed reading, test taking technique counseling, practice testing sessions, and stress reduction/desensitization strategies. The nature of the plan will depend on the circumstances and the recommendation of the faculty advisor and Program Director.

12. The program will measure and analyze Board Certification results (for certification and re-certification) to make programmatic improvements to assure the ultimate success of its future graduates.

IV. Clinical Duties

A. Family Medicine Center (FMC)

1. The resident is responsible for the care of her/his patients seen, including ordering and follow-up of laboratory and tests, paperwork, etc. **Laboratory and radiology results must be mailed to patients within 14 days of completion of the test.**
2. Residents shall be on time for the FMC responsibilities unless attending to emergent patient care problems on outside rotations. Residents should contact their respective FMC preceptor if they anticipate being late. Clinic report starts at 8:25 am and 1:25 pm for the morning and afternoon clinics respectively.
3. Residents shall precept according to government and residency-established guidelines. For the first six months of internship, all residents will present 100% of their patients to their preceptor. The preceptor will then see each patient themselves to verify the intern's findings. In the second six months of internship, interns will present 100% of cases to their preceptor. The preceptor is not required to see the intern's patients in the second six months.
4. **All OB patients will be precepted while the patients are still in clinic.**
5. **All Medicare and Medicaid patients will be precepted.** For Medicare or Medicaid patients being billed as level 4 or 5 visits, preceptors must see the patient, personally verify all findings, and write their own note.
6. Residents shall attend After Clinic Conference from 12:00 to 12:30 and from 5:00 to 5:30 when in clinic unless excused due to call or other rotation responsibilities.
7. See Appendix I for specifics on FMC Policies and Procedures.

B. Family Medicine Inpatient Service (FMS)

1. Residents are responsible for the inpatient care of patients while on the Family Medicine Service.
2. The on-service resident is required to record the name of the primary care provider in the patient chart and to notify the primary care physician when a patient is admitted.
3. **Residents are required to see their own FMC patients who are hospitalized and to direct the care of the patient.**
4. The on-service resident is responsible for completion of all discharge paperwork, including dictating discharge summaries.

C. Call

1. Residents are required to take call for Family Medicine during certain rotations in the PGY1 year and during most rotations during the PGY2 and PGY3 years.
2. EFMRP uses a night float system to cover the majority of call responsibilities. Night float runs from Sunday through Thursday, 6:30 pm to 8:30 am. Friday evening through Saturday morning (6:30 pm through 8:30 am) and Sunday from 8:30 am through 6:30 pm serve as one weekend call and the other weekend call is Saturday for 24 hours, starting at 8:30 am.
3. The chief residents create the Family Medicine resident call schedule.
4. There is also a back-up sick call system in the event a resident calls in sick and is unable to pull call.

5. Upper levels on call for Family Medicine are scheduled for back up call (different from sick call back up) and shall also answer outpatient phone calls for the practice. **Phone calls must be documented** and such documentation must be returned to the FMCs for filing in the patients' charts. The Program Director's office has a specific binder wherein residents file their phone consultations, should they be needed for future reference.
6. While on other services, the residents may be required to take call for those services as necessary.

V. Benefits

- A. Emory GME benefits for residents are outlined in the *House Staff Policies and Orientation Manual*. (Appendix E).
- B. Emory provides white coats and scrubs. The Emory GME provides each resident with a long white coat if desired.
- C. The program provides Basic Life Support (BLS)/Advanced Cardiac Life Support (ACLS)/Pediatric Advanced Life Support (PALS)/Neonatal Resuscitation Program (NRP) training to all PGY-1's. All PGY-3 residents are expected to maintain their certification, and may use CME funds and time to do so.
- D. As part of the obstetrics curriculum, EFMRP conducts an Advanced Life Support Obstetrics (ALSO) course that all PGY-1 and PGY-2 residents are expected to take once during their training.
- E. EFMRP may pay for residents to take Advanced Trauma Life Support (ATLS) if the resident feels this course will be of use in his/her future practice setting, subject to approval by the Program Director.
- F. EFMRP pays for all residents' AAFP and GAFP dues.

VI. Evaluation

A. Resident Evaluation and Development

1. Each resident will have an educational prescription (Attachment M) to aid in her/his professional development.
2. The prescription will be developed by the faculty as a whole during the Quarterly Resident Review, utilizing data from the following sources: resident self-assessment, rotation evaluations, FMC evaluations, nursing evaluations, in-training exam scores, critical incident reports, attendance records, previous educational prescriptions, and participation in residency activities.
3. Residents are responsible for completing the resident self-assessment and for ensuring that rotation evaluations have been completed and turned in by rotation preceptors.
4. Each resident's educational prescription will be summarized on the form entitled Emory Family Medicine Resident Educational Prescription by the respective faculty advisor. Each resident's educational prescription will be revised and updated at each Quarterly Resident Review.
5. The Residency Director will personally review and sign the written educational prescription to ensure its consistency with the faculty's intentions before it is presented to the resident. In the event the Residency Director's absence will significantly delay the educational prescription, the Residency Director may designate this responsibility to another faculty.

6. Faculty advisors will discuss the educational prescription with each resident within 2 weeks of the Quarterly Resident Review. Advance notice of the time frame during which residents need to meet with their advisors will be provided; it is then incumbent upon the resident to schedule an appointment. Inability to schedule an appointment with the advisor should be brought to the Residency Director's attention. The advisor and the resident will both sign the educational prescription to acknowledge that it was discussed. The resident will have the option of adding his/her written comments in the area provided on the form. A copy of the educational prescription will be furnished to the resident.
7. Whether or not the prescription was satisfactorily completed will be indicated on the backside of the form and signed and dated by the faculty advisor before the next Quarterly Resident Review. Written comments by either the advisor or the resident, particularly regarding the usefulness of learning experiences, are encouraged. Failure to complete educational prescriptions may result in adverse actions such as probation or dismissal.

B. Rotation Evaluation

1. As part of the curriculum review process, each resident is required to complete a critique (Attachment N) of each rotation and turn that in to the Program Coordinator. *Rotations are not considered to be complete until this requirement has been fulfilled.*

C. Faculty Evaluation

1. Resident Feedback on Faculty Performance is vital to ensure the best possible teaching to the residents and to aid in the development of effective teachers. It is also required by the RRC.
2. Resident Feedback on Faculty Performance consists of written assessments (on survey forms) of the residents' perceptions of the various teaching behaviors including: Clinical Precepting, Ward Attending, Large Group Presenting, Advising, Small Group Facilitating, and Citizenship/Role Modeling. This feedback will be continually collected for Clinical Precepting, Ward Attending, and Large Group (conference) Presentations and periodically collected for the overall assessments.
3. *Conference Feedback Forms* (Attachment O) are completed for every didactic session by all residents in attendance.
4. *Resident Assessment of Faculty Forms* (Attachment T) are completed annually.
5. *Preceptor Feedback Forms* (Attachment Q) are available for residents to complete.
6. *Ward Attending Feedback Forms* (Attachment R) are available for residents to complete.
7. Measures to Ensure Anonymity
 - a. Data on the dates of the feedback will not be available to the precepting or attending faculty. Data regarding the learner status and outpatient setting will not be provided to preceptors except in very large batches (e.g. six months of feedback data).
 - b. Comments will be transcribed and provided with a summary of the numerical ratings also in batches, so that no faculty will view original handwriting of residents and no fewer than 8 residents comments will be pooled.
8. Summary analyses of *Resident Feedback re: Faculty Performance* will be utilized initially by the faculty for self-assessment. They will provide data for the overall evaluation of faculty by themselves, the Chair and Chair's designee.

9. It is an explicit expectation that residents complete and turn in the designated forms as outlined in this policy.
10. Residents who do not complete the forms as required will have incompletely met the expectations of the Residency Program. This will be annotated in their Residency Folders and discussed at Quarterly Resident Reviews. Significant degrees (greater than 20%) of in-completion will be noted on individuals' Educational Prescription.

VIII. Organizational Structure

A. Organizational Chart (Appendix A)

B. Faculty Responsibilities

1. Provide a supportive learning environment
2. Be readily available when supervising.
3. Act as advisors and role models for the residents.
4. Attend Morning Report (unless excused due to schedule conflict)
5. Conduct After Clinic Conference.
6. Come to the Hospital for all ICU and Laboring patients when on-call.
7. Provide meaningful feedback to residents in a timely manner

C. Residency Staff Responsibilities (abbreviated)

1. Program Coordinator
 - a. Assist Program Director and Assistant Program Director
 - b. Scheduling
 - c. Recruitment
 - d. Budgeting
 - e. Assist Chief Residents
 - f. Maintain Current Curriculum, Brochures and Essential Personnel Data
2. Program Staff Assistant (abbreviated)
 - a. Assist Program Director and Program Coordinator
 - b. Data entry
 - c. Copying
 - d. Filing
 - e. Scheduling Pharmaceutical Representatives

D. Chief Resident Responsibilities

See Section III.V.5.a-v.

VIII. Faculty and Resident Information

A. Faculty (Appendix J)

B. Residents (Appendix K)

C. Graduates (Appendix L)

IX. Attachments

- A. Scholarly Project Approval Form
- B. Videotape Consent Form
- C. Leave Request Form
- D. Tax Exempt Letter
- E. Moonlighting Request Form

- F. Information Release Form
- G. Colposcopy Procedure Form
- H. Exercise Treadmill Procedure Form
- I. Flexible Sigmoidoscopy Procedure Form
- J. General Procedure Form
- K. Diagnosis/Procedure Card Example
- L. Elective Request Form
- M. Resident Evaluation Form
- N. Resident Critique of Rotation
- O. Conference Evaluation Form
- P. Educational Prescription Form
- Q. Quarterly Resident Evaluation Template
- R. Preceptor Feedback Form
- S. Resident Self-Assessment of Faculty Form
- T. Resident Assessment of Faculty Form
- U. Family Medicine Ward Attending Feedback Form
- V. Family Medicine Preceptor Feedback Form

X. Appendices

- A. Emory Organizational Diagram
- B. 2006-2007 Rotations
- C. Required Didactic Attendance Policy
- D. Dress Code Recommendations
- E. Emory University School of Medicine *House Staff Policies and Orientation Manual*
Web address: www.emory.edu/WHSC/MED/GME/TC_Index.html
- F. ABFM Information
- G. RRC Program Requirements
- H. RRC Institutional Requirements
- I. Family Practice Center Policies and Procedures
- J. 2006-2007 Faculty
- K. 2006-2007 Residents
- L. Graduates through June 2006
- M. Professional & General Liability Insurance