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1 INTRODUCTION

This document has been developed by the Family Medicine Residency Program in conjunction with the Department of Medical Education in order to familiarize trainees with Harnett Health System’s (HHS) - Family Medicine Residency Program. In addition to the Common Trainee Policy and Procedure Manual, this manual highlights standards for family medicine trainees and their successful completion of the residency program.

As a member of the trainee staff, you are entitled to well-defined rights and privileges while you participate in the educational goals of the program you have selected. This manual is a guidebook to the goals, regulations and policies of the training program.

The goal of our training programs is to provide high quality programs that provide each trainee a foundation for future medical training while fulfilling the accrediting bodies and its specialty college requirements for the selected program.

Family medicine is a discipline encompassing the study and practice of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness.

1.1 Mission Statement

Welcome to Harnett Health! We are happy to have you as a new member of our family!

Our Mission:

“Harnett Health is dedicated to providing quality and personalized care with respect and compassion. We are committed to making a difference throughout our communities with service excellence”.

1.2 Changes in Policies

This manual supersedes all previous trainee manuals and memos for the Family Medicine Residency Training Program. While every effort is made to keep the contents of this document current, HHS reserves the rights to modify, suspend, or terminate any of the policies, procedures, and/or benefits described in this manual with or without prior notice to trainees.
1.3 Educational Purpose

The Family Medicine Residency Program is structured to provide trainees with the fundamental knowledge and essential principles requisite to the practice of family medicine. The basic techniques of physical examination, the necessary skills for performing clinical procedures, and the capability to communicate clearly with patients, their families and other members of the health care team are stressed in this residency.

1.4 General Goals and Objectives

The specialty of family medicine consists of the prevention, diagnosis and treatment of diseases with emphasis on care of the whole patient from adolescent to elderly patients. The trainee will develop skills in building their scientific knowledge, scientific method of problem solving, evidence-based decision making, a commitment to lifelong learning, and an attitude of care that is derived from humanistic and professional values.

The major goal of the Family Medicine Residency Program is to assure the provision of safe and effective care to the individual patient; assure each trainee’s development of their skills, knowledge, and attitudes required to enter the unsupervised practice of family medicine; and, establish a foundation for continued professional growth.

In this residency program, trainees’ are expected to achieve mastery in the following core competencies:

1. Osteopathic Philosophy and Osteopathic Manipulative Medicine
   a. Integrate osteopathic principles into the diagnosis and management of patients.
   b. Apply osteopathic manipulative therapy to patient management where applicable.

2. Medical Knowledge
   a. Demonstrates medical knowledge of sufficient breadth and depth to practice family medicine
      i. Achieves an ABFM in-Training Examination or ACOFP in-Service Examination resident scaled score predictive of passing the certification examination
      ii. Appropriately uses, performs, and interprets diagnostic tests and procedures
      iii. Demonstrates life-long learning
   b. Applies critical thinking skills in patient care
3. Patient Care
   a. Cares for acutely ill or injured patients in urgent and emergent situations and in all settings
      i. Gathers essential information about the patient (history, exam, diagnostic testing, psychosocial context)
      ii. Recognizes role of clinical protocols and guidelines in acute situations
      iii. Consistently recognizes complex situations requiring urgent or emergent medical care
      iv. Appropriately prioritizes the response to the acutely ill patient
      v. Generates appropriate differential diagnoses for any presenting complaint
      vi. Develops appropriate diagnostic and therapeutic management plans for less common acute conditions
      vii. Addresses the psychosocial implications of acute illness on patients and families
      viii. Arranges appropriate transitions of care
      ix. Coordinates care of acutely ill patient with consultants and community services
      x. Demonstrates awareness of personal limitations regarding procedures, knowledge, and experience in the care of acutely ill patients
      xi. Provides and coordinates care for acutely ill patients within local and regional systems of care
   b. Cares for patients with chronic conditions
      i. Consistently applies appropriate clinical guidelines to the treatment plan of the patient with chronic conditions
      ii. Engages the patient in the self-management of his or her chronic condition
iii. Clarifies the goals of care for the patient across the course of the chronic condition and for his or her family and community

iv. Begins to manage the conflicting needs of patients with multiple chronic conditions or multiple comorbidities

v. Leads care teams to consistently and appropriately manage patients with chronic conditions and comorbidities

vi. Facilitates patients’ and families’ efforts at self-management of their chronic conditions, including use of community resources and services

vii. Personalizes the care of complex patients with multiple chronic conditions and comorbidities to help meet the patients’ goals of care

viii. Continually uses experience with patients and evidence-based medicine in population management of chronic condition patients

c. Partners with the patient, family, and community to improve health through disease prevention and health promotion

i. Explains the basis of health promotion and disease prevention recommendations to patients with the goal of shared decision making

ii. Describes risks, benefits, costs, and alternatives related to health promotion and disease prevention activities

iii. Partners with the patient and family to overcome barriers to disease prevention and health promotion

iv. Mobilizes team members and links patients with community resources to achieve health promotion and disease prevention goals

v. Tracks and monitors disease prevention and health promotion for the practice population

vi. Integrates disease prevention and health promotion seamlessly in the ongoing care of all patients

vii. Integrates practice and community data to improve population health

viii. Partners with the community to improve population health

d. Partners with the patient to address issues of ongoing signs, symptoms, or health concerns that remain over time without clear diagnosis despite evaluation and treatment, in a patient-centered, cost-effective manner

i. Facilitates patients’ understanding of their expected course and events that require physician notification

ii. Identifies the medical and social needs of patients with undifferentiated signs, symptoms, or health concerns
iii. Utilizes multidisciplinary resources to assist patients with undifferentiated signs, symptoms, or health concerns in order to deliver health care more efficiently

iv. Accepts personal responsibility to care for patients with undifferentiated signs, symptoms, or health concerns

v. Develops treatment plans that include periodic assessment and that use appropriate community and family resources to minimize the effect of the undifferentiated signs, symptoms, and health concerns for the patient

vi. Establishes rapport with patients to the degree that patients confidently accept the assessment of an undiagnosed condition

vii. Demonstrates comfort caring for patients with long-term undifferentiated signs, symptoms or health concerns

viii. Investigates emerging science and uses multidisciplinary terms to care for patients with undifferentiated signs, symptoms, or health concerns

ix. Contributes to the development of medical knowledge around undifferentiated signs, symptoms, and health concerns

e. Performs specialty-appropriate procedures to meet the health care needs of individual patients, families, and communities, and is knowledgeable about procedures performed by other specialists to guide their patients’ care.

i. Uses appropriate resources to counsel the patient on the indications, contraindications, and complications of procedures

ii. Identifies and actively seeks opportunities to assist with or independently perform additional procedures he or she will need for future practice

iii. Independently performs all procedures required for graduation

iv. Counsels the patient regarding indications, contraindications, and complications of procedures commonly performed by other specialties

v. Identifies a plan to acquire additional procedural skills as needed for practice

vi. Seeks additional opportunities to perform or assist with procedures identified as areas of need within the community.

4. Interpersonal and Communication Skills

a. Develops meaningful, therapeutic relationships with patients and families
i. Effectively builds rapport with a growing panel of continuity patients and families
ii. Respects patients’ autonomy in their health care decisions and clarifies patients’ goals to provide care consistent with their values
iii. Connects with patients and families in a continuous manner that fosters trust, respect, and understanding, including the ability to manage conflict
iv. Role models effective, continuous, personal relationships that optimize the well-being of the patient and family

b. Communicates effectively with patients, families, and the public
   i. Negotiates a visit agenda with the patient, and uses active and reflective listening to guide the visit
   ii. Engages patients’ perspectives in shared decision making
   iii. Recognizes non-verbal cues and uses non-verbal communication skills in patient encounters
   iv. Educates and counsels patients and families in disease management and health promotion skills
   v. Effectively communicates difficult information, such as end-of-life discussions, delivery of bad news, acknowledgement of errors, and during episodes of crisis
   vi. Maintains a focus on patient-centeredness and integrates all aspects of patient care to meet patients’ needs
   vii. Role models effective communication with patients, families, and the public
   viii. Engages community partners to educate the public

c. Develops relationships and effectively communicates with physicians, other health professionals, and health care teams
   i. Effectively uses Electronic Health Record (EHR) to exchange information among the health care team
   ii. Communicates collaboratively with the health care team by listening attentively, sharing information, and giving and receiving constructive feedback
   iii. Sustains collaborative working relationships during complex and challenging situations, including transitions of care
   iv. Effectively negotiates and manages conflict among members of the health care team in the best interest of the patient
   v. Role models effective collaboration with other providers that emphasizes efficient patient-centered care

d. Utilizes technology to optimize communication
   i. Ensures transitions of care are accurately documented, and optimizes communication across systems and continuums of care
ii. Effectively and ethically uses all forms of communication, such as face-to-face, telephonic, electronic, and social media

iii. Uses technology to optimize continuity care of patients and transitions of care

iv. Stays current with technology and adapts systems to improve communication with patients, other providers, and systems

5. Professionalism
   a. Completes a process of professionalization
      i. Recognizes that physicians have an obligation to self-discipline and to self-regulate
      ii. Engages in self-initiated pursuit of excellence
      iii. Embraces the professional responsibilities of being a family physician
      iv. Demonstrates leadership and mentorship in applying shared standards and ethical principles, including the priority of including the priority of responsiveness to patient needs above self-interest across the health care team
      v. Develops institutional and organization strategies to protect and maintain these principles
   b. Demonstrates professional conduct and accountability
      i. Recognizes professionalism lapses in self and others
      ii. Reports professionalism lapses using appropriate reporting procedures
      iii. Maintains appropriate professional behavior without external guidance
      iv. Exhibits self-awareness, self-management, social awareness, and relationship management
      v. Negotiates professional lapses of the medical team
      vi. Models professional conduct placing the needs of each patient above self-interest
      vii. Helps implement organizational policies to sustain medicine as a profession
   c. Demonstrates humanism and cultural proficiency
      i. Incorporates patients’ beliefs, values, and cultural practices in patient care plans
      ii. Identifies health inequities and social determinants of health and their impact on individual and family health
      iii. Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs
      iv. Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health
v. Develops organizational policies and education to support the application of these principles in the practice of medicine

d. Maintains emotional, physical, and mental health; and pursues continual personal and professional growth
   i. Actively seeks feedback and provides constructive feedback to others
   ii. Recognizes signs of impairment in self and team members, and respond appropriately
   iii. Appropriately manages situations in which maintaining personal emotional, physical, and mental health are challenged
   iv. Optimized professional responsibilities through the application of principles of physician wellness to the practice of medicine
   v. Maintains competency appropriate to scope of practice

6. Practice-Based Learning and Improvement
   a. Locates, appraises, and assimilates evidence from scientific studies related to the patients’ health problems
      i. Applies a set of critical appraisal criteria to different types of research, including synopses of original research findings, systematic reviews and meta-analyses, and clinical practice guidelines
      ii. Critically evaluates information from others, including colleagues, experts, and pharmaceutical representatives, as well as patient-delivered information
      iii. Incorporates principles of evidence-based care and information mastery into clinical practice
      iv. Independently teaches and assesses evidence-based medicine and information mastery techniques
   b. Demonstrates self-directed learning
      i. Has a self-assessment and learning plan that demonstrates a balanced and accurate assessment of competence and areas for continues improvement
      ii. Identifies own clinical information needs based, in part, on the values and preferences of each patient
      iii. Demonstrates use of a system or process for keeping up with relevant changes in medicine
      iv. Consistently evaluates self and practice, using appropriate evidence-based standards, to implement changes in practice to improve patient care and its delivery
      v. Regularly seeks to determine and maintain knowledge of best evidence supporting common practices, demonstrating
consistent behavior of regularly reviewing evidence in common practice areas

vi. Initiates or collaborates in research to fill knowledge gaps in family medicine

vii. Role models continuous self-improvement and care delivery improvements using appropriate, current knowledge and best-practice standards

c. Improves systems in which the physician provides care
   i. Uses a systematic improvement method (e.g., Plan-Do-Study-Act [PDSA] cycle) to address an identified area of improvement
   ii. Uses an organized method, such as a registry, to assess and manage populations health
   iii. Establishes protocols for continuous review and comparison of practice procedures and outcomes and implementing changes to address areas needing improvement
   iv. Role models continuous quality improvement of personal practice, as well as larger health systems or complex projects, using advanced methodologies and skill sets

7. Systems-Based Practice
   a. Provides cost-conscious medical care
      i. Coordinates individual patient care in a way that is sensitive to resource use, efficiency, and effectiveness
      ii. Partners with patients to consistently use resources efficiently and cost effectively in even the most complex and challenging cases
      iii. Role models and promotes efficient and cost-effective use of resources in the care of patients in all settings
   b. Emphasizes patient safety
      i. Uses current methods of analysis to identify individual and system causes of medical errors common to family medicine
      ii. Develops individual plan and participates in system improvement plans that promote patient safety and prevent medical errors
      iii. Consistently engages in self-directed and practice improvement activities that seek to identify and address medical errors and patient safety in daily practice
      iv. Fosters adherence to patient care protocols amongst team members that enhance patient safety and prevent medical errors
      v. Role models self-directed and system improvement activities that seek to continuously anticipate, identify and prevent medical errors to improve patient safety in all practice
settings, including the development, use, and promotion of patient care protocols and other tools

c. Advocates for individual and community health
   i. Identifies specific community characteristics that impact specific patients’ health
   ii. Understand the process of conducting a community strengths and needs assessment
   iii. Collaborates with other practices, public health, and community-based organizations to educate the public, guide-policies, and implement and evaluate community initiatives
   iv. Seeks to improve the health care systems in which he or she practices
   v. Role-models active involvement in community education and policy change to improve the health of patients and communities
d. Coordinates team-based care
   i. Engages the appropriate care team to provide accountable, team-based, coordinated care centered on individual patient needs
   ii. Assumes responsibility for seamless transitions of care
   iii. Sustains a relationship as a personal physician to his or her own patients
   iv. Accepts responsibility for the coordination of care, and directs appropriate teams to optimize the health of patients
   v. Role models leadership, integration, and optimization of care teams to provide quality, individualized patient care

General Goals and Objectives

1.5 Expected Outcome

The goal of the HHS’ Family Medicine Residency Program is to prepare trainees with the following special attributes:

- To produce outstanding clinicians in the field of family medicine.
- To produce clinicians who are grounded in evidence-based medicine.
- To produce clinicians who are compassionate and embody what it means to be a family physician.
- To view the patient in their entirety: mind, body and spirit.
- To produce clinicians who are proficient in all seven core competencies.
- To have a program that is compliant with all accrediting body’s basic and specialty standards.
• To create an environment that fosters research opportunities as well as other scholarly pursuits.
• To train family physicians and prepare individuals for career goals in hospital-based medicine, ambulatory-based medicine or fellowship training.

The expected outcomes of the HHS’ Family Medicine Residency Program are:

1. To prepare physician trainees to be holistically minded physicians in the specialty of family medicine. To be educationally well grounded in medical skills and scientific principles, and capable of providing quality comprehensive medical care to their patients.

2. To develop in trainees a sensitivity and understanding of the personal needs of individual patients and the interactions among the psychological, social and medical factors involved in patient care.

3. To provide opportunity for continual reexamination and evaluation of all facets of medical education so that the training offered remains current, effective and focused on the program objectives.

4. To provide opportunity for participants to develop leadership and teaching skills in the medical sciences as well as strengthen their own self-directed learning skills, so that they can effectively contribute to the education of their peers and physician trainees in the future.

5. To develop in physician trainees a strong understanding of the basic cognitive skills and knowledge that pertains to the physiology and pathophysiology of disease and their correlating clinical applications to medical diagnosis and management.

6. To exhibit progressive competencies in clinical and procedural medicine by performing procedures as well as learning appropriate interpretation skills as follows:

   a. **Required Procedures**: Proficiency in the following procedures, including indications, contraindications, complications, limitations, and interpretation: abdominal paracentesis, ACLS, arthrocentesis, central venous line placement, drawing venous blood, drawing arterial blood, electrocardiogram, incision and drainage of an abscess, lumbar puncture, nasogastric intubation, pap smear and endocervical culture, placing a peripheral venous line, pulmonary artery catheter placement, and thoracentesis. Proficiency will be documented by attending physicians, and record will be kept in trainees’ files.
b. **Required Interpretations:** Proficiency in interpretation of the following:
   i. EKG
   ii. Lab results

7. **Logs of Required Procedures and Interpretations:** Logs must be kept of the trainees’ caseload for each of the three years of training.

8. **Logs of ambulatory experience:** In addition, trainees must keep logs of their caseload for each of the three years of training.

Family medicine trainees are highly encouraged to track information in the [Resident Portfolio](#) of the www.theabfm.org.

### 1.6 Appointment

Appointments to HHS’ Family Medicine Residency Program are made on the recommendation of the Medical Education Executive Committee, the Program Director and the Vice President of Medical Education.

HHS is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, national origin or handicapped persons who, with reasonable accommodation, can perform the essential functions of the job.

The residency application process at HHS is as follows:

a. Interested applicants must apply through the National Residency Training Match Program (NRMP) via ERAS;
b. Upon receipt of information requested on the NRMP and available on ERAS, (i.e. three letters of professional reference, letter from your medical school Dean stating you are a student in good standing, board scores, and transcripts, the Department of Medical Education will contact applicants to arrange an appointment for an interview;
c. Trainee applicants are interviewed by the Program Director, Vice President of Medical Education, and members of the Medical Education Selection Committee;
d. Applicants are discussed at either the December or January Medical Education Committee Executive Session and either accepted or denied and a rank order list is generated;
e. HHS completes the National Intern Registration Match forms that are returned within the appropriate timeframe;
f. Once the results of the Match are returned, trainee contracts are mailed out within the time allotted by the accrediting body’s regulations.
1.7 Advanced Placement

HHS' Family Medicine Residency Program follows the guidelines for trainees requesting advanced placement of the accrediting body. The program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring trainee along with documentation of trainee evaluations. A request for advanced placement must be received from both the trainee and the program director at the advanced placement institution. This request must include the program director's assessment of the trainee's academic status/equivalency and the trainee's academic level in comparison to other trainees at the training level if advanced placement were to occur based on the accrediting body's milestones assessments. Determination of advanced placement within these guidelines shall be made to the accrediting body for consideration.

1. Advanced placement from non-family medicine fields: A maximum of one-month of credit may be awarded for each month of training in general family medicine or its subspecialties taken under the direction of an internist or medical subspecialist in an approved residency-training program.

2. Advanced placement from ACGME approved family medicine programs: A maximum of one (1) month of credit may be granted for each month of post graduate training satisfactorily completed in general or subspecialty family medicine in an ACGME approved program as verified by the program director.

3. Advanced placement from traditional osteopathic internship: One month of credit may be awarded for each month of training in family medicine or a medical subspecialty taken under the supervision of the training physician during an AOA rotating internship in an institution with an AOA or ACGME approved family medicine residency. A maximum of six months credit may be granted under this provision.

4. A request for advanced placement must be received from both the trainee and the program director at the advanced placement institution. This request must include the program director's assessment of the trainee's academic status/equivalency and the trainee's academic level in comparison to other trainees at the training level if advanced placement were to occur. Determination of advanced placement within these guidelines shall be made by the Council on Education and Evaluation of the ACOFP and reported to the COPT.
1.8 Promotion Criteria

PGY-1:

**Osteopathic Manipulative Medicine:**
1. 
2. 
3. 

**Patient Care:**
4. Consistently acquires accurate and relevant histories from patients.
5. Seeks and obtains data from secondary sources when needed.
6. Consistently performs accurate and appropriately thorough physical exams.
7. Uses collected data to define a patient’s central clinical problem(s).
8. Consistently develops appropriate care plan.
9. Recognizes situations requiring urgent or emergent care.
10. Seeks additional guidance and/or consultation as appropriate.
11. Requires indirect supervision to ensure patient safety and quality care.
12. Provides appropriate preventive care and chronic disease management in the ambulatory setting.
13. Provides comprehensive care for single or multiple diagnoses in the inpatient setting.
14. Under supervision, provides appropriate care in the intensive care unit.
15. Initiates management plans for urgent or emergent care.
16. Possesses basic technical skill for the completion of some common procedures.
17. Provides consultation services for patients with clinical problems requiring basic risk assessment.
18. Asks meaningful clinical questions that guide the input of consultants.

**Medical Knowledge:**
1. Possesses the scientific, socioeconomic and behavioral knowledge required to provide care for common medical conditions and basic preventive care.
2. Consistently interprets basic diagnostic tests accurately.
3. With assistance, understand the concepts of pre-test probability and test performance characteristics.
4. Fully understands the rational and risks associated with common procedures.

**Practice-Based Learning Improvement:**
1. Shows initiative in self-reflection and seeks assistance in acting upon those reflections.
2. Shows initiative in pursuing opportunities for learning and self-improvement.
3. Analyzes own clinical performance data and identifies opportunities for improvement.
4. Effectively participates in a quality improvement project.
5. Understands common principles and techniques of quality improvement and appreciates the responsibility to assess and improve care for a panel of patients.

6. Solicits feedback only from supervisors.

7. Is open to unsolicited feedback.

8. Shows initiative to incorporate feedback.

9. “Slows down” to reconsider an approach to a problem, ask for help, or seek new information.

10. Can translate medical information needs into well-formed clinical questions independently.

11. Aware of strengths and weaknesses of medical information resources but utilizes information technology without sophistication.

12. Seeks assistance in appraising clinical research reports, based on accepted criteria.

Interpersonal and Communication Skills:

1. Engages patients in shared decision making in uncomplicated conversations.

2. Seeks assistance in facilitating discussions in difficult or ambiguous conversations.

3. Seeks guidance or assistance to engage in communication with persons of different socioeconomic and cultural backgrounds.

4. Engages in collaborative communication with appropriate members of the team.

5. Employs verbal, non-verbal, and written communication strategies that facilitate collaborative care.

6. Health records are organized and accurate but are superficial and miss key data or fail to communicate clinical reasoning.

Professionalism:

1. Consistently respectful in interactions with patients, caregivers and members of the interprofessional team, even in challenging situations.

2. Is available and responsive to needs and concerns of patients, caregivers and members of the interprofessional team to ensure safe and effective care.

3. Emphasizes patient privacy and autonomy in all interactions.

4. Completes administrative and patient care tasks in a timely manner in accordance with local practice and/or policy.

5. Completes assigned professional responsibilities without questioning or the need for reminders.

6. Seeks to fully understand each patient’s unique characteristics and needs based upon culture, ethnicity, gender, religion, and personal preference.

7. Modifies care plan to account for patient’s unique characteristics and needs with partial success.
8. Honest and forthright in clinical interactions, documentation research, and scholarly activity.
9. Demonstrates accountability for the care of patients.
10. Adheres to ethical principles for documentation, follows formal policies and procedures, acknowledges and limits conflict of interest, and upholds ethical expectations of research and scholarly activity.

**Systems-Based Practice:**
1. Understands the roles and responsibilities of all team members but uses them with assistance.
2. Participates in team discussions when required and seeks input from other team members when necessary.
3. Recognizes the potential for error within the system.
4. Identifies obvious or critical causes of error and notifies supervisor accordingly.
5. Recognizes the potential risk for error in the immediate system and takes necessary steps to mitigate that risk.
6. Willing to receive feedback about decisions that may lead to error or otherwise cause harm.
7. Recognizes that external factors influence a patient’s utilization of health care and may act as barriers to cost-effective care.
8. Minimized unnecessary diagnostic and therapeutic tests.
9. Has a basic understanding of cost-awareness of principles for a population of patients (e.g. screening tests).
10. Recognizes the importance of communication during times of transition.
11. Communication with future caregivers is present.

**Second Year Trainee:**

**Osteopathic Manipulative Medicine:**
1. 
2. 
3. 

**Patient Care:**
1. Acquires accurate histories from patients in an efficient, prioritized, and hypothesis-driven fashion.
2. Performs accurate physical exams that are targeted to the patient’s complaints.
3. Synthesizes data to generate a prioritized differential diagnosis and problem list.
4. Effectively uses history and physical examination skills to minimize the need for further diagnostic testing.
6. Appropriately modifies care plans based on patient’s clinical course, additional data, and patient preferences.
7. Recognized disease presentations that deviate from common patterns and require complex decision-making.
8. Manages complex acute and chronic diseases.
9. Independently manages patients across inpatient and ambulatory clinical settings who have a broad spectrum of clinical disorders including undifferentiated syndromes.
10. Seeks additional guidance and/or consultation as appropriate.
11. Appropriately manages situations requiring urgent or emergent care.
12. Effectively supervises the management decisions of the team.
13. Possesses technical skill and has successfully performed all procedures required for certification.
14. Provides consultation services for patients with basic and complex clinical problems requiring detailed risk assessment.
15. Appropriately weights recommendations from consultants in order to effectively manage patient care.

Medical Knowledge:
1. 1 through 4 of PGY 1; and,
2. Possesses the scientific, socioeconomic and behavioral knowledge required to provide care for complex medical conditions and comprehensive preventive care.
3. Interprets complex diagnostic tests accurately.
4. Understands the concepts of pre-test probability and test performance characteristics.
5. Teaches the rational and risks associated with common procedures and anticipates potential complications when performing procedures.

Practice-Based Learning Improvement:
1. 1 through 12 of PGY 1; and,
2. Regularly self-reflects upon one’s practice or performance and consistently acts upon those reflections to improve practice.
3. Recognizes sub-optimal practice or performance as an opportunity for learning and self-improvement.
5. Actively engages in quality improvement initiatives.
6. Demonstrates the ability to apply common principles and techniques of quality improvement to improve care for a panel of patients.
7. Solicits feedback from all members of the interprofessional team and patients.
8. Welcomes unsolicited feedback.
9. Consistently incorporates feedback.
10. Routinely “slows down” to reconsider an approach to a problem, ask for help, or seek new information.
11. Routinely translates new medical information needs into well-formed clinical questions.
12. Utilizes information technology with sophistication.
13. Independently appraises clinical research reports based on accepted criteria.

Interpersonal and Communication Skills:
1. 1 through 6 of PGY 1; and,
2. Identifies and incorporates patient preference in shared decision making across a wide variety of patient care conversations.
3. Quickly establishes a therapeutic relationship with patients and caregivers, including persons of different socioeconomic and cultural backgrounds.
4. Incorporates patient-specific preferences into plan of care.
5. Consistently and actively engages in collaborative communication with all members of the team.
6. Verbal, non-verbal and written communication consistently acts to facilitate collaboration with the team to enhance patient care.
7. Health records are organized, accurate, comprehensive, and effectively communicate clinical reasoning.
8. Health records are succinct, relevant, and patient specific.

Professionalism:
1. 1 through 10 of PGY 1; and,
2. Demonstrates empathy, compassion and respect to patients and caregivers in all situations.
3. Anticipates, advocates for, and proactively works to meet the needs of patients and caregivers.
4. Demonstrates a responsiveness to patient needs that supersedes self-interest.
5. Positively acknowledges input of members of the interprofessional team and incorporates that input into plan of care as appropriate.
6. Prioritizes multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner.
7. Willingness to assume professional responsibility regardless of the situation.
8. Recognizes and accounts for the unique characteristics and needs of the patient/caregiver.
9. Appropriately modifies care plan to account for patient’s unique characteristics and needs.
10. Demonstrates integrity, honesty, and accountability to patients, society and the profession.
11. Actively manages challenging ethical dilemmas and conflicts of interest.
12. Identifies and responds appropriately to lapses of professional conduct among peer group.

**Systems-Based Practice:**
1. 1 through 11 of PGY 1; and,
2. Understands the roles and responsibilities of and effectively partners with all members of the team.
3. Actively engages in team meetings and collaborative decision-making.
4. Identifies systemic causes of medical error and navigates them to provide safe patient care.
5. Advocates for safe patient care and optimal patient care systems.
6. Activates formal system resources to investigate and mitigate real or potential medical error.
7. Reflects upon and learns from own critical incidents that may lead to medical error.
8. Consistently works to address patient specific barriers to cost-effective care.
9. Advocates for cost-conscious utilization of resources (i.e. emergency department visits, hospital readmissions).
10. Incorporates cost-awareness principles into standard clinical judgments and decision-making, including screening tests.
11. Appropriately utilizes available resources to coordinate care and ensures safe and effective patient care within and across delivery systems.
12. Proactively communicates with past and future care givers to ensure continuity of care.

**Third Year Trainee:**

**Osteopathic Manipulative Medicine:**
1. 
2. 
3. 

**Patient Care:**
1. 1 through 15 of PGY 2; and,
2. Obtains relevant historical subtleties, including sensitive information that informs the differential diagnosis.
3. Identifies subtle or unusual physical exam findings.
4. Efficiently utilized all sources of secondary data to inform differential diagnosis.
5. Role models and teaches the effective use of history and physical examination skills to minimize the need for further diagnostic testing.
6. Role models and teaches complex and patient-centered care.
7. Develops customized, prioritized care plans for the most complex patients, incorporating diagnostic uncertainty and cost effectiveness principles.
8. Manages unusual, rare, or complex disorders.
10. Seeks to independently perform additional procedures (beyond those required for certification) that are anticipated for future practice.
11. Teaches and supervises the performance of procedures by junior members of the team.
12. Switches between the role of consultant and primary physician with ease.
13. Provides consultation services for patients with very complex clinical problems requiring extensive risk assessment.
14. Manages discordant recommendations from multiple consultants.

Medical Knowledge:
1. 1 through 5 of PGY 2; and,
2. Possesses the scientific, socioeconomic and behavioral knowledge required to successfully diagnose and treat medically uncommon, ambiguous and complex conditions.
3. Anticipates and accounts for pitfalls and biases when interpreting diagnostic tests and procedures.
4. Pursues knowledge of new and emerging diagnostic tests and procedures.

Practice-Based Learning Improvement:
1. 1 through 13 of PGY 2; and,
2. Regularly self-reflects and seeks external validation regarding this reflection to maximize practice improvement.
3. Actively engages in self-improvement efforts and reflects upon the experience.
4. Actively monitors clinical performance through various data sources.
5. Is able to lead a quality improvement project.
6. Utilizes common principles and techniques of quality improvement to continuously improve care for a panel of patients.
7. Performance continuously reflects incorporation of solicited and unsolicited feedback.
8. Able to reconcile disparate or conflicting feedback.
9. Searches medical information resources efficiently, guided by the characteristics of clinical questions.
10. Role models how to appraise clinical research reports based on accepted criteria.
11. Has a systematic approach to track and pursue emerging clinical questions.

Interpersonal and Communication Skills:
1. 1 through 8 of PGY 2; and,
2. Role models effective communication and development of therapeutic relationships in both routine and challenging situations.
3. Models cross-cultural communication and establishes therapeutic relationships with persons of diverse socioeconomic backgrounds.
4. Role models and teaches collaborative communication with the team to enhance patient care, even in challenging settings and with conflicting team member opinions.
5. Role models and teaches importance of organized, accurate, and comprehensive health records that are succinct and patient specific.

Professionalism:
1. 1 through 12 of PGY 2; and,
2. Role models compassion, empathy and respect for patients and caregivers.
3. Role models appropriate anticipation and advocacy for patient and caregiver needs.
4. Fosters collegiality that promotes a high-functioning interprofessional team.
5. Teaches others regarding maintaining patient privacy and respecting patient autonomy.
6. Role models prioritizing multiple competing demands in order to complete tasks and responsibilities in a timely and effective manner.
7. Assists others to improve their ability to prioritize multiple, competing tasks.
8. Role models professional interactions to negotiate differences related to a patient’s unique characteristics or needs.
9. Role models consistent respect for patient’s unique characteristics and needs.
10. Assists others in adhering to ethical principles and behaviors including integrity, honesty, and professional responsibility.
11. Role models integrity, honesty, accountability, and professional conduct in all aspects of professional life.
12. Regularly reflects on personal professional conduct.

Systems-Based Practice:
1. 1 through 12 of PGY 2; and,
2. Integrates all members of the team into the care of patients, such that each is able to maximize their skills in the care of the patient.
3. Efficiently coordinates activities of other team members to optimize care.
4. Viewed by other team members as a leader in the delivery of high quality care.
5. Advocates for system leadership to formally engage in quality assurance and quality improvement activities.
6. Viewed as a leader in identifying and advocating for the prevention of medical error.
7. Teaches others regarding the importance of recognizing and mitigating system error.
8. Teaches patients and healthcare team members to recognize and address common barriers to cost-effective care and appropriate utilization of resources.
9. Actively participates in initiatives and care delivery models designed to overcome or mitigate barriers to cost-effective high quality care.
10. Coordinates care within and across health delivery systems to optimize patient safety, increase efficiency and ensure high quality patient outcomes.
11. Anticipates needs of patient, caregivers and future care providers and takes appropriate steps to address those needs.
12. Role models and teaches effective-transitions of care.

1.9 Eligibility Requirements

The program director will comply with the qualification requirements of the Institutional Requirements of the accrediting body.

Additional Eligibility Requirements for Trainees Transferring from another Program:

All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant’s level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program.

A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.

A Review Committee may grant the exception to the eligibility requirements specified in Section III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission.

Review Committees will grant no other exceptions to these eligibility requirements for residency education.
1.10 Terms of Service

The contract will be issued for a period of one year. Contracts for the next year of training will be issued in March each year upon satisfactory performance during the current year. The Program Director, Vice President of Medical Education and the Medical Education Promotion and Advancement Committee will determine if continuation in the training program will be granted.

Under qualifying circumstances, residencies may be extended through the FMLA. All leaves must be reported to the Program Director and the Vice President of Medical Education, the Medical Education Committee, Human Resources and the subcommittee on Residency Training of the accrediting body. All additional time taken off during residency must be made up at the end of the contract year and prior to the next level of training.
2 COMPORTEMENT

2.1 Area of Responsibility

1) Trainees are responsible for their respective service as noted in the curricula section of this manual.

2) Senior trainees are responsible for making sure orders are written and reviewed if written by a junior trainee for patients admitted to their service during the day and while on call for all unit patients on the in-patient service or co-managed by the attending physician.

3) History and physical forms are not the responsibility of the trainee.

4) Senior trainees are required to review the admit notes of all admissions to their service and discuss them with the junior trainees and medical students. Trainees will have a note written to supplement the admit note on all in-patients or co-managed by an attending physician with a plan or recommendation when on call.

5) Senior trainees are to round on their service patients daily, unless scheduled off and either review the note written by the junior trainee/medical students or write the daily progress note.

6) Trainees when on an in-house rotation are to actively participate in morning report.

7) Trainees are to attend all in-house lectures, unless a patient’s well-being is at risk.

8) Trainees are not to work more than 80 hours per week and must adhere to Duty Hour requirements as noted in the Common Trainee Policy and Procedure Manual throughout residency training.

9) Coverage of new trainees by junior or senior trainees shall be for a period initially of three (3) months.

10) When a trainee is called to admit a patient, a call must be made to the admitting physician.

11) It is not the responsibility of the trainee to review ER’s, EKGs, or lab work on patients not admitted.

12) Medicine trainees are not responsible for pediatric patient care unless it is a “Code Blue”.

13) It is not the trainee’s responsibility to obtain DNR’s on patients unless they are admitting the patient or it is a new change of the family’s thinking or the patient’s wishes. The trainee is not to discuss the DNR with families of patients that are not acquainted with their progress. This is the responsibility of the attending physician.

14) Trainees cannot take verbal orders from physicians that have patients on the unit. They must discuss the case with the attending physician or subspecialist who is managing the patient in the unit.

15) The trainees are to assume the role assigned by the attending physician when on service and to notify the attending of any acute change in the patient’s condition.

16) Trainees are to respond to all codes within the hospital.
17) Attend all meetings as directed by the program director.
18) Participate in an assigned hospital committee and other committees as directed by the program director.
19) Participate each year in the annual Trainee In-Service Examination.
20) Maintain certification in advanced cardiac life support that must be kept current during residency.
21) Attend continuing education program of respective college once during the training program.
22) Participate in a scholarly activity.
23) Complete formal written feedback about the program and teaching faculty.
24) Participate in an annual evaluation of program goals and curriculum.
25) Maintain and comply with all required documentation (e.g., including but not limited to: time logs, patient logs, procedure logs, etc.)
26) Function in an ethical and professional manner.

2.2 Family Medicine Program Director Job Description

JOB SUMMARY:
The Medical Education Committee will approve the hire and/or change in the program director. The program director must comply with the following actions and procedures of the accrediting body: to undergo a site visit in the required time period; to follow directives associated with an approval action; and, to supply the accrediting body with requested information. The program director will be expected to spend at a minimum of 28 hours per week in the administration, evaluation, teach, resident precepting, and scholarship of the residency training program.

ESSENTIAL JOB RESPONSIBILITIES:
• The program director will report to the director of medical education
• The program director will be responsible for verifying that each trainee is meeting or exceeding the minimum standards of the program.
• The program director will oversee and ensure the quality of didactics and clinical education at all sites that participate in the program:
  o Will approve a local director at each participating site who is accountable for trainee education
  o Will monitor trainee supervision at all participating sites
  o Shall inform the base institution of participating institution arrangements so that affiliation agreement, memorandum of understanding (MOU), and program letter of agreement (PLA) can be properly executed
  o Must submit any additions or deletions of participating sites routinely providing an educational experience, required for all trainees, of one month full time equivalent (FTE) or more through the accrediting body’s data system
• The program director will evaluate program faculty
- Will approve the selection of program faculty as appropriate
- Will approve the continued participation of program faculty based on evaluations
- The program director will oversee the program and trainees as described in accrediting body’s standards
- The program director will prepare required material for on-site program review and/or documentation as requested by the accrediting body
- The program director will provide the trainee with all documents pertaining to the training program and shall also provide to the trainee the requirements for satisfactory completion of the program
- The program director must approve and arrange supervision of the trainee's required scholarly activity
- The program director shall ensure compliance with grievance and due process procedures as set forth in the accrediting body’s common and specialty requirements and implemented by the sponsoring institution
- The program director will provide verification of residency education for all trainees, including those who leave the program prior to completion
- The program director will implement policies and procedures consistent with the institutional and program requirements for trainee duty hours and the working environment, including moonlighting
  - Will distribute policies and procedures to the trainees and faculty
  - Will monitor trainee duty hours monthly to ensure compliance with accrediting body’s requirements
  - Will adjust trainee schedules as necessary to mitigate excessive service demands and/or fatigue
  - Will monitor the demands of at-home call (if applicable) and adjust schedules as necessary to mitigate excessive service demands and/or fatigue
- The program director will monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged
- The program director will comply with the sponsoring institution’s written policies and procedures, including those specified in the accrediting body’s common and specialty requirements, for selection, evaluation and promotion of trainees, disciplinary action, duty hours, moonlighting, and supervision of trainees
- The program director will be familiar with and comply with accrediting body and review committee policies and procedures as outlined in the accrediting body’s manual of policies and procedures
- The program director will obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting information or requests to the accrediting body:
  - All applications for accrediting body’s accreditation of new programs
  - Changes in trainee complement
  - Major changes in program structure or length of training
  - Progress reports requested by the Review Committee
  - Requests for increases or any change to trainee duty hours
The program director will obtain DIO review and co-signature on all program application forms, as well as any correspondence or documents submitted to the accrediting body that addresses:
  o Program citations
  o Request for changes in the program that would have significant impact, including financial, on the program or institution

- The program director will monitor trainee stress, including mental or emotional conditions inhibiting performance or learning, and drug- or alcohol-related dysfunction
  o Both the program director and faculty will be sensitive to the need for timely provision of confidential counseling and psychological support services to trainees
  o Situations that demand excessive service or that consistently produce undesirable stress on trainees will be evaluated and modified

- The program director will be available and accessible to trainees at the primary teaching site
- The program director must maintain clinical skills by providing direct patient care
- The program director will oversee development of an effective trainee advising program
- The program director will have supervisory authority over all educational tracks in the Family Medicine Residency Program
- The program director will conduct the family medicine component of special educational tracks under the auspices of the Department of Family Medicine
- The program director will ensure that the residency does not place excessive reliance on trainees for service as opposed to education
- The program director will participate in academic societies and in educational programs designed to enhance his or her educational and administrative skills

**OTHER POSITION RESPONSIBILITIES:**
- The program director is responsible for coordinating all schedules, including lectures and educational sessions, allocating appropriate time for trainee participation. The program director must provide a method to document trainee attendance at these meetings
- The program director must administer and maintain an educational environment conducive to educating the residents in each of the accrediting body’s competency areas
- Participate in and foster an approach to continuously improving quality in the Family Medicine residency program
- Maintain all required licensure, certifications and competencies for the position
- Ability to dedicate at least 70% of associated time for program director responsibilities
- The program director must review the results of the annual in-service examination with each trainee by the end of the training year
- Performs other duties as assigned
POSITION QUALIFICATIONS:
Education: An earned degree from an accredited college of osteopathic or allopathic medicine

Experience:
• Requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee
  o A minimum of five (5) years of clinical experience in family medicine, with two years as a core faculty member in an accredited family medicine residency program
  o At least three (3) years of graduate medical education administrative experience prior to appointment
• A valid medical license and ability to obtain North Carolina licensure
• Current certification in the specialty by the American Board of Family Medicine, or specialty qualifications that are acceptable to the Review Committee
• Appropriate medical staff appointment
• Membership in good standing in all appropriate professional and governmental organizations
• Membership in good standing with specialty college and accrediting body
• Demonstrated record in teaching and leadership from an accredited medical school;
• Demonstrated potential for successful leadership of an residency training program; and,

Types of Contacts: The Program Director of Family Medicine reports directly to the Director of Medical Education.

Job Related Skills: Thorough and demonstrated knowledge of the clinical interventions and equipment necessary to meet the specific needs of the patient population served.

Interpersonal Skills: Excellent communication and human relation skills including the ability to interact effectively and professionally with co-workers, other employees, the medical staff, patients, families, and the general public.

2.3 Family Medicine Teaching Faculty (Core Faculty) Job Description

At each participating site, there must be a sufficient number of teaching-faculty with documented qualifications to instruct and supervise all trainees at that location. Core faculty members will work closely with the program director, associate program director (if applicable), faculty, and program coordinator in developing and implementing the evaluation system, trainee education and mentoring of family medicine trainees.

The teaching faculty must:
• Devote a minimum of 24 hours per week to the educational program to fulfill their supervisory and teaching responsibilities; and, to demonstrate a strong interest in the education of residents
• Administer and maintain an educational environment conducive to educating trainees in each of the accrediting body’s competency areas
• Provide advising for trainees in the areas of educational goal-setting, career planning, patient care, and scholarship
• Meet professional standards of behavior
• Report to the program director
• Attend training sessions on the evaluation and assessment of the accrediting body’s competencies
• Review all trainee notes and write an attending note on all patients
• Perform monthly chart reviews with the trainees to ensure that the charts are in compliance with appropriate guidelines

POSITION QUALIFICATIONS:
• Be licensed to practice medicine in the state in which the training site is located
• Have appropriate medical staff appointment and maintain admitting privileges
• Be certified in their area of specialty by the appropriate medical board
• Be an active member in good standing in the department they are assigned
• Be clinically active (i.e. direct patient care or in the supervision of patient care)
• Supervise all procedures performed by trainees
• Establish and maintain an environment of inquiry and scholarship with an active research component
  o Regularly participate in organized clinical discussions, rounds, journal clubs, and conferences
  o Demonstrate scholarship by one or more of the following:
    ▪ Peer-reviewed funding
    ▪ Publication of original research or review articles in peer reviewed journals, or chapters in textbooks
    ▪ Publication or presentation of case reports of clinical series at local, regional, or national professional and scientific society meetings
    ▪ Participation in national committees or educational organizations.
  o Encourage and support trainees in scholarly activities
• Is responsible for clinical teaching during clinic sessions as well as at least one lecture per month to trainees on selected family medicine topics. Family Medicine Clinic Preceptors must be present at the Family Medicine Clinic at all times when trainees are seeing patients, i.e. when trainee clinics are in session
• Maintain adequate economic records at the family medicine practice training site
• Be willing to precept medical students, interns and trainees on clinical rotations as the preceptor’s schedule permits
• Complete all paperwork as dictated by the Department of Medical Education (annual reports, quarterly evaluations, etc.)
• Must follow the rules and regulations regarding supervision of trainee physicians by CMS. Additionally, review of documentation and trainee participation in cases is required for the trainee to demonstrate within their portfolio
• Complete monthly trainee evaluations and participates in annual review of trainee performance/advancement decisions. Trainees will also complete monthly faculty evaluations, which are reviewed by the DME and program director and reported to faculty members. 360-degree evaluations are also completed on each trainee on a semi-annual basis and quarterly evaluations are performed by the program director on each trainee
• Evaluate trainee procedural and patient care competency “real-time”

2.4 Chief Resident Job Description

The Chief Resident for the Family Medicine Residency Program will be nominated by the Program Director upon consultation and advice from the Graduate Medical Education Committee, Director of Medical Education, Vice President of Medical Education and the Administrative DME (ADME).

The Chief Resident position contains both a leadership and administrative position meant to improve and facilitate the training program for medical students and trainees at Harnett Health.

Qualifications:
The Chief Resident must:
• Be a trainee in good standing at Harnett Health preferably in their senior year of training
• Demonstrate an interest and participation in the educational programs at Harnett Health
• Demonstrate excellent rapport with peers
• Receive approval for acceptance of the position of Chief Resident by the applicant’s Program Director
• Demonstrate and participate in scholarly activity, as well as possessing the work habits appropriate and consistent with the mentoring responsibilities of the position
• Be willing and able to attend training and skill development session on the evaluation and assessment of the accrediting body’s competencies

Responsibilities: (Inclusive of but not limited to)

1. Assist in development of the trainee rotation schedule.
2. Is responsible for scheduling topics for FM lectures, journal club and board review, etc.
3. Assist in development of and supervision of the trainee on-call schedule.
4. Act as liaison between the Department of Medical Education and all house staff, medical students and allied health students.
5. Act as liaison between trainees and nursing staff.
6. Attend all Graduate Medical Education Committee meetings.
7. Must keep all logs and inpatient and outpatient charts current.
8. Actively mentor trainees, medical students and allied health students in the areas of scholarly activity, professional/ethical behavior and work habits.
9. The Family Medicine Chief Resident(s) will report to the program director. In the absence of the program director, the chief resident will report to the director of medical education, Administrative DME, the Chairperson of the Graduate Medical Education Committee, and the Vice President of Medical Affairs, in this order.
8. Introduce all Guest Lecturers/Presenters at morning and noon lectures.
9. Serve as member of a peer review committee and subcommittee of the GMEC as needed.
10. Assist with the development and procurement of resources to support medical education activities at Harnett Health.
11. Attend House Staff meetings monthly.

Compensation:

Chief Resident Stipend: The Chief Resident will receive a stipend as commensurate with their level of training plus an additional $1,000 per year (i.e. PGY 3 annual salary plus $1,000)

Terms of appointment shall be for one year.

2.5 Annual In-Service Examination

The trainees are required to take, at a minimum, the annual in-service examination. Other acceptable performance standards will be determined by the program director. Those trainees scoring less than 20% shall undergo an academic prescription by their direct advisor approved through the DME/Program Director.

2.6 Research Responsibility

1. Original research, accepted for publication by peer review journal – meets all requirements
2. Original Research, accepted and presented at Local, Regional or National Convention (poster presentation) – meets all requirements

3. Participation in Journal Club, inclusive of obtaining, assigning and presenting articles with written critique of articles submitted for review by program director twice annually. Trainee participation in Journal Club will be review and evaluated twice annually by the program director

4. Participation in Review of Medical Literature Didactics, in conjunction with CUSOM, offered twice annually

5. Participation in and submittal of written reports reviewing the medical literature for Peer Review Activities in compliance with policies and procedures of the QM/UR Committee, Critical Care Committee or Department of Family Medicine

6. Participation in and submittal of written reports, inclusive of medical literature review, in conjunction with the Quality Improvement Initiatives of Harnett Health.

7. Presentation of four (4) lectures annually inclusive of medical literature review and evaluation by family medicine physicians of the presentation at either House Staff Formal Didactics, Local, Regional or National Conference, or Medical Staff/Departmental Meeting

8. Authoring a grant.

Timeline:

1. By August 1st of the first year a topic should be chosen. (PGY 1)

2. By January 1st of the 2nd year a literature review should be presented to program director/director of medical education

3. By July 1st of the 3rd year implementation and movement forward

4. By March 1st of the 3rd year a product meeting the ACOFP guidelines must be presented to the program director/director of medical education. * Resources available

5. Must meet with program director on all critical steps

Note: This is mandatory for AOA/ACOFP approval of your Residency

Return to the beginning of the Manual
3 PROGRAM SPECIFIC CURRICULUM

Goals: To create a Family Medicine Residency experience designed to prepare family medicine trainees for practice in a community and/or rural based setting. The residency program will facilitate the diagnostic and therapeutic skills of physicians in training utilizing patients encompassing the total health care of the individual and the family. This includes the physiological, emotional, cultural, economic, psychological and environmental factors as they relate to the disease process.

NOTE: Curriculum designated with an * incorporates the American Academy of Family Physicians (AAFP)’s curriculum as noted on their website: http://www.aafp.org/medical-school-residency/program-directors/curriculum.html

3.1 Family Medicine Residency Curriculum (including Community Medicine Rotations)

At the completion of the training program, the graduate shall:

A. Accurately identify potential medical problems.
   1. Describe the medical problems presented
   2. Define information in the patient record which aids in said description
   3. Elicit and record appropriate history which defines the problem
   4. Develops knowledge of diagnostic testing and procedures
   5. Perform an accurate physical examination to identify and confirm the problems
   6. Utilize and interpret laboratory and ancillary testing to define or discover problems

B. Accurately diagnose problems.
   1. Describe potential etiologies for each presenting problem
   2. Gathers and synthesized essential and accurate information to define each patient’s clinical problem(s)
   3. Develops and achieves comprehensive management plan for each patient
   4. Manages patients with progressive responsibility and independence
   5. Develops skill in performing procedures
   6. Requests and provides consultative care
   7. Identify signs and symptoms for each problem
   8. Prioritize findings with respect to potential etiologies
   9. Rank potential disorders by likelihood based on presence or absence of findings

C. Confirm the diagnosis of the problem.
   1. Describe the diagnostic resources for each disorder
   2. Generate a diagnostic plan to appropriately confirm the disorder
   3. Perform diagnostic procedures where appropriate
4. Properly interpret results of testing, recognizing the relative sensitivity and specificity of the tests
5. Understand cost effective diagnostic planning

D. Competently treats the problems.
   1. Define the needs and circumstances of the patient
   2. Describe the conventional and alternative therapies for each problem
   3. Generate treatment plans which are cost effective
   4. Monitors practice with a goal for improvement
   5. Learns and improves via performance audit
   6. Learns and improves via feedback
   7. Learns and improves at the point of care
   8. Monitor response to initiated treatment, including appropriate follow-up testing if needed
   9. Determine efficacy of chosen treatment

E. Communicate effectively.
   1. Use standard English effectively
   2. Use accepted medical terminology appropriately
   3. Communicates effectively with patients and caregivers
   4. Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals, and other support personnel)
   5. Appropriate utilization and completion of health records
   6. Develop listening skills for patient, family, and ancillary providers
   7. Effectively and sensitively respond to patient questions and fears or concerns
   8. Record data and plans clearly and completely in progress notes, summary reports, history and physical reports, and procedure reports
   9. Develop prompt responsiveness to requests for information or explanation
   10. Demonstrate reasonable facility in use of computer network information and record keeping systems

F. Demonstrate professionalism.
   1. Be characterized as competent, approachable, empathetic, conscientious, and cooperative;
   2. Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel)
   3. Accepts responsibility and follows through on tasks
   4. Responds to each patient’s unique characteristics and needs
   5. Exhibits integrity and ethical behavior in professional conduct
   6. Develop sensitive yet definitive leadership capabilities when dealing with house staff, students, or ancillary staff
   7. Demonstrate honesty, reliability, and morality
8. Develop a commitment to the medical community and the advancement of medical care in the population

G. Develop strong work habits.
1. Demonstrate ability and commitment in the use of continuing medical education tools, such as journals, computer-assisted instruction, and involvement in conference activities both as learner and instructor
2. Works effectively within an interprofessional team (e.g. peers, consultants, nursing, ancillary professionals, and other support personnel)
3. Recognizes system error and advocates for system improvement
4. Identifies forces that impact the cost of health care, and advocates, for, and practices cost-effective care
5. Transitions patients effectively within and across health delivery systems
6. Recognize personal limitations and obtain appropriate assistance where necessary
7. Perform all record keeping activities promptly and thoroughly
8. Understand requirements of operating in the managed care environment, and how to maximize efficiency
9. Recognize the medico-legal aspects of care, and manage risks appropriately

3.2 Competency-Based Evaluation

The American Academy of Family Physicians global evaluation form will be completed by the attending and reviewed by the trainee to assess all seven-core competencies:

a) Procedure Log
b) End of service examination may be given at the discretion of the attending physician

Outcome Assessment: The national in-service examination will be used to provide both the individual trainee and the attending with feedback on the rotation.

3.3 Rotation Curriculum

The Family Medicine Residency Program will consist of the following rotations:

In-patient:
Trainees must have at least 600 hours (or six months) and 750 patient encounters
dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions

ICU Patients:
Trainees must have at least 100 hours (or one month) or 15 encounters dedicated to the care of ICU patients

Emergency Medicine:
Trainees must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting

Geriatric Medicine:
Trainees must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of the older patient. The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases

Pediatrics:
Trainees must have at least 200 hours (or two months) and 250 patient encounters dedicated to the care of ill child patients in the hospital (125 minimum) and/or emergency setting (125 minimum).

Pediatrics Ambulatory Setting:
Trainees must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of children and adolescents in an ambulatory setting. Care to include well-child care, acute care, and chronic care.

Newborn Care:
Trainees must have at least 40 newborn patient encounters, including well and ill newborns.

Surgery:
Trainees must have at least 100 hours (or one month) dedicated to the care of surgical patients, including hospitalized surgical patients. This experience must include operating room experience.

Musculoskeletal:
Trainees must have at least 200 hours (or two months) dedicated to the care of patients with a breadth of musculoskeletal problems. This experience must include a structures sports medicine experience.

Women's Health:
Trainees must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and options counseling for unintended pregnancy.

Obstetrics and Gynecology:
Trainees must document 200 hours (or two months) dedicated to participating in deliveries and providing prenatal and post-partum care. This experience must include a structures curriculum in prenatal, intra-partum, and post-partum care. This experience must include prenatal care, labor management, and delivery.
management.

Health System Management:
Trainees must have at least 100 hours (or one month) dedicated to health system management experiences.

Other Disciplines:
Trainees must have experience in diagnosing and managing:
- Dermatology
- Behavioral Health
- Psychiatry
- Community Medicine
- Diagnostic Imaging Interpretation and Nuclear Medicine Therapy
- Exposure to multiple medical and surgical subspecialties

Elective:
Trainees must have at least 300 hours (or three months) dedicated to elective experiences

Vacation:
Trainees will be provided four weeks or vacation per academic year

Sample rotation schedule:
PGY 1:
Block 1: Ambulatory Family Medicine
Block 2: Elective
Block 3: Out-patient Pediatrics
Block 4: Surgery
Block 5: Gynecology
Block 6: Geriatrics
Block 7: Medical Selective
Block 8: In-patient Pediatrics
Block 9: Emergency Medicine
Block 10: Vacation
Block 11: Obstetrics and Gynecology
Block 12: In-patient Medicine
Block 13: In-patient Medicine

PGY 2:
Block 1: Dermatology
Block 2: Elective
Block 3: Radiology
Block 4: Intensive Care Unit
Block 5: Behavioral Health
Block 6: In-patient Pediatrics
Block 7: Osteopathic Musculoskeletal
Block 8: Out-patient Pediatrics
Block 9: Emergency Medicine
Block 10: Vacation
Block 11: Obstetrics and Gynecology
Block 12: In-patient Medicine
Block 13: In-patient Medicine

PGY 3:
Block 1: Ambulatory Family Medicine
Block 2: Elective
Block 3: Out-patient Pediatrics
Block 4: Ambulatory Family Medicine
Block 5: Psychiatry
Block 6: Gynecology
Block 7: Medical Selective
Block 8: Sports Medicine
Block 9: Emergency Medicine
Block 10: Vacation
Block 11: Health Systems Management
Block 12: In-patient Medicine
Block 13: In-patient Medicine

3.4 Procedures

Trainees are provided the opportunity to perform procedures as they arise. Trainees are expected to become proficient in the following procedures:

1) Sufficient experience and training to ensure proficiency in the following procedures, including indications, contraindications, complications, limitations and interpretation as specified by the specialty board:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Indications; Contraindications; Recognition &amp; Management of Complications; Pain Management; Sterile Techniques</th>
<th>Specimen Handling</th>
<th>Interpretation of Results</th>
<th>Requirements &amp; Knowledge to obtain Informed Consent</th>
<th>Perform Safely and Competently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal paracentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Advanced cardiac life support</td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Arterial line</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
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<table>
<thead>
<tr>
<th>Procedure</th>
<th>1st Rot</th>
<th>2nd Rot</th>
<th>3rd Rot</th>
<th>4th Rot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthrocentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
</tr>
<tr>
<td>Drawing venous blood</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Drawing arterial blood</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Incision and drainage of an abscess</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nasogastric intubation</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pap smear &amp; endocervical culture</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Placing a peripheral venous line</td>
<td>X</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pulmonary artery catheter placement</td>
<td>X</td>
<td>N/A</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Formal lectures, hands-on labs and videotape procedure demonstrations are used to introduce the procedure and review anatomy and indications/contraindications of the procedure. Trainees are assigned or designated as the “procedure trainee” on the internal medicine in-patient rotation. This arrangement rotates on a monthly basis and trainees are directly supervised by attending staff until proficiency develops.

Trainees will develop procedural skills on elective rotations; such as, cardiology, pulmonary, nephrology, gastroenterology, radiology and hematology under the direct tutelage of the attending physicians. Additional skills in intubation and central lines are obtained, if needed, with the assistance of the anesthesiology department, by assigning the trainee to the department in the morning hours from 0700-1000 to perform intubations, central lines and peripheral IV access.

Mastery of skills is demonstrated during the second residency year on intensive care unit and internal medicine in-patient service, trainee logs are reviewed and the trainee is signed off as independent in the procedure and the medical staff office will be notified in writing.
• All procedures are done under the supervision of an attending physician who is responsible for the care of that patient. This supervision can be direct or indirect, depending on the experience of the trainee.
• Do not start any non-emergency procedure until you obtain permission from the responsible attending physician.
• PGY 1 trainees should have first opportunity to do procedures on patients assigned to their care.
• Informed consent must be obtained before starting unless it is an emergency.
• Procedure notes must be written immediately after the procedure.
• Procedure logs must be completed by the trainee and signed by the supervising trainee/attending.
• Each time a procedure log is reviewed, the program director will assign a privilege status as follows:
  • Level I = Indirect, supervision only – PGY 1
  • Level II = Perform and teach with indirect supervision – PGY 2
  • Level III = Perform with indirect supervision; can teach and certify others – PGY 3

Trainees unable to master their skill level as indicated above will be assigned additional procedure assignments until such time that the level is mastered. Those trainees in their PGY 3 level will not be eligible for graduation. Individual adjustments and accommodations are made on a case-by-case basis for those trainees unable to master the skills as indicated above and additional training options are constantly evaluated.

3.5 Call Responsibility
1) 1st, 2nd and 3rd year trainees will provide unit coverage from 5 p.m. – 7 a.m. daily. This includes in-patient admissions, as well as, complications that develop. 1st year trainees are not responsible for consults unless specified by the attending.
2) Trainees must see and write an admit note on all admissions while they are on call.
3) The emergency room physicians will discuss the patient with the attending first before the trainee is to be involved in that patient's care.
4) Trainees are not responsible for consultations (medical) at night (5 p.m. – 7 a.m.) unless it is urgent.
5) Trainees are not to have call more frequently than once every five days.
6) Attending physicians are to be second on call for all trainees.
7) Trainees' call is between 5 p.m. – 7 a.m. on Monday through Friday and 7 a.m. – 7 a.m. on Saturday and Sunday. On designated holidays (i.e. Easter, 4th of
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3.6 Rotation Specific Curriculum

A. Continuity of Care Training

1. Continuity of care will be a major component of this residency-training program.
   a) Each trainee is expected to maintain continuity of care of 1650 in-person patient encounters. (165 of these patient encounters must be with patients younger than 10 years of age and 165 patient encounters must be with patients 60 years of age or older). When such patients require hospitalization or consultation with other health care providers. The trainee will maintain participation in the decision making process as it relates to the health of the patient.
   b) For those patients unable to visit the continuity of care site, trainees will receive experience in home care and care in long-term care facilities.
   c) Trainee patient encounters will include telephone visits, e-visits, group visits, and patient-peer education sessions.

2. The major focus of this training program is providing comprehensive primary care for patients in the ambulatory and in-patient setting.

4. The trainees will be required to monitor their patient population as it relates to age, gender, and ethnicity.

5. Each trainee will be assigned a designated panel of patients.

July, Labor Day, Thanksgiving, Christmas, New Year's Day, and Memorial Day) call will be 7 a.m. – 7 a.m.

8) On weekends the trainees will evaluate all in-patients and conduct daily care under supervision and wishes of the respective attending.

9) If an internist has a patient in the unit who is critical, they may sign out to the evening trainee if that particular internist does not have a trainee on their service.

10) It is the duty of the trainee on call to evaluate all patients in the unit who have an acute change, write a note, and notify the attending if warranted between 5 p.m. – 7 a.m. on call.

11) If an acute situation in the unit occurs and supervision or input is needed and the attending is unable to be reached, then either the Chairman of Medicine or the Director of the unit are to be called for that input or supervision until the attending has responded.

12) No patient is to be admitted to the unit unless verified or approved by the patient’s respective attending (managing the patient in the unit).

13) Trainees are not to be called to order routine lab work, x-rays, or EKGs on patients when on call.

14) If a patient is directly admitted to the unit, orders are to be written by the attending or the attending is to call the trainee with a history and preliminary diagnosis and the trainee will write the orders.
a) The trainee will be responsible, under supervision, for the health care needs of their assigned panel of patients.
b) The trainee will be identified as the healthcare provider for their panel of patients.
c) As the skill and proficiency of the trainee increases, the trainee’s schedule will be modified accordingly.

6. Trainees will see patients in their continuity of care clinic for a minimum of forty weeks per year.

7. It is the goal of the ambulatory care experience to train individuals to be both productive and efficient in a primary care setting. The trainee will become proficient in:
   a) The appropriate utilization of osteopathic principles and manipulative treatment
   b) Diagnose and management of medical and surgical conditions
   c) Their ability to perform office procedures
   d) Incorporating preventive measures
   e) Providing patient education
   f) Providing counseling
   g) Coordination of care
   h) Managing consultations
   i) Maintaining accurate and eligible medical records

B. Osteopathic Manipulative Medicine

Trainees will receive instruction in the clinical application of osteopathic manipulative medicine. At the end of the residency-training program, the trainee will:
   a) Become proficient in OMM
   b) Receive training in OMM in both the outpatient and inpatient setting
   c) Receive didactic instruction and hands on training
   d) Be exposed to multiple treatment technique approaches
   e) Understand coding and reimbursement as it relates to OMM

C. Inpatient Medicine

The trainee will become proficient in their ability to competently manage hospitalized patients. The trainee will be able to:
   a) Manage acute and chronic illness
   b) Obtain appropriate consultation
   c) Coordinate the care of the patient
   d) Manage transfer of care to and from the primary care setting
   e) Produce comprehensive medical records
   f) Organize utilization management and discharge planning

D. Emergency Medicine

The trainee will rotate 8-weeks in emergency medicine. Training shall include:
a) Didactic and clinical training
b) Triage emergency patients of all ages
c) Certification in ACLS
d) Stabilize and provide initial treatment for medical emergencies
e) Stabilize and provide initial treatment for surgical emergencies
f) Stabilize and provide initial treatment for psychiatric emergencies
g) Stabilize and provide initial treatment for pediatric emergencies

E. In-patient Medicine
The trainee will be provided clinical training in family medicine. Training shall include:
  a) 6-blocks of inpatient experience
  b) Four weeks of training in critical care medicine
c) Didactic training
d) Exposure to the following disciplines, in either inpatient or outpatient settings:
   1. Cardiology
   2. Endocrinology
   3. Gastroenterology
   4. Hematology
   5. Infectious diseases
   6. Nephrology
   7. Neurology
   8. Oncology
   9. Pulmonology
   10. Rheumatology
e) The trainee will be provided the opportunity to develop competency in:
   1. The management of hospitalized adult patients
   2. Cooperative management of patients with sub-specialists colleagues
   3. Pre-operative medical evaluation

F. Women’s Health
1. The trainee will be provided 4-weeks of training in women’s health. The trainee will receive training:
   a) Through didactic and clinical training experiences
   b) In gender specific health care needs of women
   c) In domestic violence identification and prevention
d) Gynecology
e) Obstetrics
f) Breast Disease

2. The gynecological portion of this training experience will include both ambulatory and in-hospital patient care. The trainee will become proficient in:
   a) Family planning
b) Preventive medicine  
c) Management of the abnormal PAP smear  
d) Disorders of menstruation  
e) Gynecological infections  

3. The obstetrical portion of this training experience will include both ambulatory and in-hospital patient care. The trainee will become proficient in:  
a) Prenatal care  
b) Labor and delivery  
c) Postnatal care  
d) Medical complications of pregnancy  

G. Pediatrics and Adolescent Medicine  
The residency-training program will provide 16-weeks of training in pediatrics and adolescent medicine (8-weeks in-patient; 8-weeks out-patient). The trainee will gain experience in the:  
a) Care of the newborn  
b) Ambulatory pediatrics  
c) Well childcare  
d) Inpatient pediatrics.  
e) Emergency care of children  

H. Surgery  
The residency-training program will provide the trainee with 4-weeks of training in surgical disciplines. The trainee will gain experience in:  
a) Preoperative and post-operative care  
b) Training in the following sub-specialties, which may be ambulatory or inpatient  
  1. Ophthalmology  
  2. Orthopedics  
  3. Urology  
  4. ENT  

I. Geriatrics  
The residency-training program will provide the trainee with 4-weeks of training in the care of the geriatric patient. The trainee will gain experience in:  
a) Physiological changes of aging  
b) Pharmacokinetics in the elderly  
c) Functional assessment of the elderly  
d) ECF management  
e) Hospice  
f) Home care  

J. Behavioral Medicine
The residency training program will provide the trainee with experience in behavioral science. At a minimum this shall include:
   a) Psychiatric and psychological diagnoses common to family medicine
   b) The treatment of substance abuse
   c) Didactic instruction and clinical experiences
   d) Interviewing skills
   e) Counseling skills
   f) Psychopharmacology
   g) Physician well being

K. Practice Management
   1. The residency training program will provide the trainee with structured educational experiences in practice management. This training shall include:

      a) Debt management.
      b) Retirement planning
      c) Financial planning
      d) Disability insurance
      e) Medical liability insurance
      f) Risk management
      g) Coding
      h) HIPAA requirements in the ambulatory setting
      i) OSHA requirements for private practices
      j) Payer mix and practice overhead management
      k) Personnel management
      l) The program will utilize actual practice financial data to teach the principals of office practice management

L. Community Medicine
   The residency training program will provide training with community medicine. This shall include time spent in any of the following experiences:
   a) Occupational health
   b) Mental health agencies
   c) Community based screening programs
   d) Public health agencies
   e) Community health centers
   f) Free clinics
   g) Drug and alcohol treatment centers
   h) School health programs
   i) Homeless shelters

M. Electives
The residency program will provide the trainee with the opportunity to partake in supervised electives available to all trainees during the course of their residency training. All such rotations shall be approved by the Program Director who will assess the need for out rotations.

3.7 Competencies

**Educational Purpose:** Each goal listed will provide the foundational elements for each competency-based experience. Each of these seven core competencies will be evaluated on every learning experience and service to which trainees are exposed.

**Competency 1: Osteopathic Principles and Practice:**
1. The learner shall integrate osteopathic principles into the diagnosis and management of patient clinical presentations.
2. The learner shall apply osteopathic manipulative therapy in patient management where applicable.
3. The learner shall emphasize the interactions of the neuromusculoskeletal and internal systems and the application of osteopathic principles and practices (OPP) as they relate to patients with varied clinical disorders.
4. The learner shall demonstrate implementation of OPP and OMM assessment through:
   a. Pre and post self-efficacy assessment
   b. “Osteopathic Principles” patient questionnaire
   c. Faculty direct observation assessment and chart review

**Competency 2: Patient Care:**
1. Prioritize a patient’s problem
2. Prioritize a day of work
3. Monitor and follow up on patients appropriately
4. Demonstrate caring and respectful behaviors with patients and families
5. Gather essential/accurate information via interviews and physical exams and reviews other data
6. Provide services aimed at preventing or maintaining health
7. Work with all health care professionals to provide patient-focused care
8. Know indications, contraindications, and risks of invasive procedures
9. Competently performs invasive procedures
10. Understand and weight alternatives for diagnosis and treatment
11. Use diagnostic procedures and therapies appropriately
12. Elicit subtle findings on physical examination
13. Obtain a precise, logical and efficient history
14. Interpret results of procedures properly
15. Is able to manage multiple problems at once
16. Make informed decisions about diagnosis and therapy after analyzing clinical data
17. Develop and carry out management plans
18. Consider patient preferences when making medical decisions
19. Triage patients to appropriate location
20. Spend time appropriate to the complexity of the problem

**Competency 3: Medical Knowledge:**
1. Use written and electronic reference and literature sources to learn about patients’ diseases
2. Demonstrate knowledge of basic and clinical sciences
3. Apply knowledge to therapy
4. Is aware of indications, contraindications and risks of commonly used medications and procedures
5. Demonstrate knowledge of epidemiological and social-behavioral sciences
6. Demonstrate an investigatory and analytic approach to clinical situations

**Competency 4: Practice-Based Learning Improvement:**
1. Understand his/her limitations of knowledge
2. Elicit help when needed
3. Is self-motivated to acquire knowledge
4. Is able to identify strengths, deficiencies, and limits in one’s knowledge and expertise
5. Set learning and improvement goals
6. Identify and perform appropriate learning activities
7. Analyze practice using quality improvement methods, and implement changes with the goal of practice improvement
8. Use information technology to optimize learning
9. Participate in the education of patients, families, students, trainees and other health professionals
10. Incorporate formative evaluation feedback into daily practice
11. Use PowerPoint, Word, Internet and other computerized sources of results and information such as, “Up-to-Date” to enhance patient care
12. Accept feedback and develop self-improvement plans
13. Undertake self-evaluation with insight and initiative
14. Facilitate the learning of students and other health care professionals
15. Analyze personal practice patterns systematically, and looks to improve
16. Compare personal practice patterns to larger populations
17. Locate, appraise and assimilate scientific literature appropriate to specialty
18. Apply knowledge of study design and statistics
19. Demonstrate the ability to investigate and evaluate the care of patients
20. Appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning
**Competency 5: Interpersonal and Communication Skills:**

1. Write pertinent and organized notes
2. Has timely and legible medical records
3. Use effective listening, narrative and non-verbal skills to elicit and provide information
4. Communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
5. Act in a consultative role to other physicians and health professionals
6. Work effectively as a member of the health care team
7. Create and sustain therapeutic and ethically sound relationships with patients and families
8. Provide education and counseling to patients, families and colleagues
9. Is able to discuss end-of-life care with patient/families
10. Work effectively as a member or leader of the health care team
11. Work effectively as a leader of the health care team

**Competency 6: Professionalism:**

1. Establish trust with patients and staff
2. Does not refuse to treat patients
3. Demonstrate respect for patient privacy and autonomy
4. Is accountable to patients, society and the profession
5. Is honest, reliable, cooperative and accepts responsibility
6. Show regard for opinions and skills of colleagues
7. Is free from substance abuse or satisfactorily undergoing rehabilitation
8. Demonstrate respect, compassion and integrity
9. Is responsive to the needs of patients and society, which supersedes self-interest
10. Display initiative and leadership
11. Is able to delegate responsibility to others
12. Demonstrate commitment to on-going professional development
13. Demonstrate commitment to ethical principles pertaining to the provision or withholding of care, patient confidentiality, informed consent and business practices
14. Demonstrate sensitivity to patient culture, gender, age, preferences and disabilities
15. Acknowledge errors and works to minimize them
16. Is effective as a consultant

**Competency 7: Systems-Based Practice:**

1. Is a patient advocate
2. Make constructive comments
3. Advocate for high quality patient care and assists patients in dealing with system complexity
4. Apply knowledge of how to partner with health care providers to assess, coordinate and improve patient care
5. Use systematic approaches to reduce errors
6. Work in interprofessional team to enhance patient safety and improve patient care quality
7. Participate in developing ways to improve systems of practice and health management
8. Demonstrate ability to adapt to change
9. Provide cost effective care
10. Understand how individual practices affect other health care professionals, organizations and society
11. Demonstrate knowledge of types of medical practice and delivery systems
12. Practice effective allocation of health care resources that does not compromise the quality of care

3.8 Osteopathic Manipulative Medicine and Osteopathic Principles and Practice

**Educational Purpose:** To provide the trainee, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will enhance their knowledge and skills in osteopathic manipulative medicine and osteopathic principles and practice.

**Overview:** Osteopathic Manipulative Medicine/Family Medicine is a longitudinal rotation that engages the resident in the basic tenets of osteopathic medicine with special interaction in osteopathic manipulative treatment with a diverse patient group of acute, sub-acute, and chronic complaints. These complaints may range from purely musculoskeletal problems and pain to visceral diseases with musculoskeletal components and visceral related symptoms secondary to musculoskeletal dysfunction.

The learner will spend approximately 25 hours per year engaged in didactic and reviewing hands-on osteopathic palpatory diagnosis and treatment in various related osteopathic integrated learning scenarios. These sessions will be integrated into the Sports Medicine and Practice Management months. During this time, the learner will also participate in reading assignments of up-to-date scientific articles and discussion of their impact on practice as evidence-based medical decision-making. (Most core text will be based on OMT Review 3rd edition by Robert G Savarese DO and Atlas of Osteopathic Techniques 2nd edition Dr. Alexander and Evan Nicholas). Additional educational opportunities will be grounded in hands-on-patient demonstration, videotape curriculum, OSCE, COLIS, OMT clinic, opportunities for hands-on-workshop, board review, inpatient and outpatient structural exams (Structural Exam Form – Exhibit 7.4), research review, journal club and informal didactic teaching.
Goals of Core Curriculum:

- 1st Year
  - Knowledge of OMM involving axial spine (AOA Guidelines)
  - Structural Exam
  - Understanding of viscera-somatic dysfunction
  - Competent using basis techniques – HVLA, Counterstrain, Muscle Energy
  - Understand contraindications to OMM

- 2nd and 3rd Year
  - Advanced techniques
  - Extremity Manipulation
  - Cranial
  - Coding and practice management aspects of OMM

3.9 OMM/Family Medicine Clerkship Core Competencies

Osteopathic Principles and Practice Goal: Students will integrate osteopathic principles and practice routinely into the conventional care of patients seeking an osteopathic model of care.

Objective: The student will:

1. Recognize that the Osteopathic philosophy is applicable to all patients.
2. Identify those patients who would benefit from Osteopathic Manipulative Treatment (OMT)
3. Demonstrate attitudes and behaviors consistent with the Osteopathic philosophy.
4. Appropriately educate inquisitive patients and their family, naïve to Osteopathic philosophy.
5. Demonstrate the ability to diagnose somatic dysfunction, implement an appropriate manipulative medicine prescription, and demonstrate mastery in effective OMT
6. Perform at standard at least 10-inpatient Osteopathic Structural Exams.
7. Attend monthly GME meeting on specified rotations.(when available)
8. Complete COILS evaluation at the end of rotation

Competency 1: Osteopathic Philosophy and Osteopathic Manipulative Medicine

Required Elements:

- Demonstrate competency in the understanding and application of OMT appropriate to the medical specialty.
- Integrate Osteopathic Concepts and OMT into the medical care provided to patients as appropriate.
- Understand and integrate Osteopathic Principles and Philosophy into all clinical and patient care activities.
Methods to Achieve Compliance:

- Use of hands-on workshops and didactic instruction on OMM in a mandatory rotating core curriculum that occurs in the Sports Medicine and Practice Management Rotations
- Real time evaluation in one-to-one perceptorship set up with a board certified Family Physician. This is a designed specific core curriculum to introduce basic philosophy, OMM perspectives, research, and Manual Medicine techniques
- Residents attend the GME meetings when available and are encouraged to freely interact with the committee to best optimize their education
- Additionally, they are instructed by the assistant DME in clinical practice in both the Inpatient and Outpatient arena

Methods for evaluation:

- Chart Review, Direct Observation, Simulated OSCE patients and Logs
- The residency program has approved in-patient and out-patient standard forms for Osteopathic specific evaluation and assessment of a patient.
- Quarterly review of case logs and chart review by the OEC is underway

3.10 Osteopathic Manipulation (OMT) and Precepting:

The following policy is in effect for all osteopathic trainees who have received at least 150 hours in medical school OPP/OMM training and have completed a refresher course and overview of OMT.

**Policy:** The trainee performing OMM/OPP must be supervised by an osteopathic physician. If an osteopathic physician is not available, then the trainee may use only techniques that they have become proficient in performing (i.e. demonstrated and signed proficiency). Otherwise, the patient will be rescheduled during a time when the osteopathic physician is available.

Note: The osteopathic physician must sign all OMM charts for billing purposes. A copy of all structural exams will be provided to the osteopathic DME for review and signature.

All 1st and 2nd year osteopathic trainees are credentialed in the following procedures and are competent to perform independently.

3.11 Substance Abuse*

**Educational Purpose:** To provide the trainee, through didactic and clinical experience in outpatient and inpatient settings, with educational experiences that will enhance their knowledge and skills in diagnosing and managing patients with substance abuse.

**Format:** This curriculum will be taught in both clinical and didactic formats. Training sites for residents will include substance abuse treatment programs and their own continuity practices. Other areas will include community programs, groups such as AA, talks with law enforcement agencies and participation in counseling sessions at addiction treatment facilities. Through exposure to outpatient, inpatient, and residential substance abuse treatment programs, trainees will experience the process of recovery and gain familiarity with referral resources. With their own panel of continuity patients, trainees will be able to demonstrate competency in substance abuse screening, assessment, intervention with families and individuals, and referral. Trainees will also demonstrate competency in caring for families affected by substance use disorders and in the primary prevention of substance use disorders, particularly for children, adolescents, and pregnant women.

At the completion of residency training, a family medicine trainee should:

- Demonstrate respectful, nonjudgmental, and caring behaviors toward patients who have substance use disorders
- Be able to obtain a thorough history regarding the patient’s substance use. History may include questions about behaviors that may be socially unacceptable or illegal
- Be able to develop and facilitate interventions and treatment plans for patients who have substance use problems
- Demonstrate screening, brief office intervention, and motivational interviewing techniques for patients with substance abuse disorders
- Understand and be able to educate patients and their families about the disease model of addiction and its expected course
- Be able to locate and use evidence-based resources for the diagnosis and treatment of substance abuse

I. **Core Competency 1: Osteopathic Principles**
   a. Osteopathic principles.
      i.
II. Core Competency 2: Medical Knowledge
   a. The trainee will demonstrate the ability to apply knowledge of:
      i. The epidemiology of substance use disorders and their impact on society, including:
         1. Overall prevalence of hazardous use and dependence
         2. Risk factors for substance abuse and dependence
         3. Contribution to major causes of morbidity and mortality by age groups, such as cardiovascular disease, cancer, hepatitis, cirrhosis, homicide, suicide, motor vehicle accidents, trauma, acquired immune deficiency syndrome (AIDS), and other infections including sexually transmitted diseases.
      ii. Commonly abused drugs, their physiologic effects and metabolism, and related withdrawal syndromes:
         1. Tobacco
         2. Alcohol
         3. Cannabis
         4. Sedative/hypnotics, including prescription medications such as benzodiazepines and barbiturates
         5. Opioids, buprenorphine, methadone and other prescription medications, iv, oral, transdermal, and transmucosal
         6. Amphetamines
         7. “Club” or designer drugs, including methylenedioxymethamphetamine (MDMA), gamma-hydroxybutyric acid (GHB), rohypnol, ketamine, and dextromethorphan
         8. Cocaine in all its forms
         9. Hallucinogens
         10. Anabolic steroids
         11. Inhalants
         12. PCP
         13. Other drugs common in the community served by the residency, as well as awareness of current drug use “trends”
      iii. Relevant pharmacology, including:
         1. Concepts of tolerance, cross-tolerance, physical dependence, psychological dependence, addiction, and withdrawal
         2. Use of DSM-IV, NIAAA, and NIDA terminology to describe the spectrum of substance abuse disorders
3. Definitions and differentiation of use, misuse, at risk use, abuse, addiction, and habituation
4. Routes of administration and physiologic effects of commonly abused drugs
5. Pharmacologic equivalents of various alcoholic beverages and the dose-response effect of alcohol on psychomotor skills, including driving
6. What constitutes the “standard drink” for different alcoholic beverages and what constitutes “at-risk” drinking
7. Presence of alcohol in commonly used medications
8. Appropriate prescribing of potentially addictive medications, including opioid analgesics, sedative-hypnotics, and stimulants with methods of monitoring and prevention of diversion, abuse, and addiction

iv. The disease concept of substance use disorders, including information on:

1. Criteria for distinguishing substance use along a spectrum from abstinence, low-risk use, hazardous use, and dependence to end-stage addiction, all of which are influenced by cultural norms
2. Evidence regarding genetic transmission and neurochemistry, including markers of the disease
3. The natural history of substance use disorders and the similarity of substance use disorders to other chronic medical diseases with relapsing and remitting courses
4. Signs and symptoms of early and advanced stages of substance use disorders including:
   a. Psychosocial and behavioral changes in the individual and the family
   b. Symptoms, physical signs, and laboratory evidence (e.g., chronic liver disease, track marks)
   c. Co-morbid biomedical and psychiatric diagnoses: anxiety disorders, depression, bipolar illness, hypertension, diabetes, hepatitis C, pancreatitis
5. The validity of and sensitivities and specificities of various screening/diagnostic tools, including:
   a. AUDIT-C to screen for hazardous use
b. DAST, CAGE, TWEAK, CRAAFT, ASSIST, and AUDIT to screen for dependence/addiction

c. The structured interview in the absence of an available standard screening instrument

d. An appropriate reaction to a negative screening

e. Clinical indications for drug testing as well as selection and interpretation of alcohol and other drug tests, including:
   i. Illicit-drug toxicology
   ii. Blood alcohol levels

6. Prevention strategies and their effectiveness, including:
   a. An understanding of prevention strategies, which may be primary (attempt to dissuade patient from starting substance use), secondary (attempt to curb early substance use before organic disease begins), and tertiary (attempt to minimize the consequences of existing organic substance use disease)
   b. The different models of behavior change and the assessment of a patient’s readiness to change
   c. Prevention of hazardous use using the Screening, Brief Intervention and Referral to Treatment (SBIRT) model, including:
      i. Brief office interventions, FRAMES model
      ii. Scheduled interventions
      iii. Basic motivational interviewing techniques

7. Psychosocial treatment at different stages of the disease and the relevant goals of treatment at each stage
   a. The potential advantages and disadvantages of various treatment modalities including:
      i. Intensive office interventions using motivational interviewing
      ii. Lay, self-help groups for persons who have a substance use disorder and for their families (e.g., 12-step programs)
iii. Professionally administered psychotherapy for individuals, families, and groups
iv. Intensive outpatient-partial day treatment programs
v. Inpatient treatment programs
vi. Partial residential programs, including day programs and half-way houses
b. The use of informational brochures and educational tools during the intervention
c. Facilitating referrals to various treatment options
d. Outcomes of different treatment modalities (e.g., harm reduction, abstinence-based programs, family systems)
e. An effective and acceptable follow-up plan
f. Symptoms and signs of impending relapse and appropriate interventions
   i. Pharmacologic treatment, including management of withdrawal, pharmacotherapy of addiction, and treatment for coexisting biomedical and psychiatric disorders
   ii. Pharmacologic and group treatment of nicotine addiction
8. Pharmacologic treatment of withdrawal syndromes and maintenance, risks, and benefits:
   a. Opioids: including use of methadone, buprenorphine, and clonidine for withdrawal and maintenance
   b. Alcohol: including use of disulfiram, naltrexone, and acamprosate for maintenance
   c. Sedative hypnotics: including weaning techniques
   d. Tobacco: including use of nicotine replacement, bupropion, and varenicline
9. Special considerations in the prevention, diagnosis, and treatment of:
   a. Pregnant women
   b. Children and adolescents
   c. Elderly
   d. Homeless
c. Psychiatric disorders including dual diagnosis patients
f. Cultural groups represented in the patient population where the residency program is located
g. Children in families with history of alcohol and/or substance abuse disorders

10. Family/caregiver diversion in palliative and hospice situations family dynamics, including:
   a. Dynamics of families in which one or two parents have a substance use disorder
   b. Dynamics of families in which a child or adolescent has a substance use disorder
   c. Possible psychosocial effects on adults who were raised in families with substance use disorders
   d. Enabling behavior

11. Information on health professional impairment, including:
   a. Preventive measures, including coping strategies, stress reduction, and self-monitoring
   b. Legal requirements ethical implications for health professionals who suspect impairment in a colleague
   c. The role of hospital-based impaired-physician committees, state impaired-physician programs, and state licensure boards

12. Legal and ethical issues concerning:
   b. Chain of possession and informed consent for serum and urine drug testing
   c. Laws regarding driving sand substance use disorders
   d. Court-appointed treatment

13. Knowledge of local resources and unmet needs in the community.

III. Core Competency 3: Professionalism
   a. A belief that individuals and families who have substance use disorders are to be respected, supported, and treated nonjudgmentally by their family physicians. An understanding that
expressions of denial, dishonesty, anger, irrationality, and other potentially offensive behaviors are often inherent symptoms of substance use.

b. An awareness of their own attitudes towards substance abuse and their potential implications in the therapeutic relationship

c. An assurance that substance abuse can be treated successfully and patients restored to a healthy life and lifestyle.

IV. Core Competency 5: Patient Care

a. The trainee will demonstrate the ability to independently perform or appropriately refer:
   i. Substance abuse prevention strategies
      1. Providing primary preventing with the SBIRT model for tobacco, alcohol, and drug use problems for all patients
      2. Community advocacy
         a. Support and maintenance of effective local resources
         b. Advocate for resources to address unmet needs
   b. Utilize appropriate tools to screen all patients for tobacco, alcohol, and other drug use
   c. Assess patients for:
      i. Social, psychological, and physical problems if screening results are positive for hazardous substance use or abuse, or for dependence of tobacco, alcohol, or other drugs
      ii. Readiness to change in all patients with hazardous or dependent use of tobacco, alcohol, or other drugs
   d. Treatment of substance abuse disorders
      i. Office-based brief intervention
         1. With a goal of secondary prevention in persons with hazardous drinking but without symptoms and signs of alcohol dependence
         2. With a goal of abstinence, harm reduction, or referral for further treatment in patients who have alcohol or other drug dependence
      ii. Permission is needed from the patient to proceed with a brief intervention
      iii. Appropriate documentation and coding for a brief intervention
      iv. Motivational interviewing to facilitate behavior changes
      v. Inclusion of family in assessment and initial treatment
      vi. Pharmacotherapy and medical management of withdrawal syndrome
vii. Pharmacotherapy and medical management of maintenance, including the use of office-based buprenorphine maintenance, and disulfiram, naltrexone, and acamprosate maintenance

e. Referral to specialized treatment programs and other community resources
   i. Consultation with and referral to specialized treatment programs
   ii. Consultation with and referral to community tobacco, alcohol, and drug treatment programs
   iii. Work with and referral to self-help programs for tobacco, alcohol, and other drug problems
   iv. Perform ongoing monitoring to help the patient and family achieve desirable outcomes
   v. Recognize symptoms and signs of relapse and engage patients and families in additional treatment

f. Management of acute and chronic pain, including appropriate use of opioid analgesics, while minimizing the risk of addiction
   i. In hospitalized and ambulatory settings
   ii. In patients with and without a history of substance use disorders
   iii. In patients on methadone or buprenorphine maintenance

V. Educational Materials

a. Mandatory Reading
   1. Section on substance abuse in Rakel's; AND,
   2. Section on substance abuse in Cecil’s Textbook of Medicine

b. Suggested reading
20. Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse ranking its health


VI. Evaluation

a. Trainee Evaluation
   i. The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to substance abuse.

b. Program Evaluation
   i. The trainees will fill out an evaluation of the rotation at the end of the month.
   
   ii. Any constructive criticism, improvements, or suggestions to further enhance the training are welcome at any time.

VII. Feedback
a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rotation.
b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.
c. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

### Substance Abuse

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### 3.12 Women’s Medicine*

**Educational Purpose:** To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. The trainee will be provided the knowledge and skill to manage obstetrical and gynecologic illnesses.

**Format:** The trainee will gain the core cognitive ability and skills required in a structured rotation in obstetrics and gynecology. This rotation will occur in an ambulatory care setting where the trainee will participate in the counseling, examination, and outpatient procedures. Trainees will obtain additional experience in their continuity of care for both pregnant and non-pregnant women throughout their three years of longitudinal experience in their family medicine clinic, and will return to the family medicine clinic for scheduled time during obstetric and gynecologic rotations. Workshops in gynecologic procedures, didactics, and communication seminars will enhance the trainee’s clinical experience.

The trainee will demonstrate competency in their ability to:

- Communicate effectively with female patients of all ages, demonstrate active listening skills, a respectful approach to sensitive issues, and collaborative care planning with the patient
- Perform a comprehensive pelvic examination with appropriate screening tests and wellness counseling based on the patient’s age and risk factors
- Perform routine gynecologic procedures
- Develop treatment plans for common conditions affecting female patients, including reproductive issues, and utilize community resources when indicated
- Counsel and understand appropriate exercise during adolescence, reproductive years, pregnancy, and the postmenopausal period
- Understand appropriate screening guidelines for osteoporosis and be able to develop treatment plans for patients with decreased bone density
- Demonstrate effective primary care counseling skills for psychosocial, behavioral, and reproductive problems in women
- Consult with obstetrician-gynecologists (OB-GYNs), other physician specialists, and
allied health care professionals to provide optimum health services for women
- Act as patient advocate and coordinator of care for female patients across the continuum of outpatient, inpatient, and institutional care

I. Core Competency 1: Osteopathic Principles
   a. Osteopathic principles.
      1. Myofascial release to the sacrum
      2. Vasculo-lymphatic drainage techniques
      3. Thoracolumbar junction therapy for autonomic tone to pelvis
      4. Evaluation of Chapman's reflex points

II. Core Competency 2: Medical Knowledge
   a. The trainee will demonstrate the ability to independently perform or appropriately refer the following:
      i. Women’s Health:
         1. Control of fertility
            a. Counseling for all forms of birth control (including use of oral contraceptives and other hormonal contraception, and natural family planning)
            b. IUD insertion and removal
            c. Diaphragm fitting
            d. Implantation devices (including removal)
            e. Emergency contraception
         2. Diagnostic
            a. Microscopic diagnosis of urine
            b. Vaginal wet mount preparation
            c. Obtaining cervical cytology, HPV tests, and cultures
            d. Gynecologic and breast examination, including a traumatic (patient-centered) speculum and bimanual exam
         3. Counseling
            a. Pregnancy options (including adoption, abortion, and parenting)
            b. Pregnancy loss and infertility
            c. Contraceptive choices
            d. Results of cervical cytology, mammography, osteoporosis screening, and other tests
            e. Family and relationship stresses
            f. Intimate partner and family violence
         4. Pregnancy management
            a. Prenatal counseling about aspects of normal pregnancy, delivery, and family adaptation
b. Evaluation of gestational age and pregnancy risks in early pregnancy
c. Low-risk prenatal care
5. Labor and delivery management
ii. Gynecology
1. General
   a. Screening examination of the female breast and reproductive tract
   b. Obtaining vaginal and cervical cytology (with HPV testing, as indicated)
   c. Colposcopy, cervical biopsy, and endocervical curettage
   d. Cervical polypectomy
   e. Endometrial biopsy
   f. Cervical cryosurgery
   g. Cautery for benign disease
   h. Microscopic diagnosis of urine and vaginal smears
   i. Bartholin duct cyst management
   j. Vulvovaginal biopsy
   k. Vaginal foreign body removal
   l. Breast cyst aspiration
   m. Uterine aspiration for incomplete first trimester abortion
2. Family planning and contraception
   a. IUD insertion and removal
   b. Diaphragm counseling and fitting
   c. Subcutaneous implant insertion and removal
3. Gynecologic surgery
   a. Assistance with common major surgical procedures, including hysterectomy and bilateral tubal ligation
   b. Post-operative management following gynecologic or obstetric surgery
4. Advanced skills in gynecology
   a. Loop electrosurgical excision procedure with paracervical block
   b. Culdocentesis
5. Advanced skills in family planning and contraception
   a. Voluntary interruption of pregnancy up to 10 weeks of gestation
   b. Bilateral tubal ligation
   c. Hysteroscopic sterilization

III. Educational Materials
   a. Mandatory Reading
1. Section on women’s medicine in Rakel's; AND,
2. Section on women’s medicine in Cecil’s Textbook of Medicine

b. Suggested reading


IV. Evaluation

a. Trainee Evaluation
   i. Faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the seven competencies as related to women’s health.

b. Program Evaluation
   i. The trainees will complete an evaluation of the rotation at the end of the month.
   ii. Any constructive criticism, improvements, or suggestions to further enhance the training in women’s health are welcome at any time.

V. Feedback

a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rotation.

b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.

c. Attending physicians are encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee will be done at the end of the rotation.

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3.13 Adolescent Medicine*

Educational Purpose:
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. To provide the trainee with educational experiences that will enhance their knowledge and skills in diagnosing and managing adolescent patients.

Format: The trainee will gain the core cognitive ability and skills required in a structured rotation in adolescent medicine. Diverse experiences in community-based clinics in conjunction with a “teen panel” in the trainee’s primary care clinic will provide rich and diverse experiences for the trainee. Examples of community-based clinics in existing family medicine residencies include school-based health centers, teen clinics, and reproductive health clinics (such as Planned Parenthood).

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
This curriculum will be taught in both a focused and longitudinal fashion throughout the residency experience. The trainee will take primary responsibility for adolescent patients and be active as the decision maker. The trainee will gain experience in comprehensive well-teen evaluations, comprehensive screening for psychosocial issues, pre-participation sports physicals, and comprehensive reproductive and sexual health evaluation and treatment (including treatment of STIs, contraceptive counseling, options counseling for unintended pregnancy, and care of pregnant and parenting teens).

At the completion of residency training, the trainee will:

- Be able to develop patient-centered treatment plans for adolescents based on comprehensive risk-based assessments that take into account the cultural, linguistic, and socioeconomic backgrounds of adolescent patients
- Optimize treatment plans based on knowledge of adolescent care resources that include local, state, and federal agencies
- Be able to coordinate ambulatory, inpatient, and institutional care and advocate for adolescents across health care providers, institutions, and governmental agencies
- Demonstrate the ability to communicate effectively with the adolescent patient and his or her family in order to establish and maintain therapeutic relationships in the context of confidentiality
- Demonstrate sensitivity and responsiveness to the adolescent patient’s race, ethnicity, culture, language, gender, sexual orientation, gender identity, and disabilities

I. **Core Competency 1: Osteopathic Principles**
   a) Osteopathic principles
      i.

II. **Core Competency 2: Medical Knowledge**
   a) The trainee will demonstrate the ability to independently perform or appropriately refer:
      i. In the general care of the adolescent patient:
         a. Establish clinical rapport with teens based on respect
         b. Explain confidential services to teens and parents
         c. Respond to parental questions and concerns
         d. Collect data and information regarding a teen's history, including risk factors and strengths
            1. Use assessment tools, such as the American Medical Association (AMA) Guidelines for Adolescent Preventive Services (GAPS), bioelectric impedance analysis (BIA), and/or the HEADSSS questionnaire to ensure acquisition of comprehensive information in teen patients
         e. Perform both complete physical exam and focused teen exam
f. Evaluate adolescent patients for sports eligibility with appropriate history, exam, and testing

g. Interpret body mass index (BMI) and make recommendations for nutrition and activity
   1. Assess daily eating habits and counsel regarding nutrition (e.g., sugar and its role in obesity, avoidance of diets high in saturated fat and fast food diets)
   2. Emphasize important effects of exercise on weight, mood, and overall health
   3. Screen patients for eating disorders and make referrals for specialty care when needed

h. Assess blood pressure in the context of normal ranges for age and height

i. Perform and interpret screening tests, including STI screening, tuberculosis (TB) screening, and targeted screening for cholesterol and diabetes

j. Assess well-being at home and counsel regarding family relationships

k. Assess progress at school and counsel regarding school issues, including school failure and bullying

l. Assess peer relationships and counsel about healthy and ethical decision making

m. Assess tobacco, alcohol, and drug experimentation and counsel regarding best health practices

n. Assess for illicit drug use (including anabolic steroids)

o. Assess sensitive topics, including sexual activity, sexual and reproductive health, sexual orientation, and gender identity, by using active listening skills and objectively discussing concerns and questions


q. Teach skills in building and expressing positive self-esteem

r. Screen teenagers for challenges they may be experiencing in developing a sexual identity, and counsel patients on responsible behaviors, including self-care, attention to mental health, sexual health, and reproductive health

s. Assess sexual behaviors and counsel on healthy practices including:
   1. Prevention, diagnosis, and treatment of STIs (including HIV)
   2. Contraceptive counseling and prescribing for teens in a patient-centered manner that takes into account the teen’s need for confidentiality, her or his beliefs about
what methods are right for her or him, and current medical evidence regarding the effectiveness of all available methods
a) Include counseling on emergency contraception and “quick start” protocols
b) Include counseling on long-acting reversible contraceptive methods, including intrauterine devices (IUDs) and implants, as first-line options for adolescents
3. Routine condom use
4. Options counseling for unintended pregnancy (including continuing the pregnancy and raising a child, continuing the pregnancy and making an adoption plan, and medication or aspiration abortion)
t. Assess mental health status, counsel on positive mental health activities, and decide appropriate treatments and referrals
u. Counsel and assess adolescents relative to stressors typical for developmental stage (e.g., peer pressure and risky behaviors). Suggest mind-body stress-alleviation techniques, such as breath-work and meditation
v. Assess exposure to violence in each adolescent patient’s life. Counsel on conflict resolution and decide appropriate referrals and interventions
w. Assess accident and safety risks and counsel on ways to prevent injury
ii. In the ambulatory setting:
a. Design a program of preventive services appropriate for various clinical settings
b. Select screening methods appropriate for ambulatory clinical settings
c. Describe the characteristics of a “teen-friendly clinic”
d. Design a continuous quality improvement program to monitor provision of teen services
iii. In the community:
a. Promote educational programs in schools that advocate healthy teen behavior
b. Promote quality teen health services in schools, including school-based health centers
c. Promote the support of teen clinical services in communities by government and health organizations
d. Coordinate the care of at-risk youth (including lesbian, gay, bisexual, transgender, and intersex [LGBTI] youth; immigrant
III. Core Competency 3: Professionalism
a) An ability to communicate effectively and compassionately with patients and families
b) An ability to communicate effectively with physicians and other health care professionals and to work effectively in a team
c) A capacity to work effectively and efficiently to assess the patient according to the urgency of the patient’s problem
d) An awareness of the importance of cost containment and the need to appropriately utilize medical resources
e) An awareness of the role of the emergency department in disaster planning for a community
f) An understanding of the role of the family physician in disaster planning, training, and integration into the various government and private agencies responding to natural and man-made disasters.

IV. Core Competency 5: Patient Care
The trainee will demonstrate the ability to:
a) Recognize that each adolescent has strengths that serve as protective factors and support his or her development during adolescence
b) Acknowledge that connection to parents, school, and community is essential to an adolescent’s successful development
c) Understand that adolescence is a time of experimenting, learning, and developing and offer guidance that encourages healthy behaviors and responsible decision making
d) Support confidentiality while also encouraging the adolescent to communicate with his or her parents (and other supportive adults)
e) Treat each encounter with an adolescent as an opportunity to act as a caring adult and to engage the adolescent in conversations about healthy living

V. Educational Materials
a. Mandatory Reading
   1. Section on adolescent medicine in Rakel’s; AND,
   2. Section on adolescent medicine in Cecil’s Textbook of Medicine
b. Suggested reading


VI. Evaluation

a) Trainees will be evaluated on their performance in the following manner:

1. Patient evaluations will be reviewed with the attending physicians.
2. Patient presentations and conference presentations will be reviewed.
3. Procedures done by the trainee will be documented giving the indications, outcomes, diagnoses, level of competence and assessment by the supervisor of the ability of the trainee to perform it independently.
4. Mid-rotation evaluation session between the faculty members working with the trainee.

b) Feedback - Trainees will receive feedback with respect to achieving the desired level of proficiency and working out ways in which they can enhance their performance when the desired level of proficiency has not been achieved. Evaluation and feedback will occur during the rotation. In addition, we are developing a real time evaluative tool for trainee performance. It is anticipated that this will improve feedback.
3.14 Allergy/Immunology*

**Educational Purpose:**
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. To provide the trainees with educational experiences that will enhance their knowledge and skills in diagnosing and managing the medical component of the disease.

**Format:** The development of core cognitive knowledge and appropriate skills in the care of the allergic patient will be in an outpatient setting with qualified physician teachers and allergy/immunology consultants.

A typical week of activities might include hospital rounds, departmental conference, informal discussion with the allergy/immunology consultant, evaluation of patients under the supervision of the allergy/immunology consultant, and participation in administration of immunotherapy, skin testing, and pulmonary-function tests. Trainees will obtain substantial additional clinical experience in allergy/immunology therapy throughout the three years of their experience in the family medicine center. A significant number of patients who have allergic and immunologic conditions will be a part of each trainee's family medicine panel of patients.

The trainee will demonstrate competency in their ability to:

- Understand the physiology of the allergic response
- Be able to demonstrate knowledge of the diagnosis, treatment, and prevention of allergic and immunologic conditions, including but not limited to rhinitis, asthma, urticarial, anaphylaxis, immunodeficiency, and hypersensitivity reactions.
- Be familiar with the performance and interpretation of spirometry and skin testing.
- Be able to discuss diagnostic, therapeutic, and preventive strategies of allergic and immunologic conditions with the patient and his or her family in a compassionate, effective manner.
- Demonstrate respect and sensitivity to patients and their families.
- Be familiar with the appropriate application of evidence-based guidelines regarding allergic and immunologic conditions.
- Appropriately utilize allergy and immunology consultation and be familiar with established reporting processes for allergies and allergic reactions.
- Understand immunosuppression
- Understand the role of somatic dysfunction and the relationship of osteopathic principles and treatment on the immune system

I. Core Competency 1: Osteopathic Principles
   a. Osteopathic principles.
      i.

*The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.*
II. **Core Competency 2: Medical Knowledge**

a. The trainee will demonstrate their ability to apply knowledge of:
   i. The biochemical and histological basis of the immune response, including the role and function of:
      1. T and B lymphocytes
      2. Cytokines
      3. IgE immunoglobulins
      4. Mast cells
      5. Complement
   b. The classification scheme of immune damage.
      i. Type I (anaphylactic / immediate, late phase, and dual reactions)
      ii. Type II (cytotoxic reactions)
      iii. Type III (Arthus reaction)
      iv. Type IV (delayed)
      v. Type V (antireceptor)
   c. The pathophysiology, identification, and treatment of primary and secondary immunodeficiency syndromes
   d. Asthma, including:
      i. Definition and ability to understand and use the National Institutes of Health severity index
      ii. Impact on quality of life and cost for both the individual and society
      iii. Major pathologic factors in airway obstruction
          1. Inflammatory mucosal edema
          2. Smooth muscle-mediated bronchoconstriction
          3. Sputum secretions
          4. Airway remodeling
      iv. Triggers of asthma symptoms
          1. Infection
          2. Irritants, including tobacco smoke and environmental pollutants
          3. Exercise
          4. Allergens
          5. Drugs
          6. Gastrointestinal reflux disease
          7. Acute emotional stress
      v. Triggers of inflammation, such as allergens, occupational exposure, and infection
      vi. Diagnosis and differential diagnosis of asthma, including:
          1. Appropriate history and physical examination
          2. Allergy evaluation
          3. Pulmonary function testing
          4. Methacholine challenge testing
vii. Monitoring of symptoms using peak flow meters
viii. Appropriate use of preventive measures, such as avoidance of triggers and immunotherapy
ix. Ability to complete and implement an asthma action plan
x. Medical treatment of asthma
   1. Beta-2 agonists
   2. Methylxanthines
   3. Anticholinergics
   4. Mast cell stabilizers
   5. Leukotriene receptor antagonists
   6. Steroids (both inhaled and systemic)
xi. Identification and management of status asthmaticus
xii. Management of asthma in patients who have concurrent medical conditions, such as pregnancy, diabetes, preoperatively, and heart disease
xiii. Management of asthma in the athlete, including evaluation and management of exercise-induced bronchospasm
xiv. Factors in compliance, such as:
    1. Education
    2. Avoidance of environmental triggers
    3. Early intervention of social and behavioral components
xv. Rhinitis including:
    1. Symptoms, signs, and pathophysiology of:
       a. Seasonal allergic rhinitis
       b. Perennial allergic rhinitis
       c. Perennial nonallergic rhinitis
       d. Vasomotor rhinitis
       e. Rhinitis medicamentosa
    2. Triggers
       a. Inhalant allergens (household, outdoor environmental)
       b. Irritants
       c. Physiologic factors
       d. Endocrinologic factors
       e. Occupational agents
    3. Appropriate use of diagnostic testing, such as nasal smears, skin testing and in vitro testing (RAST)
    4. Management
       a. Environmental
       b. Pharmacotherapy
          i. Antihistamines
          ii. Sympathomimetics
          iii. Mast cell stabilizers
iv. Steroids (inhaled and systemic)

v. Anticholinergics

c. Immunotherapy

d. Associated conditions

i. Sinusitis

ii. Orthodontics

iii. Otitis media, serous otitis media, nasal polyps, anosmia, allergic conjunctivitis

iv. Sleep disorders

5. Adverse reactions to drugs, foods, and biological

a. Drugs

i. Classification: toxicity, intolerance, side effects, allergic, interactions, genetic, idiosynratic

ii. Diagnosis: history, physical examination, skin testing

iii. Management: pharmacotherapy of acute reactions, avoidance, therapeutic desensitization

b. Foods

i. Classification: toxicity, intolerance, physiologic reactions, genetic, allergic, additives, dermal allergy

ii. Diagnosis: history, physical examination, in vitro testing, elimination diet, challenge diet

c. Dermatitis

i. Etiology and pathophysiology of allergic contact dermatitis and atopic dermatitis

ii. Distribution and clinical characteristics

iii. Patch Testing

iv. Management: avoidance, environmental control, soaks and baths, lubricants, steroids, antipruritic drugs, diet

d. Anaphylaxis

i. Precipitating factors: stinging insects, latex, pharmaceuticals

ii. Pathophysiology

iii. Signs and symptoms: skin, respiratory, gastrointestinal tract, cardiovascular

iv. Diagnosis

v. Treatment: epinephrine, fluids, antihistamines, steroids, vasopressors, endotracheal intubation

e. Prevention:

i. Patient education: anaphylactic kit, sting avoidance, sources of allergenic
ii. Indications for venom immunotherapy
f. Urticaria and angioedema
i. Classification
   1. Acute urticarial and angioedema
   2. Recurrent acute urticarial
   3. Chronic urticarial
   4. Hereditary angioedema
ii. Wheal and flare response
iii. Immunologic and nonimmunologic mechanisms
iv. Diagnosis
v. Management: environmental, diet, antihistamines, sympathomimetics, steroids

VI. Core Competency 5: Patient Care
The trainee will demonstrate their ability to independently perform or appropriately refer:

a. Appropriate performance and interpretation of pulmonary function tests:
   i. Peak expiratory flow rate (PEFR)
   ii. Spirometry, including measurements of forced expiratory flow (FEV), forced vital capacity (FVC), and FEV/FVC ratio and response to bronchodilator administration
   iii. Flow volume loops
   iv. Exercise challenge testing

b. Appropriate ordering and interpretation of:
   i. Skin testing
   ii. Puncture or prick testing
   iii. Intradermal
   iv. Interfering conditions and medications

c. In vitro testing
   i. IgE assay techniques
   ii. Methods of reporting
   iii. Interpretation, sensitivity and specificity

d. Counseling patients and their families about the proper techniques to avoid environmental triggers for allergic conditions

e. Conducting a comprehensive history and physical examination with special emphasis on the diagnosis of allergic and immunological conditions

f. Integrating factors in the patient’s family, home, and general lifestyle into the diagnostic and therapeutic process

g. Consulting with physicians and other healthcare professionals, including the critical evaluation and selective use of consultant advice and the integration of management in critical care situations

h. The use of local and national reporting systems for allergic reactions
to pharmaceutical agents

VII. Educational Materials

a. Mandatory Reading
1. Section on allergy and immunology in Rakel’s; AND,
2. Section on allergy and immunology in Cecil’s Textbook of Medicine

b. Suggested reading

VIII. Evaluation

a. Trainee Evaluation
i. The faculty will complete the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in
each of the seven competencies as related to allergy/immunology.

b. Program Evaluation
   i. The trainees will fill out an evaluation of the rotation at the end of the month.
   ii. Any constructive criticism, improvements, or suggestions to further enhance further training are welcome at any time.

IX. Feedback
   a. The trainee will receive frequent (generally daily) feedback in regards to his or her performance during the rotation.
   b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.
   c. The attending physicians are encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

Allergy/Immunology

3.15 Behavioral Medicine/Science*

Educational Purpose:
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. To provide the trainee with educational experiences that will enhance their knowledge and skills in diagnosing and managing the psychological component of disease. To provide training so the trainee will understand the importance of their own well-being and the prevention of impairment.

Format: Training in human behavior and mental health will be accomplished primarily in the outpatient setting through a combination of longitudinal experiences, supervised experiences and didactic teaching. This combination will include experience in diagnostic assessment, psychotherapeutic techniques, and psychopharmacologic management. Learning tools such as Balint Groups, video review, direct observation, and role-playing will be used. Trainees will utilize mental health professionals, including psychiatrists, psychologists, and other mental health professionals as resources.

The trainee will demonstrate competency in their ability to:

- Understand normal and abnormal psychosocial growth and development across the life cycle and be able to apply this knowledge to the care of the individual patient.
- Be able to recognize, initiate treatment for, and utilize appropriate referrals for mental health disorders to optimize patient care.
• Demonstrate the ability to effectively interview and evaluate patients for mental health disorders using appropriate techniques and skills to enhance the doctor-patient relationship.
• Have sensitivity to and knowledge of the emotional aspects of organic illness.
• Be able to intervene effectively and professionally in emergent psychiatric, domestic violence, child abuse, and disaster situations.
• Understand the impact of mental health disorders on the family unit

I. **Core Competency 1: Osteopathic Principles**
   a. Osteopathic principles.
      i. 
      ii. 

II. **Core Competency 2: Medical Knowledge**
The trainee will demonstrate the ability to apply knowledge of:
   a. Basic behavioral knowledge
      i. Normal, abnormal, and variant psychosocial growth and development across the life cycle
      ii. Recognition of interrelationships among biologic, psychologic, and social factors in all patients
      iii. Reciprocal effects of acute and chronic illnesses on patients and their families
      iv. Factors that influence adherence to a treatment plan
      v. Family functions and common interactional patterns in coping with stress
      vi. Awareness of one's own attitudes and values, which influence effectiveness and satisfaction as a physician
      vii. Stressors on physicians and approaches to effective coping
      viii. Ethical issues in medical practice, including informed consent, patient autonomy, confidentiality, and quality of life
   b. Mental health disorders
      i. Disorders principally diagnosed in infancy, childhood, or adolescence
         1. Mental retardation
         2. Learning disorders
         3. Motor skills disorders
         4. Communication disorders
         5. Pervasive developmental disorders
         6. Attention deficit and disruptive behavior disorders, i.e., Oppositional Defiant Disorder, Conduct Disorder
         7. Feeding and eating disorders of infancy or early childhood
         8. Tic disorders
         9. Elimination disorders
   c. Delirium, dementia, amnestic and other cognitive disorders
   d. Substance-related disorders
i. Alcohol

ii. Amphetamines

iii. Caffeine

iv. Cannabis

v. Cocaine

vi. Hallucinogens

vii. Inhalants

viii. Nicotine

ix. Opioids

x. Phencyclidine

xi. Sedative-, hypnotic- or anxiolytic-related disorders

xii. Poly-substance-related disorder

e. Psychotic disorders

i. Schizophrenia

ii. Paranoid

iii. Disorganized

iv. Catatonic

f. Mood Disorders

i. Major depressive disorder

ii. Dysthymic disorder

iii. Bipolar disorders, including hypomanic, manic, mixed and depressed

g. Anxiety disorders

i. Panic attack

ii. Phobias

iii. Obsessive-compulsive disorder

iv. Post-traumatic stress disorder

v. Acute stress disorder

vi. Generalized anxiety disorder

h. Somatoform disorders

i. Somatization disorder

ii. Conversion disorder

iii. Pain disorder

iv. Hypochondriasis

i. Factitious disorders

j. Dissociative disorders

k. Sexual and gender identity disorders

i. Sexual desire disorder

ii. Sexual aversion disorder

iii. Orgasmic disorders

iv. Sexual pain disorders

v. Sexual dysfunction related to a general medical condition

vi. Gender identity disorder

l. Eating disorders
i. Anorexia nervosa
ii. Bulimia nervosa

m. Sleep disorders
i. Insomnia
ii. Hypersomnia
iii. Narcolepsy
iv. Breathing-related sleep disorder
v. Circadian-rhythm sleep disorders
vi. Parasomnias

n. Impulse control disorders
i. Pathological gambling
ii. Trichotillomania

o. Adjustment disorders
i. Depressed mood
ii. Anxiety
iii. Mixed anxiety and depressed mood
iv. Disturbance of conduct

p. Personality disorders
i. Paranoid
ii. Schizoid
iii. Schizotypal
iv. Antisocial
v. Borderline
vi. Histrionic
vii. Narcissistic
viii. Avidant
ix. Dependent
x. Obsessive-compulsive

q. Problems related to abuse or neglect

r. Additional conditions
i. Non adherence/noncompliance
ii. Malingering
iii. Borderline intellectual functioning
iv. Age-related cognitive decline
v. Bereavement
vi. Marital discord
vii. Academic problem
viii. Occupational problem
ix. Identity problem
x. Religious or spiritual problem
xi. Acculturation problem
xii. Phase-of-life problem

III. Core Competency 3: Professionalism
a. The trainee will demonstrate attitudes that encompass:
   i. Awareness of and willingness to overcome the trainee’s own attitudes and stereotypes of mental illness and social diversity, as well as a recognition of how attitudes and stereotypes affect patient care
   ii. Recognition of the complex bidirectional interaction between family and social factors and individual health
   iii. Acceptance of patient’s right to self-determination
   iv. Respect and compassion for the psychosocial dynamics that influence human behavior and the doctor/patient relationship
   v. Recognition of the prevalence of abuse in society and willingness to help patients escape abusive situations
   vi. Understanding of the importance of a multidisciplinary approach to the enhancement of individualized care
   vii. Commitment to lifelong learning about the interaction of the biological, social, psychological, and psychiatric interaction of the human life cycle

IV. **Core Competency 5: Patient Care**
The trainee will demonstrate the ability to independently perform or appropriately refer:

a. Use of evaluation tools and interviewing skills, which enhance data collection in short periods of time and optimize the doctor/patient relationship
b. Techniques to elicit the context of the visit [BATHE (background, affect, trouble, handling and empathy) or other techniques]
c. Mental status examination
d. Evaluation of indications for special procedures in psychiatric disorder diagnosis, including psychologic testing, laboratory testing and brain imaging
e. Elicit and recognize the common signs and symptoms of the disorders
f. Teach patients methods for evaluating and selecting reliable websites for medical information
g. Assessment of depression [PHQ-9, Beck, Zung, Hamilton Scales, SIG-E-CAPS mnemonic (sleep, interest, guilt, energy, concentration, appetite, psychomotor and suicidal ideation)]
h. Evaluation of indications for psychiatric consultation
i. Management of emotional aspects of nonpsychiatric disorders
j. Techniques for enhancing compliance with medical treatment regimens
k. Initial management of psychiatric emergencies: the suicidal patient, the acutely psychotic patient
l. Proper use of psychopharmacologic agents
   i. Diagnostic indications and contraindications
   ii. Dosage, length of use, monitoring of response, side effects and compliance
   iii. Drug interactions
   iv. Associated medical problems
m. Family support therapy  
   n. Behavioral modification techniques  
      i. Stress management  
         1. Breathing  
         2. Muscle relaxation  
         3. Imagery  
         4. Cognitive restructuring  
      ii. Smoking cessation, obesity management and other lifestyle changes  
      iii. Chronic pain management  
   o. Utilization of community resources  
      i. Community resources  
      ii. Patient care team of other mental health professionals  
   p. Crisis-counseling skills  
   q. Modification of patient environment  
   r. Variations in treatment based on the patient's personality, lifestyle and family setting  
   s. Identification of, intervention in and therapy for drug and alcohol dependency and abuse  
   t. Appropriate care of health disorders listed under psychopathology  
   u. Appropriate referral procedures to ensure continuity of care, provide optimal information sharing and enhance patient compliance  
      i. Indications  
      ii. Process  
      iii. Follow-up  

V. Educational Materials  
   a. Mandatory Reading  
      i. Section on behavioral health in Rakel's; AND,  
      ii. Section on behavioral health in Cecil's Textbook of Medicine  
   b. Suggested reading  


Ebell MH. Point-of-care guides: screening instruments for depression. *Am Fam Physician.* 2008;78(2):244-246


VI. Evaluation

a. Trainee Evaluation

i. The faculty will complete the standard evaluation form using the
criteria for evaluations as delineated above to grade the trainee in each of the competencies.

b. Program Evaluation
   i. The trainees will fill out an evaluation of the rotation at the end of the month.
   ii. Any constructive criticism, improvements, or suggestions to further enhance the training in the rotation are welcome at any time.

VII. Feedback
   a. The trainee will receive frequent (generally daily) feedback in regards to his or her performance on the rotation.
   b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation.
   i. Attending physicians are encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

Behavioral Medicine

3.16 Musculoskeletal and Sports Medicine*

Educational Purpose:
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. To provide the trainee with educational experiences that will enhance their knowledge and skills in diagnosing and managing the psychological component of disease. To provide training so the trainee will understand the importance of their own well-being and the prevention of impairment.

Format: This curriculum will be implemented longitudinally throughout the three years of residency training. Trainees will have at least minimal experience in inpatient orthopedics. Preceptors who are competently trained will be available to work individually with trainees, and to teach and assess performance of trainees’ desired skills. The teaching of musculoskeletal care will take part in osteopathic lectures and labs. Experience will be provided in bone, muscle, and joint examination; splinting; taping; casting; arthrocentesis; and rehabilitative measures. Electives can be used in orthopedic or sports medicine training to obtain a greater concentration of common problems, or to provide experience with unusual problems (e.g., acute ski injury clinics, military bases, and paratrooper training, gait and balance clinics for the elderly).

The trainee will demonstrate competency in their ability to:

- Perform an appropriate musculoskeletal history and physical examination, and formulate an appropriate differential diagnosis and recommend treatment, including requisite subspecialty referrals
• Perform an evidence-based, age-appropriate, and activity-specific pre-participation physical examination
• Communicate effectively with a wide range of individuals regarding musculoskeletal health care, including patients, their families, coaches, school administrators, and employers
• Understand how exercise impacts disease states such as diabetes and hypertension and be able to formulate an appropriate exercise prescription
• Understand that sports medicine involves caring for the medical conditions of athletes in addition to the musculoskeletal conditions

I. Core Competency 1: Osteopathic Principles
   a. Osteopathic principles.
      i.
      ii.

II. Core Competency 2: Medical Knowledge
The trainee will demonstrate the ability to apply knowledge of:
   a. Normal anatomy and physiology
   b. Normal growth and development
   c. Musculoskeletal history taking
   d. Principles of musculoskeletal physical examination
   e. Indications, contraindications, and interpretation of laboratory data (e.g., joint fluid)
   f. Indications, limitations, contraindications, and informed consent for office-based musculoskeletal procedures such as:
      i. Common joint aspirations
      ii. Common joint injections
      iii. Common injections for bursitis
      iv. Common injections for tendinopathy
   g. Testing
      i. Interpretation of radiographs
      ii. Use of magnetic resonance imaging (MRI), computed tomography (CT) scanning, bone scanning, and musculoskeletal ultrasound
      iii. Indications for arthrogram, myelogram and arthroscopy
      iv. Application of electromyography (EMG) and nerve conduction studies
   h. Pathogenesis/pathophysiology and recognition of:
      i. Joint pain, swelling and erythema
      ii. Muscular pain, swelling, and injury
      iii. Musculoskeletal trauma
      iv. Fractures
      v. Dislocations
      vi. Tendinopathy spectrum
      vii. Tendon ruptures (partial and complete)
viii. Nerve injuries.
ix. Bone and joint deformities
x. Bone and joint infections
erm
xiv. Compartment syndrome
xv. Avascular necrosis
xvi. Osteoporosis
xvii. Overuse syndromes
xviii. Back pain syndromes

i. Pediatric problems
i. Hip dislocation
ii. Congenital hip dysplasia
iii. Legg-Calvé-Perthes disease
iv. Osgood-Schlatter disease
v. Slipped capital femoral epiphysis
vi. “Clubfoot” (talipes equinovarus)
vii. Intoeing (metatarsus adductus, tibial torsion, femoral anteverision)
viii. “Bowleg” (genu varum) and “knock knee” (genu valgum)
ix. Physeal injuries (Salter-Harris classification)
x. Transient synovitis
xi. Child abuse patterns of injury
xii. Dislocation of the radial head (nursemaid’s elbow)
xiii. Blount disease
xiv. Rickets
xv. Osteopenesis imperfecta
xvi. Thoracolumbar Scoliosis

j. Sports medicine-specific considerations
i. General considerations
ii. Ethical, psychosocial, economic, and medicolegal issues
iii. Interaction with members of the sports medicine team
iv. Nutrition, fluids, and electrolytes, and dietary supplements

k. Injury prevention
i. Discouraging use of improper techniques
ii. Promoting rule changes and enforcement of rules designed to enhance Participant safety.
iii. Proper equipment, fit, and maintenance
iv. Taping, strapping, and bracing techniques
v. Environmental facts affecting participant and spectator safety

l. Conditioning and training techniques, including principles of aerobic and resistance training

m. Appropriate exercise prescription for:
i. Healthy persons of all ages, taking into account physiologic differences related to age and sex
ii. Patients who have chronic illnesses, including diabetes, hypertension, congestive heart failure, asthma, and chronic obstructive pulmonary disease
iii. Pregnant women
iv. Physically or mentally challenged athletes
v. Patients who have various cardiovascular conditions, especially those known to increase the risk of sudden death
n. Sports medicine education promotion for patients and their families, athletes and their families, allied health professionals, coaches, and school administrators
o. Patient care aspects
i. The important role of family physicians as part of a team of physicians for organized sports
ii. The role of family physicians as medical directors and/or on-site medical care providers for mass participation sporting events
iii. Appropriate assessment and care of acutely injured athletes, including, but not limited to:
   1) Evaluation, on-field management, and transport of suspected cervical spine injury
   2) Evaluation, and on-field and sideline management of suspected concussion or other head injury
   3) Evaluation, on-field management and transport of severe fractures and dislocations
iv. Medical management of ill and injured athletes, taking into account important sport-specific considerations
v. Rehabilitation oversight for ill and injured athletes, and return to play decision- making
p. Medical care considerations for special athlete groups
i. Preadolescent athletes
ii. Adolescent athletes
iii. Female athletes
iv. Geriatric athletes
v. Physically challenged athletes
vi. Student athletes
vii. Recreational athletes
viii. Athletes who have chronic diseases
q. Communication and interaction with patients and their families, athletes and their families, coaches, and school administrators
r. Exercise-induced asthma testing
s. Understanding of cardiac screening for exercise-related cardiac problems
t. Problems associated with exercise
i. Exercise addiction
ii. Abuse of anabolic steroids and other performance-enhancing drugs
iii. Pressures placed on athletes by themselves, family members, teammates, coaches, and fans to participate even when injured
iv. Performance pressures placed on athletes by themselves, family members, teammates, coaches, and fans
v. The intermittent exerciser
vi. How to deal with unmet and unrealistic expectations
vii. Alcohol and illicit drug use and abuse
viii. Eating disorders

u. Management and therapy
i. Outline of expected course with and without therapy
ii. Patient education for acute and chronic problems
v. Targeted pharmacologic treatment
w. Supportive/corrective devices, including braces, casts, splints, and orthotics
x. Complementary and alternative modalities

y. Prevention
i. Pre-participation screening
ii. Conditioning and training
iii. Injury prevention
iv. Physical fitness/exercise prescription
v. Bone loss
   1) Nutrition
   2) Exercise
   3) Pharmacology

z. Rehabilitation
i. Physical therapy
   1) Cold, heat
   2) Ultrasound and phonophoresis
   3) Exercises
   4) Electrical stimulation (e-stim) and iontophoresis
ii. Occupational therapy
iii. Complementary modalities (e.g., osteopathic manipulative therapy [OMT], massage, acupuncture)
iv. Psychosocial aspects of trauma

aa. Surgery and follow-up care
i. Internal and external fixation devices
ii. Artificial joint replacement
iii. Arthroscopy

III. Core Competency 3: Professionalism
a. The trainee will demonstrate attitudes that encompass:
   i. The importance of diagnosing and treating musculoskeletal injuries in family medicine
i. Exercise as an important and beneficial part of patients' lives
ii. Appropriate pre-participation evaluation of athletes
iii. Awareness of the special needs of patients who have acute injuries
iv. Proper rehabilitation of acute musculoskeletal injuries to help speed recovery, maximize function, and minimize the risks of re-injury, chronic pain, and chronic disability
v. Prevention strategies as an important part of the care of the musculoskeletal system

IV. Core Competency 5: Patient Care

The trainee will demonstrate the ability to independently perform or appropriately refer:

a. Basic management of:
   i. Fractures (simple, stable, closed, and non-displaced that do not require surgical correction)
   ii. Ligament sprains
      1) Finger
      2) Toe
      3) Ankle
      4) Knee
      5) Vertebral column
      6) Wrist
      7) Elbow
      8) Shoulder

b. Muscular strains (e.g., hamstring, trapezius)
c. Other problems
   i. Costochondritis
   ii. Bursitis, tendinopathy, tenosynovitis
   iii. Common fibrocartilage injuries such as labral and meniscal tears
   iv. Neurologic conditions (e.g., concussions, nerve entrapment syndromes, brachial plexopathies)
   v. Synovial cysts (e.g. Baker cyst, ganglion cysts)
   vi. Patellofemoral syndrome apophysitis (e.g., Osgood-Schlatter disease)
   vii. Osteochondroses/aseptic necrosis
   viii. Osteoarthritis/crystalline-induced arthritis (e.g., gout, pseudogout)
   ix. Metabolic bone disease (osteoporosis, Paget disease)
   x. Acute and chronic low back pain
   xi. Foot conditions
      1) Hallux valgus (bunions)
      2) Plantar fasciitis
      3) Morton neuroma
   xii. Osteomyelitis
   xiii. Rheumatologic disorders

d. Procedures (indications, contraindications, and complications)
i. Joint aspiration (arthrocentesis)
ii. Joint injection
iii. Common injections for bursitis
iv. Common injections for tendinopathy
v. Splints (upper and lower extremity)
vi. Plaster and fiberglass casts
   1) Short let
   2) Short and long arm
   3) Thumb spica
   4) Cast problems
vii. Dislocation reduction
   1) Simple anterior shoulder
   2) Radial head
   3) Simple posterior elbow
   4) Phalanges
   5) Patella
   6) Mandible
e. Additional skills
i. Fractures
   1) Closed tarsal and carpal bones, particularly navicular
   2) Smith and Colles fractures
   3) Nondisplaced medial or lateral epicondyle of humerus
   4) Nondisplaced Salter-Harris Type I or Type II epiphyseal injuries in children
   5) Dancer’s and Jones fractures (proximal 5th metatarsal)
f. Meniscal tears
g. Recurrent dislocations (e.g., patella, shoulder)
h. Orthopedic emergency recognition and stabilization
i. Acute compartment syndrome
ii. Hip dislocation
iii. Knee dislocation
iv. Unstable pelvis fracture
v. Cervical spine fracture
vi. Spinal cord injury
vii. Cauda equine syndrome
viii. Neurovascular compromise
i. Functional rehabilitation
   i. Prescription of home exercise programs
   ii. Prescription of physical therapy
j. Surgical assistance

V. Educational Materials
c. Mandatory Reading
i. Section on musculoskeletal and sports medicine in Rakel’s; AND,
Section on musculoskeletal and sports medicine in Cecil's Textbook of Medicine

Suggested reading

i. *American Family Physician* by Topic: Musculoskeletal Care. (Multiple articles)
   www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=17


    www.aafp.org/afp/2006/0315/p1014.pdf


    www.aafp.org/afp/20070401/1008.pdf


    www.aafp.org/afp/2006/1015/p1357.pdf


VI. Evaluation
a. Trainee Evaluation
   i. The faculty will complete the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the competencies.

b. Program Evaluation
   i. The trainees will fill out an evaluation of the rotation at the end of the month.
   ii. Any constructive criticism, improvements, or suggestions to further enhance the training in the rotation are welcome at any time.

VII. Feedback
a. The trainee will receive frequent (generally daily) feedback in regards to his or her performance on the rotation.

b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation.

c. Attending physicians are encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.17 Palliative and End-of-Life Care*

**Educational Purpose:**
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings. To provide the trainee with educational experiences that will enhance their knowledge and skills in diagnosing and managing the patient’s disease.

**Format:** This curriculum will be taught in a combination of longitudinal and block learning experiences over the 3 years of residency training. The curricular content will be integrated into the core conference schedule and will include exposure to hospice care, home visits, and bereavement counseling whenever possible. The faculty will function as role models for trainees in the care of dying patients and their families. Active learning techniques such as role playing, simulated patients, case discussions, and topic presentations will be utilized.
At the completion of residency training, a family medicine trainee will:

- Be able to identify a plan of care for terminally ill patients that are based upon a comprehensive interdisciplinary assessment of the patient and family's expressed values, goals and needs, and be able to effectively communicate the plan to the patient and family.
- Be able to recognize that quality of life is what is defined by the patient and not by the physician.
- Be able to identify the primary decision maker when the patient is unable to communicate and/or make medical decisions, and be aware of the ethical and legal issues from which terminally ill patient's preferences and choices may be based upon and/or limited within.
- Be able to facilitate patient autonomy, access to information, as well as choice, and be able to provide palliative care throughout the continuum of illness while addressing physical, emotional, social, and spiritual needs.
- Recognize the signs and symptoms, as well as anticipate the needs, of the imminently dying patient.
- Demonstrate systematic recognition, assessment, and management of pain syndromes utilizing evidence-based medicine. This should include both pharmacologic (opiate and non-opiate) and non-pharmacologic treatments and possible side effects.

I. Core Competency 1: Osteopathic Principles
   a) Osteopathic principles
      i.

II. Core Competency 2: Medical Knowledge
The trainee will demonstrate the ability to apply knowledge of:
   a) Palliative and End-of-life care
      i. Mission
         1. Improving quality of life
         2. Alleviate suffering
         3. Autonomy of the patient
         4. Patient-family centered care
            a. The 8 Domains of Quality Hospice and Palliative Care
               1) Structure and process of care
               2) Physical aspects of care
               3) Psychosocial and psychiatric aspects of care
               4) Social aspects of care
               5) Spiritual, religious, and existential aspects of care
6) Cultural aspects of care
7) Care of the imminently dying patient
8) Ethical and legal aspects

b. Concept of total pain, inclusive of spiritual, physical, and existential components

c. Transition from palliative care to hospice care

b) Hospice team roles
i. Physicians:
   1. Identification of appropriate patients for hospice care
      a. Cancer-related
      b. Non-cancer related
         1) Pulmonary
         2) Cardiovascular
         3) Neurologic
         4) Infectious
         5) Liver
         6) Kidney
   2. Referral process and criteria
   3. Insurance and Medicare coverage in various settings.

ii. Nurses

iii. Family

iv. Pharmacists

v. Home health care aides

vi. Social worker

vii. Chaplain

viii. Volunteers

c) Prognostication
i. Accuracy of prognosis

ii. Karnofsky Index

iii. ECOG Scale

iv. Palliative Prognostic Scale

d) Pain control
i. Opiates (long- and short-acting)

ii. Conversion of opiates (equianalgesic table)

iii. Non-opiates

iv. Addiction, habituation, and dependence

v. Baseline dosing and rescue

vi. Complementary and alternative medicine

vii. Non-pharmacologic pain control measures

viii. Side effects of pain control measures

e) Causes and treatment of non-pain symptoms
i. Nausea

ii. Shortness of breath
iii. Loss of appetite
iv. Vomiting
v. Sleeplessness
vi. Depression
vii. Anxiety
viii. Cough
ix. Constipation
x. Diarrhea
xi. Xerostomia
xii. Secretions
xiii. Seizures
xiv. Incontinence
xv. Encopresis

f) Nutrition and hydration in the terminally ill
   i. Artificial feeding
   ii. Intravenous fluids
   iii. Withholding feeding and fluids

g) Care locations
   i. Emergency department
   ii. Inpatient
   iii. Outpatient
   iv. Extended-care facilities
   v. Home

h) Data related to end-of-life care in the United States
   i. The bereavement process
      1. Normal grief reaction
      2. Identify/differentiate characteristics of a dysfunctional grieving process, including depression, anxiety, guilt, substance abuse, and reconciled relationships

i) Legal issues
   i. Patient competency
   ii. Advance directives
   iii. Do-not-resuscitate (DNR) orders
   iv. Durable Power of Attorney for health care
   v. Living will
   vi. Estate planning for patient and family
   vii. Withholding and withdrawing life support
   viii. Pronouncement of death
   ix. Completion of death certificate

III. Core Competency 3: Professionalism
The trainee will be evaluated on their ability to demonstrate attitudes that encompass:
   a) The ability to compassionately and empathetically deliver bad news
b) An understanding of the psychosocial issues and family dynamics affecting the terminally ill patient

c) An understanding of the spiritual and religious issues affecting the terminally ill patient as well as the family members

d) A respect of the cultural beliefs and customs of the patient and family in the context of death and dying

e) An understanding of the dying patient’s need for palliative care, pain relief, control, and dignity

f) An understanding of the special issues associated with children, either as terminally ill patients or as family members of a terminally ill patient

V. Educational Materials

a. Mandatory Reading

1. Section on palliative and end-of-life care in Rakel’s; AND,

2. Section on palliative and end-of-life care in Cecil’s Textbook of Medicine

b. Suggested reading

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee’s responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.

VI. Evaluation
   a) Trainee Evaluation
      1. The faculty will complete the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to the specialty.

   b) Program Evaluation
      1. The trainees will complete an evaluation of the rotation at the end of the month.
      2. Any constructive criticism, improvements, or suggestions to further enhance the training are welcome at any time.

   c) Feedback
      1. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rotation.
      2. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.
      3. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.18 In-Patient Medicine

Educational Purpose:
The general medicine rotation is structured to provide family medicine trainees with the fundamental knowledge base of internal medicine, the essential principles in the approach to internal medicine in-patients, the basic techniques of physical examination, the necessary skills in performing clinical procedures, and the capability to communicate clearly with patients, their families and other members of the health care team.

To provide the trainee, through didactic and clinical experiences in outpatient and inpatient settings, educational experiences that will expand their knowledge and skills in the management of medical diseases in all ages.

The trainee will demonstrate competency in their ability to:

- Recognize those patients who should be managed in a hospital setting.
• Manage patients in the outpatient and hospital setting.
• Manage hospitalized patients after discharge.
• Seek specialty consultation when appropriate and maintain direct responsibilities for the management of the patient.
• Perform specific medical procedures as outlined in the procedure section of each discipline.
• Understand and utilize appropriate pharmacologic interventions.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods - The trainees are expected to use a major textbook of medicine to obtain the necessary knowledge about their patients' medical problems. In addition, trainees will also gather more information/teaching at morning report, attending rounds, noon conferences, grand rounds, sub-specialties consultations, and board review sessions.

   a. Team Structure - Attending Physician, Upper and Lower Level Trainee, Medical Student
   b. Roles of Team Members:

      Faculty Attending: The attending will make rounds with their team at 10:00 a.m. every weekday. The on-call attending will do rounds with the on-call team during the weekend or holidays. The trainees or medical students present new admissions to the attending, which will discuss patient history, clinical findings, and results of laboratory tests. The attending will help the trainees to develop a working diagnosis, and a therapeutic plan. At the bedside, the attending will interview and examine the patient to verify or modify any abnormal findings reported by the trainees. The attending will do formal teaching rounds on non-post call days on topics in general Family Medicine. The attending will supervise the trainees when the upper level trainee is not available.

      Trainee: The trainee is responsible for running the general medicine team on a day-to-day basis. The upper level trainee will also be responsible for direct supervision of lower level trainees and medical students. The trainee is expected to conduct work rounds, which are separate from those of the attending. The trainee will be responsible for dictating the discharge summary, providing scholarly activities such as literature searches, or coordinating presentations on specific topics.

      Trainee/Medical Student: The team trainees will be responsible for admitting all patients to the team and performing a complete history and physical exam. The trainees will be responsible for day-to-day management of the team patients. They will be responsible for documenting and reporting
to the trainee or team attending about patients' status, recording daily notes, discharging the patients from the team, and coordinating outpatient follow-up. The trainees may help the trainee dictate discharge summary of their patients.

II. Core Competency 5: Patient Care
a. Objectives:
   1. Obtain a complete history and recognize common abnormal physical findings.
   2. Construct a master problem list, a working diagnosis, and a group of differential diagnoses.
   3. Be familiar with different diagnostic tools such as the electronic thermometer, sphygmomanometer, ophthalmoscope, EKG machine, pulse oximetry, and defibrillator.
   4. Become familiar with the concept of pre-test and post-test probabilities of disease.
   5. Be able to perform various clinical procedures such as venipuncture, thoracentesis, paracentesis, lumbar puncture, arthrocentesis, skin punch biopsy, bone-marrow aspiration, endotracheal intubation, and central line placement. Trainees should know indications of potential complications of each of these procedures.
   6. Understand how to improve patient/physician relationships in a professional way. Trainees should be compassionate, but humble and honest, not only with their patients, but also with their co-workers.
   7. Trainees are encouraged to develop leadership in teaching and supervising trainees and medical students.
   8. Actively participate in all phases of patient care. Trainees are encouraged to read on related topics, to share new learning with their colleagues and to keep their fund of knowledge up-to-date.
   9. Learn to use the computer for literature searches, to read and analyze scientific articles.

b. Evaluation of Patient Care - Trainees will be evaluated using the following criteria:
   1. Completeness and accuracy of medical interviews and physical examinations.
   2. Thoroughness of the review of the available medical data on each patient.
   3. Performance of appropriate maneuvers and procedures on patients.
   4. Accuracy and thoroughness of patient assessments.
   5. Appropriateness of diagnostic and therapeutic decisions.
7. Consideration of patient preferences in making therapeutic decisions.
8. Completeness of medical charting.

III. Core Competency 2: Medical Knowledge
a. Objectives - Objectives will be taught through bedside teaching, attending rounds and the trainee’s readings relating to specific patient problems:
1. Human Growth, Development, and Aging: adolescent medicine, aging and introduction to geriatric medicine, management of common problems in the elderly.
2. Preventive Medicine: principles of preventive medicine, immunization, alcohol and substances abuse.
3. Principles of Diagnosis and Management: clinical approach to the patient, clinical decision-making, interpretation of laboratory data.
4. Cardiovascular Diseases: Congestive heart failure, cardiac arrhythmias, hypertension, coronary heart disease, interpretation of EKG, interpretation of echocardiogram, nuclear medicine imaging, indication for cardiac catheterization.
5. Respiratory Diseases: Respiratory failure, COPD, asthma, pulmonary embolism, pleural effusion, interpretation of pulmonary function tests.
6. Renal Diseases: disorders of electrolytes and acid-base, acute renal failure, chronic renal failure, glomerulonephritis, tubulointerstitial diseases, vascular disorders.
7. Gastrointestinal Diseases: gastrointestinal bleeding, small bowel obstruction, large bowel obstruction, ischemic bowel diseases, pancreatitis, and diarrhea.
15. Infectious Diseases: Septic shock, principles of antimicrobial therapy, pneumonias, UTI, soft tissue infections, osteomyelitis, infective endocarditis, bacterial meningitis, enteric infections, tuberculosis, fungal infections, HIV infection, treatment of AIDS and related
disorders.

b. Evaluation of Medical Knowledge - The following will assess the trainee’s medical knowledge:
   1. The trainee’s ability to answer directed questions and to participate in attending rounds.
   2. The trainee’s presentation of patient history and physical exam, where attention is given to differential diagnosis and pathophysiology.
   3. When time permits, trainees may be assigned short topics to present at attending grounds. These will be examined for completeness, accuracy, organization and the trainees understanding of the topic.
   4. The trainee’s ability to apply the information learned from attending round sessions to the patient care setting.
   5. The trainees interest level in learning.

IV. Core Competency 3: Professionalism
a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objective:
   1. The trainee should continue to develop their ethical behavior, and must show the humanistic qualities of respect, compassion, integrity and honesty.
   2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
   3. The trainee must be responsible and reliable at all times.
   4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
   5. The trainee must maintain a professional appearance at all times.

V. Core Competency 4: Interpersonal & Communication Skills
a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   1. The trainee should learn when to call a sub-specialist for evaluation and management of a patient.
   2. The trainee should be able to clearly present a case to the attending staff in an organized and thorough manner.
   3. The trainee must be able to establish rapport with a patient and listen to the patient's complaints to promote the patient’s welfare.
   4. The trainee should provide effective education and counseling for patients.
   5. The trainee must write organized legible notes.
   6. The trainee must communicate any patient problems to the attending staff in a timely fashion.
VI. **Core Competency 6: System-Based Practice**
   a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should improve in the utilization of and communication with many health services and professionals such as nurses, dieticians, respiratory therapists, physical therapists, social workers as well as other medical consultants.
      2. The trainee should improve in the use of cost effective medicine.
      3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
      4. The trainee will assist in development of systems improvement if problems are identified.

VII. **Core Competency 7: Practice Based Learning Improvement**
   a. Objectives and Evaluation - The trainee’s performance will be evaluated on their willingness and ability to attain the following objectives:
      1. The trainee should use feedback and self-evaluation in order to improve performance.
      2. The trainee should read pertinent required material and articles provided to enhance learning.
      3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.
      4. The trainee should use information provided by senior trainees and attending physicians from rounds and consultations to improve performance and enhance learning.

VIII. **Educational Materials**
   a. Mandatory Reading
      1. Appropriate sections in Rakel’s; AND,
      2. Appropriate sections in Cecil’s Textbook of Medicine
   b. Suggested Readings
      1. Pertinent sections of MKSAP booklets.
   c. Medical Literature - The trainee is encouraged to read current medical literature particularly articles that pertain to current patient problems. Examples of appropriate current medical literature are the New England Journal of Medicine, Society of Hospitals Medicine, Annals of Family Medicine, Archives of Family Medicine and Journal of the American Medical Association.

IX. **Evaluation**
   a. Trainee Evaluation
      1. The attending will closely supervise and monitor the ward team activities and the performance of trainees.
      2. The attending is expected to give constructive suggestions and/or criticisms as soon as the attending identifies any significant
deficiencies.
3. The attending will provide trainees with a mid-rotation evaluation to comment on their performance.
4. The attending will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies.

b. Program Evaluation
   1. The trainee will fill out an evaluation of the rotation at the end of the month.
   2. Any constructive criticism, improvements or suggestions to further enhance training are welcome at any time.

X. Feedback
   a. Trainees are encouraged to discuss with the faculty advisor, attending physician, program director their learning experiences, difficulties or conflicts.
   b. Faculties are encouraged to use the feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.19 Critical Care Unit

Educational Purpose:
The goal of the Critical Care faculty is to train the trainee to evaluate and treat critically ill patients, use consultants and paramedical personnel effectively, and stress sensitive, compassionate management of patients and their families.

I. Principal Teaching Methods

   a. The trainees and trainees work under supervision of an ICU attending.
   b. Rounds typically begin in the ICU conference room for a formal presentation of the new admissions.
   c. The team then makes rounds on all patients. Diagnostic and treatment strategies are discussed at the bedside.
   d. If time allows, patient discussion is complemented by small, informal lectures on ICU medicine given by the faculty. The Hospitalist attending 2 times a week also provides formal teaching lectures.
   e. Reading assignments and literature searches are given to each and every house officer in the team, and they are to be discussed after working rounds are done.
   f. Time to go to noon conference is always provided to the whole team, the trainees will make him/her available to the nurses for emergencies. Lectures by subspecialty faculty are to stress critical aspects of their specialty.
II. **Core Competency 5: Patient Care**
   a. Trainees will learn to obtain a logical, chronological history from critically ill patients and their families and to do an effective physical examination in this challenging milieu. Use of information from old charts and private physicians is stressed.
   b. Trainees will learn to integrate physiological parameters and laboratory data with the clinical history and physical exam to make clinical diagnostic and management decisions.
   c. Trainees will learn the appropriate use of daily progress notes in patient follow-up, and the need for frequent reevaluation of the unstable patient.

III. **Core Competency 2: Medical Knowledge**
   a. Objectives
      1. Understand blood gas results and respond appropriately.
      2. Understand cardiovascular hemodynamics in a wide range of disease states.
      5. Nutritional support of the critically ill.
      6. Management of acute myocardial ischemia.
      8. Acute endocrinology emergencies.
      10. Sepsis and the sepsis syndrome.
      11. Acute treatment of cardiac arrhythmias.
   b. Procedural Skills
      1. Cardiopulmonary resuscitation
      2. Endotracheal intubation
      3. Central venous access
      4. Hemodynamic monitoring (Pulmonary Artery Catheterization)
      5. Thoracentesis
      6. Paracentesis
      7. Lumbar puncture
      8. Arterial cannulation
      9. Placement of a temporary transvenous and transcatheter pacemaker

IV. **Core Competency 3: Professionalism**
   a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
In the ICU, these goals are met in several ways:

a. Sensitive handling of a do-not resuscitates order.

b. Respect and compassion for the depersonalized, intubated, non-communicative patient.

c. Appropriate use of consultants and paramedical personnel.

d. Compassionate handling of families and development of rapport with them.

e. Trainees should learn to ask permission for an autopsy in a forthright, non-threatening way and should be available to family members to discuss autopsy findings.

f. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.

g. The trainee must be responsible and reliable at all times.

h. The trainee must always consider the needs of patients, families, colleagues, and support staff.

i. The trainee must maintain a professional appearance at all times.

V. **Core Competency 6: System-Based Practice**

a. Objectives - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. The trainee should improve in the utilization of and communication with colleagues and other health professionals.

2. The trainee should improve in the use of cost effective medicine.

3. The trainee will assist in determining the root cause of any error, which is identified and methods for avoiding such problems in the future.

4. The trainee will assist in development of systems’ improvement if problems are identified.

b. Educational Materials - Mandatory Reading:

1. The ICU Book - John Marini (2nd edition)

2. Critical Care Medicine: Civetta


c. Medical Literature - References of basic (classic and recent) articles in critical care medicine are provided. These are to be read and discussed with the team.

VI. **Core Competency 7: Practice Based Learning Improvement**

a. Objectives

1. The trainee should use feedback and self-evaluation in order to improve performance.

2. The trainee should read the required material and articles provided to enhance learning.

3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.
VII. Evaluation - Monthly evaluations by faculty of trainees and by trainees of faculty are submitted. Trainee evaluations are written with input from the nursing staff, patients or families as regards specific attitudes towards the critically ill patients. Faculty supervises most of the daytime procedures done in the ICU and evaluation and feedback here is immediate and ongoing.

VIII. Feedback - At the midway point of the rotation, trainees are given feedback (informally) on their performance to date. Areas and methods of improvement are suggested. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.20 Ambulatory Medicine Clinic

Educational Purpose:
To provide the trainee guidance and supervision as they develop a timely clinical approach to the patient in the outpatient setting. This would include the ability to formulate differential diagnoses based on the patient's specific complaints, the art of effective and appropriate communication with patients and other members of the health care delivery team.

The trainee will demonstrate competency in their ability to:

- Promote and teach the principles of preventive medicine
- Primary and secondary prevention in screening of asymptomatic adults

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. Trainees are assigned to the ambulatory teaching clinic and will be assigned on a regular basis to the ambulatory teaching clinic. The attending supervisor will oversee the activities of the trainee. The attending will review and discuss each case with the clinic trainees. The attending will supervise no more than four trainees in any given clinic.
   b. The patients seen in the ambulatory clinics are primarily indigent, community patients.
   c. The trainee will also see insured and Medicare/Medicaid patients.
   d. The trainee will be assigned to the ambulatory clinic based on program requirements.
   e. Teaching attending physicians will provide didactic guidance during case reviews that is relevant to their field of study. Trainees will be provided with website resources.

II. Core Competency 5: Patient Care
   a. Objectives - These objectives will be taught in relation to specific patients
whenever possible in the clinic or while on the in-patient service. Otherwise, they will be discussed in the scheduled didactic sessions.

1. Evaluate complaints from a symptom-oriented approach in terms of developing a management plan with the patient and establishing a diagnosis. Perform an efficient and thorough history, physical examination and diagnostic evaluation.

2. Become familiar with common complaints of ambulatory patients.

3. Perform concise and targeted histories and physical examinations. Perform a focused and targeted laboratory evaluation, including demonstrating reasonable discretion in terms of when to order expensive diagnostic tests.

4. Communicate effectively, using the telephone or other techniques, with physicians, patients and nurses.

b. Evaluation of Patient Care - The trainee will be evaluated using the following criteria:

1. Accuracy and completeness of history taking, medical interviewing and physical examination appropriate to the outpatient setting.

2. Thoroughness of the review of the available medical data on each patient.

3. Performance of appropriate maneuvers and procedures on patients.

4. Accuracy and thoroughness of patient assessments.

5. Appropriateness of diagnostic and therapeutic decisions.

6. Consideration of patient preferences in making therapeutic decisions.

7. Completeness of medical charting.

8. The trainee will gain experience in technical procedures as available in the subspecialty clinics, such as: arthrocentesis, lumbar puncture, anoscopy, rectal and pelvic examinations and OMT/OPP skills.

9. Ability to identify the patient who needs emergent attention versus the patient whose complaints can be evaluated over a longer period of time.

10. Completeness of medical charting.

11. Participation in the AOA CAP program per training program guidelines.

III. Core Competency 2: Medical Knowledge

a. Objectives - These objectives will be taught through the didactic sessions and at bedside teaching as they relate to specific patients in the clinic.

1. Diabetes - Classification, pathogenesis, diagnosis, management, comprehensive preventive care, management and identification of complications in accordance with the ADA guidelines.

2. Lipid Disorders - Classification, pathogenesis, diagnosis, screening, therapy and monitoring of lipid disorders in accordance with the ATP III guidelines.
3. Anticoagulation management - Pathogenesis, INR goal achievement, indications, length of treatment, complications of anticoagulation therapy in accordance with the most recent ACCP Consensus Conference on Antithrombotic Therapy (CHEST guidelines).


5. Congestive heart failure - Pathogenesis, classification, diagnosis, management and prognostication in accordance with ACC guidelines.

6. Osteoporosis - Pathogenesis, diagnosis, causes of secondary osteoporosis, and management in accordance with National standards.

7. Osteoarthritis - Pathogenesis, diagnosis and management in accordance with National Standards.

8. Headache - Pathogenesis, diagnosis and management.

b. Evaluation of Medical Knowledge - The trainee’s medical knowledge of endocrinology will be assessed by the following:
   1. The trainee’s ability to answer directed questions and participate in didactic sessions.
   2. The trainee’s ability to apply the information learned in the resources to the patient care setting.
   3. The trainee’s participation in the AOA CAP program.

IV. **Core Competency 3: Professionalism**
   a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should continue to develop their ethical behavior and must show the humanistic qualities of respect, compassion, integrity, and honesty.
      2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
      3. The trainee must be responsible and reliable at all times.
      4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
      5. The trainee must maintain a professional appearance at all times.

V. **Core Competency 4: Interpersonal and Communication Skills**
   a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should learn when to call a subspecialist for evaluation and management of a patient.
      2. The trainee should be able to clearly present the consultation cases
to the staff in an organized and thorough manner.

3. The trainee must be able to establish a rapport with the patients and listen to the patient's complaints to promote the patient's welfare.

4. The trainee should provide effective education and counseling for patients.

5. The trainee must write organized and legible notes.

6. The trainee must communicate any patient problems to the staff in a timely fashion.

7. The trainee will demonstrate empathy, compassion, patience and concern for the patient in relation to their medical complaints.

8. The trainee will learn how to deal with psychosocial issues including depression, poverty and family abuse on an outpatient basis.

9. The trainee will learn how to communicate in a clear, concise and polite manner with physicians, patients, nurses and other healthcare providers.

10. The trainee will listen carefully to patient complaints and determine the appropriate course of action for those complaints, which occasionally may require no more than reassurance and understanding.

11. The trainee will build on the attitudes developed in the ambulatory clinic to foster the belief in working cooperatively with physicians from other fields as well as other health professionals for the benefit of the patient.

12. The trainee will gain an appreciation for multifaceted differences in approach that various healthcare practitioners have in the outpatient setting. They will learn to respect these differences and work with other healthcare professionals for the common good of the patient.

VI. Core Competency 6: System-Based Practice

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, ophthalmologist, physical therapist, surgeon, and nuclear medicine specialist.

2. The trainee should improve in the use of cost effective medicine.

3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.

4. The trainee will assist in development of systems’ improvement if problems are identified.
VII. **Core Competency 7: Practice Based Learning Improvement**
   a. Objectives and Evaluation - The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives:
      1. The trainee should use feedback and self-evaluation in order to improve performance.
      2. The trainee should read the required material and articles provided to enhance learning.

VIII. Educational Materials
   a. Mandatory Reading - Trainees are encouraged to read appropriate textbook material that is germane to the types of medical problems that they see in clinic. The respective subspecialist in that clinic may give trainees that rotate in the subspecialty clinics additional readings.
   b. Suggested Reading and videos
      1. MKSAP booklet on Primary Care
      3. Teaching series videos (skin biopsy, effective communication, arthrocentesis technique).
      4. U.S. Preventive Task Force
   c. Medical Literature - A collection of updated review articles will be available which address basic areas of general ambulatory medicine. The trainee is encouraged to read as many of these articles as possible.

IX. Evaluation
   a. Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies.
   b. Program Evaluation
      1. The trainees will fill out an evaluation of the clinic rotation at the end of the month.
      2. Any constructive criticism, improvements, or suggestions to further enhance the training, are welcome at any time.

X. Feedback
   a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the ambulatory medicine rotation. Feedback should be sought from each faculty member on a daily basis.
   b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done twice annually.

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**3.21 Cardiology**

**Educational Purpose:**
To provide the trainees with formal intensive instruction and clinical experience
To provide the opportunity to acquire expertise in the evaluation and management of cardiovascular disorders

**Format:** Core cognitive ability and skill will be obtained in block rotations or through cardiology experiences in intensive care and cardiac care units. Trainees will obtain substantial cardiology experience throughout the three years of experience in the family medicine center, on their family medicine service, and internal medicine rotations. Trainees will accomplish proficiency in ECG interpretation and cardiopulmonary resuscitation.

Family medicine trainees electing additional training in cardiology, particularly trainees who are planning to practice in communities without readily available consultation resources, may require skills for which additional training in a structured cardiology education program is strongly recommended. Longitudinal experience in the center for family medicine and on the family medicine hospital service will add experiences in ECG interpretation, stress testing, coronary care, and continued follow-up of patients with cardiovascular problems.

Additionally, trainees will be encouraged to evaluate the fashion in which they provide cardiology care for their patients. Using a Plan-Do-Study-Act cycle, learners will engage in practice-based learning and improvement to ensure that patients receive optimum care founded in evidence-based medicine.

The trainee will demonstrate competency in their ability to:

- Understand basic and clinical knowledge of cardiac anatomy and pathophysiology of common cardiovascular diseases.
- Perform an appropriate cardiac history and physical examination, document findings, develop an appropriate differential diagnosis, and plan for further evaluation and management.
- Use evidence based knowledge regarding primary and secondary prevention of cardiovascular disease.
- Review current practices regarding the care of patients with cardiovascular disease and develop plans to improve the care.
- Work with physicians, nurses, pharmacists, dieticians, and other health care professionals who care for patients with common cardiovascular diseases.

1. **Core Competency 1: Osteopathic Concepts**
   i. Reflex inhibition to thoracic trigger points T1 T5, predominantly for sympathetic discharge which may affect tachydyrsrhythms or spasm;
ii. Occipito-atlantal therapy for parasympathetic outflow with potential effect in bradyarrhythmias;
iii. Limb fascial release for vascular insufficiency.

2. **Core Competency 5: Patient Care**
The trainee will demonstrate the ability to perform or appropriately refer:

1. Diagnostic procedures
   a. Performance of history taking and physical examination
   b. Mechanics and interpretation of ECG
   c. Interpretation of chest radiographs
   d. Treadmill/bicycle stress test monitoring and interpretation
   e. Ambulatory ECG monitoring and interpretation

2. Therapeutic procedures
   a. Risk management
   b. Cardiopulmonary resuscitation (CPR), both basic life support (BLS) and advanced cardiac life support (ACLS)
   c. Treating dysrhythmias and conduction disturbances
   d. Use of external temporary pacemakers
   e. Management of acute myocardial infarction, post-infarction care, and complications
   f. Congestive heart failure
   g. Hypertensive emergencies
   h. Supervision and management of cardiovascular rehabilitation
   i. Psychosocial issues
      i. Sexual functioning
      ii. Depression
      iii. Family dynamics
   j. Management of patients after an intervention
      i. Lifestyle adjustments
      ii. Coronary artery bypass surgery
      iii. Valve surgery
      iv. Congenital heart disease surgery
      v. Catheter-related interventional procedures

3. **Core Competency 2: Medical Knowledge**

1. Normal cardiovascular anatomy and physiology
2. Changes in cardiovascular physiology with age and pregnancy
3. Risk factors
   a. Coronary artery disease
      i. Hyperlipidemia
      ii. Cigarette smoking
      iii. Genetic predisposition
      iv. Sedentary life style
      v. Hypertension
      vi. Diabetes mellitus
vii. Obesity
viii. Nutrition
ix. Hormonal status
x. Emotional stress
b. Valvular heart disease

4. Cardiovascular history
5. Cardiovascular physical examination
6. Non-invasive examinations
   a. Electrocardiography
   b. Chest radiography
c. Stress testing, including treadmill/bicycle or pharmacologic techniques
d. Echocardiography/Doppler imaging, both rest and stress, using treadmill/bicycle or pharmacologic techniques
e. Radiosotope imaging, both rest and stress, using treatment/bicycle of pharmacologic techniques
f. ECG monitoring, in-hospital and ambulatory
g. Vascular Doppler and ultrasound examinations
h. Computerized Tomography (CT)
i. Magnetic resonance imaging (MRI) and Magnetic angiogram (MRA)

7. Invasive examinations
   a. Diagnostic cardiac catheterization and angiography
   b. Diagnostic carotid and peripheral vascular angiography
c. Intracoronary and peripheral vascular intervention using appropriate devices
   i. Central venous and peripheral arterial catheter
d. Electro physiologic studies
e. Indications and contraindications of therapeutic interventions
   i. Coronary artery bypass
   ii. Angioplasty techniques and stent placement
   iii. Pacemaker insertion
   iv. Implantable cardioverter defibrillator
   v. Valve replacement repair, percutaneous balloon valvotomy
   vi. Electro physiologic ablation

8. Relevant laboratory interpretation, including serum enzymes, isoenzymes, lipids, and b-type natriuretic peptide (BNP) or pro-BNP

9. Specific diseases/conditions
   a. Coronary artery disease
   i. Stable/unstable angina
   ii. Myocardial infarction, with and without complications
      1. Cardiogenic shock
      2. Dysthymias
      3. Papillary muscle dysfunction and rupture
      4. Ventricular rupture
5. Aneurysm
   iii. Sudden death
b. Syncope, cardiogenic and non-cardiogenic
c. Dysrhythmias
   i. Tachyarrhythmia
      1. Supraventricular
      2. Ventricular
      3. Reentrant
   ii. Bradyarrhythmia
   iii. Ectopy
      1. Atrial
      2. Ventricular
d. Hypertension
   i. Essential
   ii. Secondary
   iii. Pulmonary
c. Pulmonary heart disease
   i. Cor pulmonale
f. Heart failure
   i. Systolic dysfunction
   ii. Diastolic dysfunction
g. Venous thromboembolic disease (VTE)
h. Valvular heart disease
   i. Rheumatic
   ii. Congenital
   iii. Degenerative
   iv. Mitral valve prolapse syndrome
i. Congenital heart disease
   i. Common left to right shunts (acyanotic)
   ii. Common right to left shunts (cyanotic)
   iii. Common obstructive problems
j. Dissecting aneurysm
k. Innocent heart murmurs
l. Peripheral vascular disease
   i. Aneurysm
   ii. Carotid atherosclerosis
   iii. Arterial disease
   iv. Arteriosclerosis obliterans
m. Cardiomyopathies
   i. Congestive (dilated)
   ii. Restrictive
   iii. Hypertrophic cardiomyopathy
   iv. Postpartum
n. Pericardial disease
o. Infection-related
   i. Viral myocarditis
   ii. Subacute bacterial endocarditis
   iii. Kawasaki’s disease
   iv. Other cardiac disorders
   v. Immunologic
      1. Acute rheumatic fever
      2. Autoimmune disorders
   vi. Psychogenic
   vii. Traumatic
   viii. Nutritional
   ix. Myxoma
   x. Thyroid dysfunction
   xi. Marfan syndrome
   xii. Drug-related such as cocaine, steroids and chemotherapeutic agents
p. Evaluation of cardiac patient for non-cardiac surgery
   i. Cardiac risk including preoperative assessment tools
   ii. Preoperative and postoperative management
q. Antibiotic prophylaxis for valvular disease
10. Cardiovascular pharmacology

4. Core Competency 3: Professionalism
   a. The trainee will demonstrate attitudes that encompass:
      i. The importance of physician and patient working as partners to promote optimal cardiovascular health.
      ii. A compassionate approach to the care of patients with cardiac disease.
      iii. The psychosocial and economic impact of cardiovascular disease on the individual and family and use of the health care system to assist as needed.
      iv. Support of the individual and family through consultation, evaluation, treatment, and rehabilitation.
      v. The importance of lifestyle factors on the development and exacerbation of cardiovascular disease.
      vi. A multidisciplinary approach to the care of individuals with cardiovascular disease

5. Core Competency 4: Interpersonal & Communication Skills
   Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   i. The trainee should learn when to call a subspecialist for evaluation and management of a patient with a cardiovascular disease.
   ii. The trainee should be able to clearly present the consultation cases to
the staff in an organized and thorough manner.

iii. The trainee must be able to establish a rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.

iv. The trainee should provide effective education and counseling for patients.

v. The trainee must write organized and legible notes.

vi. The trainee must communicate any patient problems to the staff in a timely fashion.

6. **Core Competency 6: System-Based Practice**

   Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

   i. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, ophthalmologist, physical therapist, surgeon, and nuclear medicine specialist.

   ii. The trainee should improve in the use of cost effective medicine.

   iii. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.

   iv. The trainee will assist in development of systems’ improvement if problems are identified.

7. **Core Competency 7: Practice Based Learning Improvement**

   The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives:

   a. Objectives

      i. The trainee should use feedback and self-evaluation in order to improve performance.

      ii. The trainee should read the required material and articles provided to enhance learning.

      iii. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

8. Educational Materials

   a. Mandatory Reading

      i. The Heart, Braunwald et al; AND,

      ii. Related section in Rakel’s; OR,

      iii. Related section in Cecil’s Textbook of Medicine

   b. Suggested Reading

      i. Related section in MKSAP booklet

   c. Medical Literature


9. Evaluation
   a. Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the seven competencies.
   b. Program Evaluation
      i. The trainees will fill out an evaluation of the rotation at the end of the month.
      ii. Any constructive criticism, improvements, or suggestions to further enhance the training are welcome at any time.

10. Feedback
    a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rotation. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.
    b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

Cardiology

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3.22 Dermatology

Educational Purpose:
To provide the trainees with formal intensive instruction and clinical experience

To provide the opportunity to acquire expertise in the evaluation and management of cutaneous disorders

The trainee will demonstrate competency in their ability to:

- Recognize and manage common dermatological conditions.
- Identify allergic etiologies of dermatologic lesions.
- Know the indications for dermal biopsy.
- Recognize dermatologic manifestations of systemic disease.

  a. History
  i. Describe lesions by color, size, distribution;
  ii. Sensory findings;
  iii. Familial occurrence;
  iv. Exposure history;
  v. Question regarding the following: acne, discoloration, changes in moles, warts, cysts, corns/calluses, rashes, ulcers, blisters, pain/itching, nodules, masses, sore toenails, hair changes, toxic topical exposures.

  b. Physical exam.
  i. Recognize macule, papule, bulla, plaque, nodule, wheal, vesicle, pustule, cyst, atrophy, ulcer, scaling, crusts, purpura, petechiae, stria, tumor;
  ii. Detect the difference between primary and secondary bulla;
  iii. Detect normal and abnormal hair patterns;
  iv. Demonstrate proper lighting technique and full skin examination;
  v. Recognize common nail disorders.

  c. Basic principles.
  i. Drug eruption;
  ii. Skin cancer;
  iii. Immune mediated skin disorders;
  iv. Skin infections;
  v. Photosensitivity syndromes;
  vi. AIDS lesions (Kaposi's).
  vii. Diagnostics/therapeutics.
  viii. Utilize laboratory for above disorders where appropriate;
  ix. KOH slide for fungi;
  x. Appropriate therapy for each disorder above.

  d. Health maintenance
  i. Education on sunscreen use;
  ii. Surveillance of suspicious lesions.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. The trainee will receive individual instruction by private practice dermatologists in a private practice or Dermatology Clinic setting.
   b. The trainee will see a wide variety of patients from various ages, socioeconomic, educational, and cultural backgrounds.
   c. Outpatients will be evaluated by the trainee, and then discussed and seen with the dermatologist.
   d. All dermatology inpatient consults will be seen and discussed with the
dermatologist.
e. The dermatologists will give didactic teaching lectures weekly, as the
dermatologists and the trainees schedule allows... The schedule will vary
according to how the patient schedule runs on any particular week. A variety
of lecture topics will be available for the trainee.
f. The trainees will be responsible for reviewing a current journal review article
on a dermatology topic or be asked to do some simple research on a
dermatology topic and give a short presentation on these topics.
g. Additional instruction on how to set up and manage a private practice office
will be available for those interested.

II. **Core Competency 5: Patient Care**

a. Objectives - These objectives will be taught in relation to specific patients
whenever possible in the clinic or on the consult service. Otherwise they will
be discussed in the didactic sessions.

i. To become familiar with dermatology terminology and jargon.
ii. To be able to reliably recognize primary and secondary skin lesions.
iii. To learn how to categorize dermatologic conditions into sub-groups
based on pathophysiology.
iv. To gain a basic understanding of the diagnosis and management of
the most common dermatology conditions, which the trainee will
encounter.
v. To gain a working knowledge of various systemic and topical
therapies used in the treatment of skin disease.
vi. To learn how to perform diagnostic tests such as the use of the
Wood's lamp, KOH prep, scabies prep, Tzanck prep.
vii. To learn the indications for and the techniques necessary to perform
shave, punch, scissors-snip and excisional biopsies.
viii. To learn indications for and the techniques necessary to safely
perform liquid nitrogen treatments, intraleisional steroid injections,
electrodesiccation and wound care.
ix. To understand the appropriate use of steroid agents in dermatologic
therapy.
x. To understand the basics of dermatologic surgery and Mohs surgery.
xi. To understand the principles and applications of ultraviolet light
therapy.
xii. To learn the importance of an appropriate diagnosis being made
before treatment is instituted.

b. Patient Care - The trainee will be evaluated using the following criteria:

i. Completeness and accuracy of medical interviews and physical
examinations.
ii. Thoroughness of the review of the available medical data on each
patient.
iii. Performance of appropriate tests and procedures on patients.
iv. Accuracy and thoroughness of patient assessments.

v. Appropriateness of diagnostic and therapeutic decisions.

vi. Soundness of medical judgment.

vii. Consideration of patient preferences in making therapeutic decisions.

viii. Completeness of medical charting.

ix. Ability to establish a trusting, non-adversarial, communicative and satisfying relationship with the patient.

x. The trainee's timeliness, punctuality and attendance for the rotation.

III. Core Competency 2: Medical Knowledge

a. Objectives - These objectives will be taught through the didactic sessions and at bedside teaching as they relate to specific patients in the clinic and on the consult service.


b. Evaluation of Medical Knowledge - The trainee's Medical knowledge of dermatology will be assessed by the following:

i. The trainee's ability to answer directed questions and to participate in the didactic sessions.

ii. The trainee's presentation of assigned short topics. These will be examined for their completeness, accuracy, organization, and the trainee's understanding of the topic.

iii. The trainee's ability to apply the information learned in the didactic sessions to the patient care setting.
iv. The trainee's interest level in learning.

IV. **Core Competency 3: Professionalism**
Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
3. The trainee must be responsible and reliable at all times.
4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
5. The trainee must maintain a professional appearance at all times.

V. **Core Competency 4: Interpersonal & Communication Skills**
Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

i. The trainee should learn when to call a sub specialist for evaluation and management of a patient with a dermatologic disease.
ii. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
iii. The trainee must be able to establish a rapport with the patients and listens to the patient's complaints to promote the patient's welfare.
iv. The trainee should provide effective education and counseling for patients.
v. The trainee must write organized and legible notes.
vi. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. **Core Competency 6: System-Based Practice**
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

i. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, family physician, allergist, physical therapist, surgeon, and hematologist.
ii. The trainee should improve in the use of cost effective medicine.
iii. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
iv. The trainee will assist in development of systems' improvement if problems are identified.

VII. **Core Competency 7: Practice Based Learning Improvement**
The trainee's performance will be evaluated on their willingness and ability to
achieve the following objectives.

a. Objectives
   i. The trainee should use feedback and self-evaluation in order to improve performance.
   ii. The trainee should read the required material and articles provided to enhance learning.
   iii. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Educational Materials
a. Mandatory Reading: Fitzpatrick T. *Color Atlas and Synopsis of Clinical Dermatology*
b. Suggested Reading: MKSAP booklet on Dermatology
c. Medical Literature: A collection of updated review articles will also be provided which address basic areas of dermatology. The trainee is strongly encouraged to read as many of these articles as possible.

IX. Evaluation
a. Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to dermatology.
b. Program Evaluation - The trainees will fill out an evaluation of the dermatology rotation at the end of the month. Any constructive criticism, improvements, or suggestions to further enhance the training in dermatology are welcome at any time.

X. Feedback
a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the dermatology rotation. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the dermatology rotation.
b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation, evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.23 Endocrinology

**Educational Purpose:**
To provide the trainees with formal intensive instruction and clinical experience

To provide the opportunity to acquire expertise in the evaluation and management of endocrine disorders.
The trainee will demonstrate competency in their ability to:

- Diagnose and manage uncomplicated endocrine disorders.
- Understand the indications for surgery in the management of endocrine disorders.

a. History.
   i. Genital maturation/ menarche
   ii. Growth and development
   iii. Thyroid dysfunction
   iv. Steroid use
   v. Endocrine surgery/ trauma
   vi. Weight variation
   vii. Edema
   viii. Radiation exposure

b. Physical exam.
   i. Height/ weight/ proportion
   ii. Skin fold thickness.
   iii. Hyperpigmentation, stria, acne
   iv. Hirsuitism
   v. Exophthalmous
   vi. Thyroid nodule, size texture
   vii. Voice changes, breath odor
   viii. Inappropriate breast development
   ix. Genital structure and health.

c. Basic principles.
   i. LEVEL I:
      1. Adrenal insufficiency;
      2. Hyperadrenalism endogenous/exogenous
      3. Hyperaldosteronism
      4. Diabetes mellitus
      5. Diabetic ketoacidosis
      6. Hyperosmolar coma
      7. Hypoglycemia/ insulinoma
      8. Thyroid imbalance
      9. Goiter hypo and hyperfunctioning
     10. Thyroid nodules/ thyroiditis
     11. Parathyroid imbalance
     12. SIADH
     13. Diabetes insipidus
     14. Osteoporosis
     15. Calcium imbalance/ Paget's disease of bone
     16. Protein calorie malnutrition
17. Vitamin deficiencies  
18. Obesity/anorexia/bulimia  
19. Pheochromocytoma  
20. Hyperlipidemia  
21. Polycystic ovarian disease/amenorrhea;  
22. Impotence.

ii. LEVEL II:  
1. Reidel's struma  
2. Thyroid carcinoma  
3. Acute suppurative thyroiditis  
4. Carcinoid  
5. Dwarfism  
6. Hypogonadism  
7. Porphyrias  
8. Wilson disease  

d. Diagnostics/therapeutics.  
i. Suppression/stimulation testing:  
ii. Fasting stress (insulinoma)  
iii. TRH  
iv. ACTH  
v. Dexamethasone suppression  
vi. Water deprivation.  
vii. Special lab tests:  
viii. Glycosylated hemoglobin  
ix. Glucose tolerance test  
x. Serum hormone levels  
xi. Insulin and c-peptide  
xii. Serum catecholamines  
xiii. Plasma renin activity/aldosterone  
xiv. Urine VMA/metanephrines  
xv. Urine HCG.

e. Imaging procedures:  
i. Sella turcica x-ray/MRI  
ii. Thyroid radionuclide study  
iii. Ultrasound thyroid  
iv. Structural exam.

f. Health maintenance.  
i. Dietary support for diabetics  
ii. Hypertension control

The trainees will obtain competency in all of the above goals by meeting the following criteria:
II. Principal Teaching Methods
   a. The trainee will receive individual instruction by the endocrine attending physicians by seeing patients in the endocrine outpatient clinics and inpatient consultation.
   b. The trainee will see a wide variety of patients from various ages, socioeconomic, educational, and cultural backgrounds.
   c. Each outpatient will be evaluated by the trainee, and then discussed and seen with the staff endocrinologist. The trainee must complete a thorough progress note on every outpatient and the staff endocrinologist must countersign this.
   d. All endocrinology inpatient consults will be seen and consultation notes completed by the trainee. The cases must be discussed with the endocrinology attending who will then see the patient with the trainee, do bedside teaching rounds, and complete the consultation note.
   e. The endocrinology staff will give didactic teaching lectures weekly.
   f. The trainees will be responsible for reviewing 2-3 general endocrine topics for the month and giving short presentations on these topics.

III. Core Competency 5: Patient Care
   a. Objectives - These objectives will be taught in relation to specific patients whenever possible in the clinic or on the consult service. Otherwise they will be discussed in the didactic sessions.
      1. Recognize symptoms of hyperglycemia and hypoglycemia. Seek pertinent physical exam and laboratory information to identify systemic complications that occur as a result of diabetes such as diabetic retinopathy, neuropathy, nephropathy, CAD, or gastroparesis.
      2. Become familiar with the nutritional treatment of diabetes, aspects of home glucose monitoring, and the adjustments of hypoglycemic therapy required in association with abnormal glucose levels, exercise, concurrent illness, surgical procedures, etc.
      3. The trainee will be taught to do an appropriate and thorough foot exam of diabetic patients, including the use of the monofilament for neuropathy testing.
      4. Identify signs and symptoms of thyrotoxicoses and hypothyroidism. The trainee will be taught perform an adequate examination of the thyroid gland and this will be specifically demonstrated during this rotation.
      5. The trainee may observe or have the technique of fine needle aspiration for sampling thyroid nodules explained if none are done during the month.
      6. Identify signs and symptoms of lipid disorders and their management, including the use of the National Cholesterol
Education Program guidelines for treatment.
7. Identify signs and symptoms of adrenal disorders and their management, including the use of the cosyntropin stimulation test.
8. Identify signs and symptoms of pituitary disorders and their management.
9. Identify signs and symptoms of bone and calcium disorders and their management including interpretation of bone density tests.
10. Identify signs and symptoms of gonadal disorders and their management.
11. Use and interpretation of endocrine/metabolic testing. This is an important and practical component of this rotation. The trainee will become familiar with the appropriate and cost effective laboratory and radiologic work up of the endocrine disorders listed in the knowledge objectives and their interpretation.
12. The trainee should learn the importance of preventative medicine in routine health care and specifically in the area of diabetes management.

b. Evaluation of Patient Care - The trainee will be evaluated using the following criteria:
1. Completeness and accuracy of medical interviews and physical examinations.
2. Thoroughness of the review of the available medical data on each patient.
3. Performance of appropriate maneuvers and procedures on patients.
4. Accuracy and thoroughness of patient assessments.
5. Appropriateness of diagnostic and therapeutic decisions.
7. Consideration of patient preferences in making therapeutic decisions.
8. Completeness of medical charting.

IV. Core Competency 2: Medical Knowledge
a. Objectives - These objectives will be taught through the didactic sessions and at bedside teaching as they relate to specific patients in the clinic and on the consult service.
2. Thyroid Disease - Pathogenesis, diagnosis, and treatment of Hypothyroidism, Hyperthyroidism, Thyroid Nodules, Goiters, and Thyroid Cancer.
3. Lipid Disorders - Classification, pathogenesis, diagnosis, complications, and therapy of lipid disorders.
4. Adrenal Disease - Pathogenesis, diagnosis, and treatment of Adrenal Insufficiency, Pheochromocytoma, Primary
Hyperaldosteronism, and Incidental Adrenal Lesions.

5. Pituitary Disease - Pathogenesis, diagnosis, and treatment of Cushing’s Syndrome, Acromegaly, Hyperprolactinemia/ Prolactinomas, Glycoprotein- Secreting Tumors, Non-functioning Tumors, and Hypopituitarism.


10. Hyponatremia - Pathogenesis, diagnosis, and treatment of Central and Nephrogenic DI.


b. Evaluation of Medical Knowledge - The trainee’s Medical knowledge of endocrinology will be assessed by the following:

1. The trainee’s ability to answer directed questions and to participate in the didactic sessions.

2. The trainee’s presentation of assigned short topics. These will be examined for their completeness, accuracy, organization, and that the trainee understands the topic.

3. The trainee’s ability to apply the information learned in the didactic sessions to the patient care setting.

4. The trainee’s interest level in learning.

V. **Core Competency 3: Professionalism**

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.

2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.

3. The trainee must be responsible and reliable at all times.

4. The trainee must always consider the needs of patients, families, colleagues, and support staff.

5. The trainee must maintain a professional appearance at all times.

VI. **Core Competency 4: Interpersonal & Communication Skills**
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
1. The trainee should learn when to call a subspecialist for evaluation and management of a patient with an endocrine disease.
2. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
3. The trainee must be able to establish a rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.
4. The trainee should provide effective education and counseling for patients.
5. The trainee must write organized and legible notes.
6. The trainee must communicate any patient problems to the staff in a timely fashion.

VII. Core Competency 6: System-Based Practice
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
1. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, ophthalmologist, physical therapist, surgeon, and nuclear medicine specialist.
2. The trainee should improve in the use of cost effective medicine.
3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
4. The trainee will assist in development of systems’ improvement if problems are identified.

VIII. Core Competency 7: Practice Based Learning Improvement
The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives:
a. Objectives
1. The trainee should use feedback and self-evaluation in order to improve performance.
2. The trainee should read the required material and articles provided to enhance learning.
3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

IX. Educational Materials
a. Mandatory Reading
1. Section on endocrine-metabolic disease in Rakel’s; OR,
2. Section on endocrine-metabolic disease in Cecil’s Textbook of Medicine.

b. Suggested Reading
1. MKSAP booklet on Endocrinology
c. Medical Literature - A collection of updated review articles will also be provided which address basic areas of endocrinology. The trainee is strongly encouraged to read as many of these articles as possible.

X. Evaluation
   a. Trainee Evaluation
      1. The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to endocrinology.
   b. Program Evaluation
      1. The trainees will fill out an evaluation of the endocrine rotation at the end of the month.
      2. Any constructive criticism, improvements, or suggestions to further enhance the training in endocrinology are welcome at any time.

XI. Feedback
   a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the endocrinology rotation. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the endocrinology rotation.
   b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

Endocrinology

3.24 Gastroenterology

Educational Purpose:
To provide the trainees with formal intensive instruction and clinical experience

To provide the opportunity to acquire expertise in the evaluation and management of gastroenterological disorders

The trainee will demonstrate competency in their ability to:

- Screen appropriately for colorectal cancer.
- Understand the role of osteopathic principals and treatment in the diagnosis and management of gastrointestinal disease.
- Understand the indications for surgery in gastrointestinal disease.
- Manage uncomplicated diseases of the gastrointestinal system.

a. History.
i. Family history of inflammatory bowel disease, peptic ulcer, bowel cancer or polyps, celiac disease or lactase deficiency;
ii. Sexual history;
iii. Mouth and tongue symptoms including bleeding, pain, soreness, ulcer, swelling, lumps;
iv. Dysphagia, eructation, dyspepsia, odynophagia;
v. Vomiting/nausea/anorexia;
vi. Abdominal pain/bloating/swelling;
vii. Blood in stool, constipation, diarrhea, stool changes;
viii. Anal discharge;
ix. Anal pruritis/worms;
x. Pain or mass in rectum or perirectal area;
xi. Jaundice;
 xii. Weight loss or gain;
xiii. Food intolerance.
b. Physical exam.
i. Abdominal shifting dullness/ballottement;
ii. Sequential exam of the acute abdomen: auscultation first, light palpation least tender area next, then most tender area;
iii. Ebound, guarding, spasm;
iv. Know importance of serial abdominal exam;
v. Rectal/pelvic exam;
vi. Light/deep palpation for masses, hernia;
vii. Auscultation for bruits;
viii. Palpatory examination of the spleen, liver, abdominal aorta, hernias of the abdominal wall, masses;
ix. Detection of voluntary vs. Involuntary guarding, rigidity;
x. Performance and understanding of the iliopsoas and obturator tests.
c. Basic principles.
i. Reflux esophagitis/varices;
ii. Hiatal hernia;
iii. Acid peptic disease;
v. Upper and lower GI bleeding;
vi. Diarrhea: acute, chronic, physiologic;
vii. Diverticular disease;
viii. Inflammatory bowel disease;
ix. Irritable bowel syndrome;
x. Esophageal motility disorder;
xi. Diabetic gastropathy and enteropathy;
xii. Gut infections bacterial, parasitic, viral;
xiii. Pseudomembranous colitis;
xiv. Hemorrhoids/anal fissures/pruritis ani;
xv. Hyperbilirubinemas conjugated and unconjugated familial;
xvi. Drug induced cholestasis;
xvii. Cirrhosis alcoholic, cardiac;
xviii. Hepatitis A, E, toxic, chronic persistent and chronic active;
xix. Cholangitis/cholecystitis/cholelithiasis;
xx. Pancreatitis/pseudocyst/cancer;
xxi. Malnutrition/malabsorption;
xxii. Volvulus/Meckel's diverticulum;
xxiii. Ischemic bowel;
xxiv. Gay bowel syndrome;
xxv. Hernias.
d. Diagnostics/therapeutics.
i. Flexible sigmoidoscopy;
ii. Paracentesis;
iii. Insertion of central venous catheter for parenteral nutrition;
iv. Insertion of nasogastric tube;
v. Liver biopsy assist;
vi. Structural examination and therapy;
vii. Interpretation of appropriate laboratory tests to confirm findings in areas listed above;
viii. Understand indications for appropriate surgical procedures to include:
ix. Cholecystectomy;
x. Peptic ulcer surgery;
xi. Hiatal hernia repair;
 xii. Abdominal wall herniorrhaphy;
xiii. Exploratory laparotomy;
xiv. Bowel resection;
 xv. Enterostomy/gastrostomy;
xvi. Peritoneal shunts;
xvii. Endoscopic procedures assist:
xviii. Esophageal dilation;
xix. Sclerotherapy for esophageal variceal bleeding;
xx. Palliative therapy for esophageal, gastric and colonic tumors;
xxi. Sphincterotomy of the Ampulla of Vater;
xxii. Stenting of bile duct;
xxiii. Polypectomy.
e. Health maintenance.
i. Recommended bowel screening protocol;
ii. Colonic surveillance for polyps;
iii. Dietary management of colonic disease and malabsorption;
iv. Psychosocial support for gut dysfunction.
f. Core Competency 1: Osteopathic Concepts
i. Liver pump drainage technique;
ii. Direct myofascial release to rectus abdominus and psoas spasm;
iii. Focus paraspinal areas for sympathetic reflexes:
iv. T5 T9 for gastric and esophageal motility;
v. T12 L2 for bowel function and IBS;
vi. Occipito-atlantal therapy for parasympathetic outflow with nausea and gastroparesis.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods - Formal instruction includes emphasis on the pathogenesis, manifestations and complications of gastrointestinal disorders. The impact of different modes of therapy and the appropriate utilization of laboratory tests and procedures is stressed.
   a. Patients with gastrointestinal disorders and clinical problems are seen by trainees during their Family Medicine ward rotations, gastroenterology consult service rotation, and in the outpatient clinics - trainees may either call in consults or perform consults, depending upon their current rotation.
   b. Gastroenterology faculty provide didactic teaching and teaching on rounds.
   c. Trainees rotating on the consultative service see all Gastroenterology consultations and also participate in outpatient care at the weekly gastroenterology clinic.
   d. Trainees become familiar with diagnostic and therapeutic upper endoscopy, colonoscopy, ERCP, capsule endoscopy, liver biopsy, and esophageal motility studies in our modern endoscopy unit and radiology department.

II. Core Competency 5: Patient Care
   a. Trainees will have formal instruction, clinical experience, and opportunities to acquire expertise in the evaluation and management of patients with most of the following clinical problems:
      1. Dysphagia
      2. Abdominal pain
      3. Acute abdomen
      4. Nausea and vomiting
      5. Diarrhea
      6. Constipation
      7. Gastrointestinal bleeding
      8. Jaundice
      9. Abnormal liver chemistries
     10. Cirrhosis and portal hypertension
     11. Malnutrition
     12. Genetic/inherited disorders
     13. Surgical care of gastrointestinal disorders
   b. Trainees will have instruction in the indications, contraindications, complications, limitations and exposure to the interpretation of the
following diagnostic and therapeutic procedures:
1. Imaging of the digestive system including: ultrasound procedures, computed tomography, nuclear medicine procedures, vascular radiology procedures, and magnetic resonance imaging.
2. Endoscopic procedures including EGD, PEG, sclerotherapy, variceal banding, electrocoagulation, esophageal dilation, colonoscopy, polypectomy, ERCP including sphincterotomy and therapeutic procedures, and capsule endoscopy.
3. Specialized dilation procedures
4. Percutaneous cholangiography
5. Percutaneous endoscopic gastrostomy
6. Liver and mucosal biopsies
7. Gastrointestinal motility studies
8. Enteral and parenteral alimentation
c. Opportunities will be provided for the trainee to gain competence in the performance of the following procedures:
   1. The abdominal examination
   2. Paracentesis
   3. Sengstaken-Blakemore tube placement
   4. Rigid and/or flexible sigmoidoscopy, EGD and colonoscopy

III. **Core Competency 2: Medical Knowledge**
a. Knowledge Objectives - Trainees will have formal instruction, clinical experience, and opportunities to acquire expertise in the evaluation and management of some or all of the following disorders:
   1. Diseases of the esophagus
   2. Acid-peptic disorders of the gastrointestinal tract
   3. Motor disorders of the gastrointestinal tract
   4. Irritable bowel syndrome and other functional GI disorders
   5. Disorders of nutrient assimilation
   6. Inflammatory bowel diseases
   7. Vascular disorders of the gastrointestinal tract
   8. Gastrointestinal infections
   9. Gastrointestinal and pancreatic neoplasms
   10. Gastrointestinal diseases with an immune basis
   11. Pancreatitis
   12. Gallstones and cholecystitis
   13. Alcoholic liver disease
   14. Viral and immune hepatitis
   15. Cholestatic syndromes
   16. Drug-induced hepatic injury
   17. Hepatobiliary neoplasms
   18. Chronic liver disease
   19. Gastrointestinal manifestations of HIV infections
b. Evaluation of Medical Knowledge - Trainees will be evaluated on their performance in the following manner:
   1. Consults will be reviewed with the attending physicians.
   2. Patient presentations and conference presentations will be reviewed.
   3. Procedures done by the trainee will be documented, giving the indications, outcomes, diagnoses, level of competence and assessment by the supervisor of the ability of the trainee to perform it independently.
   4. Mid-rotation evaluation session with the faculty member working with the trainee.
   5. The trainees will also fill out an evaluation of the Gastroenterology rotation at the end of the month.

IV. Core Competency 3: Professionalism
a. The program wishes to develop the following attitudes, values and habits:
   1. Respect for the risks and benefits of diagnostic and therapeutic Procedures.
   2. Prudent, cost-effective and judicious use of special instruments, test and therapy in the diagnosis and management of gastroenterological disorders.
   3. Appropriate method of calling gastroenterology consults.
   4. Need for continually reading current literature on gastroenterology–liver diseases to stay current in terms of diagnosis and treatment of diseases.

V. Core Competency 4: Interpersonal and Communication Skills
a. Trainees should develop the following lifelong learning habits to insure their continuing development and education:
   1. The ability to ask gastroenterology consultants a precise and clear question.
   2. The development of critical reading skills for the gastroenterology literature.
   3. Ability to give clear patient presentations to consultants and at conferences in gastroenterology.

VI. Core Competency 6: System Based Practice
a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   1. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, surgeon, radiologist and pathologist.
   2. The trainee should improve in the use of cost effective medicine.
   3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the
future.
4. The trainee will assist in development of system’s improvement if problems are identified.

b. Educational Materials - The trainee will be oriented to the major textbooks and journals in gastroenterology and hepatology available in the Library. Articles related to major topics will also be made available.

VII. Core Competency 7: Practice Based Learning Improvement
a. The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives:
   1. The trainee should use feedback and self-evaluation in order to improve performance.
   2. The trainee should read the required material and articles provided to enhance learning.
   3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Evaluation
a. Trainee Evaluation
   1. The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to gastroenterology.

b. Program Evaluation
   1. The trainees will fill out an evaluation of the gastroenterology rotation at the end of the month.
   2. Any constructive criticism, improvements, or suggestions to further enhance the training in gastroenterology are welcome at any time.

IX. Feedback - Trainees will receive feedback with respect to achieving the desired level of proficiency and working out ways in which they can enhance their performance when the desired level of proficiency has not been achieved. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.25 Hematology/Oncology

Educational Purpose: To give the trainees formal instruction, clinical experience, and the opportunity to acquire expertise in the evaluation and management of malignant disorders.

Hematology:

The trainee will demonstrate competency in their ability to:

- Manage common Hematologic disorders.
• Understand hematopoiesis.
• Understand the diagnosis and management of coagulopathies.

a. History.
   i. Fatigue, early exhaustion, anorexia, weight loss;
   ii. Abnormal bleeding;
   iii. Skin lesions, lumps, swellings, masses;
   iv. Family history of tumors;
   v. Medications, drug use, alcohol, toxin exposure, smoking;
   vi. Fever of unknown origin;
   vii. Trauma and prior surgery.

b. Physical exam.
   i. Observe changes in fundi, sclera, conjunctiva, mouth, nose;
   ii. Lymph nodes;
   iii. Nails and nail beds;
   iv. Tongue;
   v. Bones and joints;
   vi. Liver and spleen;
   vii. Structural examination.

c. Basic concepts.
   i. Iron deficiency anemia and sideroblastic anemia;
   ii. Megaloblastic anemia;
   iii. Bone marrow failure;
   iv. Aplastic anemia and myelophthisis;
   v. Anemia of chronic disease;
   vi. Hemolytic anemia;
   vii. Hemoglobinopathies;
   viii. Platelet disorders;
   ix. Clotting/bleeding disorders;
   x. Blood typing and transfusion medicine;
   xi. Polycythemia vera;
   xii. Myeloproliferative disorders;
   xiii. Diseases of the reticuloendothelial system;
   xiv. Acute and chronic leukemia;
   xv. Hodgkin's disease/lymphoma;
   xvi. Myeloma/gammopathy;
   xvii. AIDS and its cancers.

d. Diagnostics/therapeutics.
   i. Bone marrow aspiration and core biopsy;
   ii. Peripheral blood smear interpretation;
   iii. Template bleeding time;
   iv. Lumbar puncture for intrathecal therapy assist;
   v. Thoracentesis, paracentesis, skin biopsy for diagnostic purposes;
vi. Osteopathic structural examination.

e. Health promotion.
   i. ACS cancer screening protocols for GI, GYN, prostate, breast cancer;
   ii. Hospice;
   iii. Chronic pain management;
   iv. Advanced directives.

**Oncology:**

The trainee will demonstrate competency in their ability to:

- Screen for and diagnose common cancers.
- Participate with the oncologist in the care of cancer patients.
- Utilize a team approach for the care of cancer patients.
- Utilize Hospice in the management of the terminally ill patient.

a. History.
   i. Carcinogens in environment/workplace;
   ii. Family history and genetic predisposition;
   iii. Exposure to radiation, toxins, drugs, hormones;
   iv. Tobacco use;
   v. Sun exposure;
   vi. Fatigue, weakness, weight loss, anorexia;
   vii. Bleeding;
   viii. Masses, lumps, changes in skin lesions;
   ix. Bowel habit change, bloating;
   x. Fever, sweats;
   xi. Dysphagia, mouth sores;
   xii. Jaundice, abdominal pain;
   xiii. Dypsnea, edema;
   xiv. Mental status change, delirium, neurologic abnormalities, personality change;
   xv. Chronic cough.

b. Physical exam.
   i. Masses;
   ii. Pallor;
   iii. Edema;
   iv. Skin changes;
   v. Complete lymph node examination;
   vi. Rectal exam and occult blood testing;

c. Basic concepts.
   i. Pathophysiology of neoplasia: growth patterns, doubling time, etiologies;
ii. Cancer chemotherapy principles: first and second order cell kill, marrow salvage;
iii. Breast cancer;
iv. Ovarian cancer;
v. Genital cancer/testicular cancer;
vi. Prostatic hypertrophy and malignancy;
vii. Skin cancers;
viii. Paraneoplastic syndrome;
ix. Oncologic emergencies including hemorrhage, sepsis, hypercalcemia, seizures, coma, cauda equina syndrome;
x. Hemochromatosis;
xi. Liver/gall bladder/ductal carcinoma;

xii. GI tract cancer and pancreas;

xiii. Lung cancer;

xiv. Urinary tract cancer;

xv. Radiation injury;

xvi. Endocrine neoplasms: Zollinger-Ellison, gastrinoma, carcinoid thyroid/parathyroid cancer;
xvii. CNS tumors.

d. Diagnostics/therapeutics.
   i. Bone marrow aspiration/biopsy;
   ii. Thoracentesis/paracentesis;
   iii. Osteopathic structural exam.

e. Health promotion.
   i. Hospice care;
   ii. Pain management;
   iii. Psychosocial support;
   iv. Rehabilitation;
   v. Nutritional support.

f. Core Competency 1: Osteopathic Concepts
   i. Liver/spleen pump techniques;
   ii. Lymphatic drainage techniques.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. The trainee will receive individual instruction by the hematology/oncology attending through seeing patients in the hematology/oncology outpatient clinic. The trainee will also be responsible for patients on the oncology inpatient service and the inpatient consult service. The attending or fellows will provide didactic teaching sessions.

   b. The trainee will see a wide variety of patients from various ages, socioeconomic, educational, and cultural backgrounds.
c. Each outpatient will be evaluated by the trainee, and then discussed and seen with the staff hematologist/oncologist. The trainee will review the medical records, evaluate, and examine each patient; followed by discussion with hematology/oncology staff that will examine the patient and reassess the patient care and follow-up plan. The trainee must complete the history and physical examination on the outpatient visit sheet and complete the recommendations after discussion with the attending.

d. The trainee will also be responsible for the inpatient oncology service to include admission history and physical examination and daily rounds (Monday through Friday). The trainee will dictate all discharge summaries for the month they are on service.

e. All inpatient hematology/oncology consults will be seen and consultation notes completed by the trainee Monday through Friday. The trainee will perform a complete history, physical exam, and review pertinent laboratory, radiologic and pathologic data. The case will be presented to the attending along with a discussion of the primary diagnosis and differential diagnosis, as well as a suggested therapeutic plan. The attending will then see the patient with the trainee, do bedside teaching rounds, and write the recommendations on the consultation form.

II. Core Competency 5: Patient Care

a. Objectives: - These objectives will be taught in relation to specific patients in the clinic or on the consult service:

1. Recognize the signs and symptoms of oncologic emergencies (fever and neutropenia; hypercalcemia; tumor lysis syndrome; hyperleukocytosis; spinal cord compression; superior vena cava syndrome). Seek pertinent physical exam, laboratory information, radiographic, and pathology reports necessary to identify the oncologic emergency.

2. Become familiar with the evaluation of hematologic disorders (anemia, thrombocytopenia, leukocytosis, coagulopathies). Seek pertinent history, physical exam, and laboratory information necessary to identify the oncologic emergency.

3. Become familiar with the hematologic malignancies (leukemias, non-Hodgkin's lymphomas, Hodgkin's disease, multiple myeloma). Seek pertinent physical exam, laboratory information, radiographic, and pathology reports necessary to identify the hematologic malignancies.

4. Become familiar with the common solid tumors to include breast, colon, lung and prostate cancer. Seek pertinent physical exam, laboratory information, radiographic, and pathology reports necessary for formulating a therapeutic plan.

5. Become familiar with the complications of cancer treatment. Seek pertinent physical exam, laboratory information, radiographic, and
pathology reports necessary to identify the complications.

6. Recognize the common paraneoplastic syndromes: hypercalcemia, SIADH, Eaton Lambert, ectopic ACTH. Seek pertinent physical exam, laboratory information, radiographic, and pathology reports necessary to identify the paraneoplastic syndrome.

7. Become familiar with management of metastatic disease. Seek pertinent physical exam, laboratory information, and radiographic studies to identify the metastatic disease.

8. Learn the concepts of pain management. Seek pertinent physical exam, radiographic studies necessary to manage pain appropriately.

9. Become familiar with hospice care and end of life issues. Learn when referral to hospice is appropriate.

b. Evaluation of Patient Care - The trainee will be evaluated using the following criteria:

1. Completeness and accuracy of medical interviews and physical examinations.

2. Thoroughness of the review of the available medical data on each patient.

3. Performance of appropriate maneuvers and procedures on patients.

4. Accuracy and thoroughness of patient assessments.

5. Appropriateness of diagnostic and therapeutic decisions.


7. Consideration of patient preferences in making therapeutic decisions.

8. Completeness of medical charting.

III. Core Competency 2: Medical Knowledge

a. Objectives - These objectives will be taught at bedside teaching as they relate to specific patients in the clinic and on the consult service.

1. **Breast cancer** - Screening, diagnosis, treatment, and follow up after completion of therapy, according to the guidelines as established by the National comprehensive Cancer Network (NCCN) guidelines.

2. **Colon cancer** - Screening, diagnosis, treatment, and follow up after completion of therapy, according to the guidelines as established by the National comprehensive Cancer Network (NCCN) guidelines.

3. **Lung cancer** - Determination of respectability, appropriate therapy for cell type and stage according to the guidelines as established by the National comprehensive Cancer Network (NCCN) guidelines.

4. **Oncologic emergencies** - Recognition of signs and symptoms and appropriate management of hypercalcemia, superior vena caval syndrome, neutropenic fever, tumor lysis syndrome, hyperleukocytosis, spinal cord compression.

5. **Hematologic disorders** - Importance of an accurate and complete history and physical examination. Appropriate laboratory studies
b. Evaluation of Medical Knowledge - The trainee’s Medical knowledge of Hematology/Oncology will be assessed by the following:
   1. The trainee’s ability to answer directed questions and to participate in case management.
   2. The trainee’s presentation of assigned short topics. These will be examined for their completeness, accuracy, organization, and that the trainee understands the topic.
   3. The trainee’s ability to apply the information to the patient care setting.
   4. The trainee’s interest level in learning.

IV. Core Competency 3: Professionalism
   a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
      2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
      3. The trainee must be responsible and reliable at all times.
      4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
      5. The trainee must maintain a professional appearance at all times.

V. Core Competency 4: Interpersonal and Communication Skills
   a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should learn when to call a subspecialist for evaluation
and management of a patient with hematology or oncologic problem.
2. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
3. The trainee must be able to establish a rapport with the patients and listen to the patient's complaints to promote the patient's welfare.
4. The trainee should provide effective education and counseling for patients.
5. The trainee must write organized and legible notes.
6. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. **Core Competency 6: Systems-Based Practice**

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. The trainee should improve in the utilization of and communication with many health services and professionals such as the radiologist, surgeon, and pathologist.
2. The trainee should improve in the use of cost effective medicine.
3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
4. The trainee will assist in development of systems’ improvement if problems are identified.

VII. **Core Competency 7: Practice Based Learning Improvement** - The trainee's performance will be evaluated on their willingness and ability to achieve the following objectives:

a. The trainee should use feedback and self-evaluation in order to improve performance.
b. The trainee should read the required material and articles provided to enhance learning.
c. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases

VIII. Educational Material

a. Harrison’s Principles of Family Medicine; OR,
b. Cecil’s Textbook of Medicine
c. MKSAP (Oncology & Hematology booklets)
e. Journal of Clinical Oncology (www.jco.org)
f. Blood (www.bloodjournal.org)
g. Understanding the benefits of adjuvant chemotherapy in Breast and Colon cancer patients (www.adjuvantonline.com)

IX. Evaluation
a. Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to hematology/oncology.

b. Program Evaluation - The trainees will fill out an evaluation of the hematology/oncology rotation at the end of the month. Any constructive criticism, improvements, or suggestions to further enhance the training in hematology/oncology are welcome at any time.

X. Feedback
a. The trainee should receive frequent feedback in regards to his or her performance during the hematology/oncology rotation. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the hematology/oncology rotation.

b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.26 Infectious Diseases

**Educational purpose:**
To provide the trainee with didactic and clinical experiences in both outpatient and inpatient settings.

To provide educational experiences that will expand their knowledge and skills in the management of infectious diseases.

The trainee will demonstrate competency in their ability to:

- Diagnose and manage common infectious diseases.
- Understand the epidemiology of infectious diseases.
- Appreciate the role of the health care team in the control of infectious disease.
- Understand the role of the immune system in health and disease.
- Understand the role of antibacterial, anti-fungal, and anti-viral agents in the management of infectious disease.

a. History.
   i. Fever curve;
   ii. Recent patient contacts;
   iii. Travel and family history;
   iv. Complete sexual history;
   v. Work/environmental exposures;
vi. Surgical/dental procedures or trauma;

vii. Detection of immunocompromising disorders (diabetes, carcinoma, steroid use, alcohol, etc.);

viii. Drug abuse/smoking;

ix. Discharges, odors, sores, swellings, and rashes.

b. Physical exam.
   i. Skin lesions typical of specific organisms;
   ii. Typical fever patterns of specific organisms;
   iii. Identify and differentiate findings for the following:
   iv. Skin abscess, cellulitis, lymphangitis, phlebitis;
   v. Conjunctivitis, sty, uveitis, blepharitis, periorbital cellulitis;
   vi. Pharyngitis and pharyngeal abscess;
   vii. Otitis externa, media, and serous otitis;
   viii. Bronchitis, pneumonia, abscess, empyema;
   ix. Peritonitis, cholangitis, pelvic infection, abscess;
   x. Septic joint, bursitis, osteomyelitis;
   xi. Urethritis, cystitis, nephritis, abscess;
   xii. Sialoadenitis, thyroiditis;
   xiii. Paronychia/felon;
   xiv. Meningitis, brain and epidural abscess;
   xv. Botulism, Guillian-Barre, transverse myelitis;
   xvi. Infectious mononucleosis;
   xvii. Food poisoning;
   xviii. Systemic fungemias;
   xix. Osteopathic structural examination.

c. Basic concepts.
   i. Septic shock;
   ii. Iatrogenic infections;
   iii. Infected prosthetic devices or central lines;
   iv. Endocarditis;
   v. Toxic shock;
   vi. Human and animal bites;
   vii. Infectious pericarditis/mediastinitis;
   viii. Travel related immunizations;
   ix. AIDS;
   x. Urinary tract infections;
   xi. Gram negative sepsis;
   xii. Tuberculosis;
   xiii. Sexually transmitted diseases;
   xiv. Antibiotic associated colitis;
   xv. Fever of unknown origin.

d. Diagnostic/therapeutics.
   i. X-ray interpretation: chest, bone, soft tissue;
The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Principal Teaching methods**
   a. The trainee will receive individual instruction by the Infectious Diseases (ID) attending while evaluating patients at the ID/HIV clinic and on the consult service and by didactic teaching sessions.
   b. The trainee will see a wide variety of infectious processes in a heterogeneous population.
   c. The trainee will review the medical record and examine each patient followed by discussion with the ID staff that will examine the patient and reassess the medical problems, patient care and follow up plan. The trainee must complete a thorough note that will be countersigned by the ID staff.
   d. For in-patient ID consultations, the trainee will perform a complete history and physical examination and establish a diagnostic/therapeutic plan. The cases must be discussed with the ID staff with discussion of findings, bedside teaching, review of data and complete the consultation note. The ID staff must countersign the trainee’s consult note.
   e. The ID attending will give didactic teaching lectures each week.
   f. The trainee will review a topic of infectious disease or review the literature in an interesting ID case diagnosed or followed by the ID service.
   g. The trainee will spend two (2) sessions, one (1) hour each, in the Microbiology lab to be familiar with the routine preparation of body fluid specimens. The trainee will be trained to perform and interpret Gram stains by the microbiology laboratory coordinator.

II. **Core Competency 2: Medical Knowledge and Core Competency 5: Patient Care**
   a. Objectives - These objectives will be taught in relation to specific patients whenever possible in the outpatient clinic or in-patient consult service:
      1. Acquire the skills to construct chronologies of symptoms in a febrile patient, recognizing possible exposures or risk factors and treatment that the patient may have received.
2. Become familiar with the workup of a febrile patient and differentiate from non-infectious causes of fever.


4. Recognize and interpret the importance of certain life styles and life events in the risk for specific infections, including intravenous drug abuse, sexual orientation or behavior, socioeconomic status, travel, animal exposure and environmental exposure.

5. Identify sign and symptoms and management of patients presenting with primary HIV infection and follow the Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents.

6. Identify clinical manifestations of patients with HIV infection presenting with an opportunistic infection.

7. Identify sign and symptoms and management of patients that present with skin and soft tissue infections.

8. Recognize and appropriately manage patients with infected medical devices.

9. Recognize physical signs of intravascular infections including infective endocarditis and select appropriate treatment.

10. Distinguish common rashes associated with infectious and antibiotic therapy.

11. Recognize the role of the following underlying medical conditions in various infectious entities: Advanced age, diabetes mellitus, renal failure, malnutrition, alcoholism, COPD and cardiovascular disease, congenital or acquired immunodeficiency (including HIV infection).

12. Select appropriate antimicrobial therapy in a variety of infectious entities both in community acquired or nosocomial infections. This requires knowledge of general antimicrobial therapy with an understanding of the risks and benefits of specific antibiotics and current understanding of the current resistance pattern.

13. Recognize and identify differential diagnosis for fever in association with other symptoms such as headache, altered mental status, abdominal pain, cough, shortness of breath, dysuria, back pain, arthralgia/arthritis, rash and new neurological deficit.

14. Recognize and understand the natural course and pathogenesis of sepsis syndrome.

15. Recognize and understand the natural and pathogenesis of sepsis associated with infection at specific organ system:
   a. Upper and lower respiratory tract infections
   b. Urinary tract infections and genitourinary tract (including STDs)
c. Bone and joint infections

d. CNS infections (including meningitis, encephalitis, brain abscess, epidural abscess)

e. Gastrointestinal infections (food poisoning, hepatitis, colitis, pancreatitis)

f. Intra-abdominal infections (Including peritonitis)

16. Infections of the eye.

17. Understanding end-of-life issues that pertain to the management of opportunistic and Hospitals-acquired infections.

18. Perform and interpret Gram stains.

19. Understand basic fundamental of microbiologic procedures.

III. Evaluation of Medical Knowledge - The trainee’s Medical Knowledge of Infectious Diseases will be evaluated by their:

a. Ability to perform and adequate consultation and plan of care.

b. Capacity to participate in didactic infectious diseases discussions.

c. Ability to apply the information learned in the didactic sessions to the patient care setting.

IV. **Core Competency 3: Professionalism** - The performance of the trainees will be evaluated according to their ability to:

a. Understand the ethical conflict between the care of an individual and the welfare of the community.

b. Understand the ethical conflicts pertaining to antimicrobial therapy, preventive measures and vaccination.

c. Acknowledge medical errors and determine how to avoid future mistakes.

d. Be responsible and timely with the consulting staff and with patients.

e. Maintain a professional appearance at all times.

f. Understand how personal and cultural characteristic impacts the efforts to control the spread of communicable diseases.

g. Develop ethical behavior and humanistic qualities of respect, compassion, integrity, and honesty.

V. **Core Competency 4: Interpersonal and Communication Skills** - The performance of the trainees will be evaluated according to their ability to:

a. Communicate with the personnel of the microbiology laboratory to obtain pertinent microbiologic data form patient's samples.

b. Appropriately call a subspecialist for evaluation and management of a patient with an infectious disease.

c. Ask precise questions of infectious diseases consultants.

d. Understand the essential elements of a thoughtful consult report and organize it in a systematic manner to be useful for the consultant physician and the patient.

e. Establish a rapport with the patients.

f. Provide efficient education and counseling to the patients.

g. Write legible and organized consultation notes.
h. Clearly present problems to consultants and at infectious diseases conferences.

VI. **Core Competency 6: System-Based Practice** - The performance of the trainees will be evaluated according to their ability to:
   a. Familiarize with the system to provide intravenous antibiotic in the outpatient setting.
   b. Understand the issues implicated with the transmission of an infectious agent and the responsibility of the physician to protect uninfected individuals.
   c. Apply evidence-based, cost-effective strategies for prevention, diagnosis and disease management.

VII. **Core Competency 7: Practice Based Learning Improvement** - The performance of the trainees will be evaluated according to their ability to:
   a. Identify parameters to monitor care.
   b. Maintain currency with patient's clinical progress.
   c. Keep up to date with medical literature related to interesting cases seen in the consult service.

VIII. Educational materials
   a. Mandatory reading:
      2. Section on Infectious Diseases in Harrison's Principles of Family Medicine.
      3. A practical approach to Infectious Diseases. Richard Reese and Robert Betts
   b. Suggested reading:
      1. Section on Infectious Diseases in MKSAP – (current edition)

IX. Evaluation
   a. Trainee evaluation
      1. Trainees are formally evaluated at the end of the infectious diseases rotation. The faculty will complete a standard written evaluation form used by the department.
      2. Mid-rotation evaluation session between the trainee and the infectious diseases staff will also be conducted.
   b. Program evaluation - The trainees will complete a formal written evaluation of the infectious diseases rotation at the end of the month.

X. Feedback - Trainees will receive frequent feedback concerning their performance during the infectious diseases rotation. Ways in which they can enhance their performance will be discussed when the desired level of proficiency has not been met. The faculty is encouraged to use feedback throughout the rotation.
Infectious Diseases

3.27 Nephrology

Educational Purpose:
To train the trainee in the identification, subsequent work-up and care of the patient with renal disease in conjunction with the nephrology subspecialist.

Another goal of the rotation is to teach medicine house staff and medical students, basic renal physiology and pathophysiology with application toward the care of patients with a variety of renal ailments.

The trainee will demonstrate competency in their ability to:

- Understand electrolyte and acid-base disturbances.
- Understand the etiology and diagnosis of nephritic diseases.
- Diagnose and manage common medical disorders of the kidney.
- Utilize pharmacologic agents appropriately in patients with renal disease.

a. History.
   i. Urine frequency/volume/color/odor;
   ii. Dysuria, change in stream, hesitancy, urgency, dribbling;
   iii. Urinary incontinence;
   iv. Hematuria;
   v. Flank pain, groin pain;
   vi. Stones, abscesses;
   vii. Family history of renal disease;
   viii. Edema/hypertension;
   ix. Sexual activity.

b. Physical exam.
   i. Uremic "frost";
   ii. Renal masses;
   iii. Phimosis;
   iv. Urinalysis;
   v. Lloyd's sign;
   vi. Edema;
   vii. Urethral discharge;
   viii. Prostate evaluation;
   ix. Genital skin lesions;
   x. Scrotal contents abnormalities.

c. Basic concepts.
   i. LEVEL I:
1. Prostatitis/epididymitis/orchitis;
2. Testicular torsion/varicocoele/tumor/hydrocele;
3. Erectile dysfunction;
4. Prostatic hypertrophy/masses;
5. Balanitis/genital ulcers;
6. Condyloma/genital granulomas;
7. Basic infertility;
8. Hypertension: essential, secondary, accelerated, malignant, crisis;
9. Primary glomerulopathies: histology, natural history;
10. Nephrotic and nephritic syndrome;
11. Diabetic kidney;
12. Immune complex nephropathy;
13. Hepatorenal syndrome;
14. Myeloma/amyloid kidney;
15. Vasculitis;
16. AIDS;
17. Interstitial nephritis;
18. Nephrolithiasis;
19. Obstructive uropathy;
20. Hereditary tubular disorders;
21. Acute and chronic renal failure;
22. Renal osteodystrophy;
23. Vitamin D metabolism;
24. Renin-aldosterone axis;
25. Renal tubular acidosis;
26. Electrolyte management;
27. Acid/base;

ii. LEVEL II
1. Genital neoplasms;
2. Prostatic abscess;
3. Priapism;
4. Urethral stenosis;
5. Phimosis;
6. Prostatic malignancy;
7. Peyronie's disease.

d. Diagnostics/therapeutics.
i. Renal function evaluation: glomerular filtration rate, urine/serum osmolarity, fractional excretion of sodium, renal failure index, creatinine clearance;

ii. Renal imaging: IVP, ultrasonography, renal scan;
iii. Renal biopsy assist;
iv. Urinalysis with microscopic;
v. Arterial blood gas analysis;
vi. Temporary vascular access for hemodialysis assist;
 vii. Insertion of peritoneal dialysis catheter (temporary);
 v. Peritoneal dialysis;
ix. Osteopathic structural exam.
e. Health promotion.
   i. Outpatient dialysis prescription;
   ii. Support group advising for dialysis patients;
   iii. Donor acquisition for transplant program;
   iv. Dietary management for chronic renal failure.
f. **Core Competency 1: Osteopathic Concepts**
   i. Lower thoracic and upper lumbar segmental reflexes in ureteral spasm and adjunct pain management;
   ii. Upper lumbar segmental reflexes for bladder dysfunction and spasm

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Principal Teaching Methods**
   a. The trainee will receive individual instruction by the nephrology attendings through evaluation of patients in renal outpatient clinics and on the consult service and at didactic teaching sessions. The trainee will attend renal outpatient clinics and an outpatient dialysis center with the supervising nephrologist.
   b. The trainee will see patients referred from the outpatient clinics, local private practitioners, and other services such as surgery, outpatient orthopedics, OBG, and neuropsychiatry. The trainee will also attend outpatient dialysis clinic at least once during the rotation.
   c. Each patient will be evaluated by the trainee, and then discussed and seen with the staff nephrologist. The trainee must complete a thorough progress note on every patient and this must be completed and countersigned by the staff nephrologist with whom the patient was discussed.
   d. All nephrology inpatient consults will be seen and consultation notes completed by the trainee. The cases will be discussed with the renal attending that then sees the patient with the trainee, does bedside teaching rounds, and completes the consultation note.
   e. The nephrology staff will give didactic teaching lectures weekly.
   f. The trainee will be assigned one or two topics to prepare and present per week.

II. **Core Competency 5: Patient Care**
   a. Objectives
      1. Take a good history including family and social history, drug history and systemic review in order to recognize and diagnose renal disease.
2. Do a complete physical examination and recognize physical signs relevant to kidney disease.
3. Learn to do simple urinalysis and microscopy, which is instrumental to diagnosing presence and types of renal disease.
4. Develop a problem list, working diagnosis and differential diagnoses.
5. Formulate a management plan following the above steps in the comprehensive evaluation of patients with suspected or known renal disease.
6. Understand the special patient-doctor relationship and then learn how to foster and strengthen it in order to perform in a professional manner.
7. Participate fully and actively in all aspects of patient care; from initial consultation to follow-up in both in-patient and outpatient care settings.

b. Evaluation of Patient Care - The trainee will be evaluated with the following criteria:
   1. Accuracy and completeness of history taking and physical examination.
   2. Thoroughness of the review of available medical data on each patient.
   3. Performance of appropriate maneuvers and procedures (when relevant) on each patient.
   4. Accuracy and thoroughness of patient assessments.
   5. Appropriateness of diagnostic and therapeutic decisions.
   7. Consideration of patient preferences in making therapeutic decisions.
   8. Completeness and neatness of medical charting.

III. Core Competency 2: Medical Knowledge
   a. Objectives - The following objectives will be taught through didactic sessions, at bedside teachings both in the ambulatory care clinics and consult service on the wards, and the trainee’s mandated readings when assigned:
      1. Classification of renal failure into acute and chronic types.
      2. Staging of chronic kidney disease into Stages 1 to 5 according to the NKFK/DOQI Guidelines.
      3. Primary and secondary Glomerulopathies; their etiologies, pathogenesis, pathology, clinical presentation, diagnosis and treatment.
      5. Obstructive nephropathy both acute and chronic and their
management.
6. Hereditary nephropathy especially Autosomal Dominant Polycystic Kidney Disease (ADPKD) and Alport's Syndrome.
7. Special attention and consideration towards diabetic nephropathy, primary and secondary hypertension, lupus nephritis and nephritic syndrome; details on their diagnosis, work-up and treatment strategies will be emphasized.
8. Types of acid-base disorders and their management will be taught and discussed.
9. Fluid and electrolyte disorders and their management will also be taught.
10. The role & importance of urinalysis and microscopy will be taught hands-on.
11. Kidney biopsy indications for diagnosis and management of kidney disease will be taught and the trainee will be able to watch the attending perform ultrasound guided renal biopsy when it is done.
12. Acute and chronic dialysis indications, principles of dialysis procedures and complications of dialysis will be taught. The trainee will be able to see dialysis being performed.
13. The basics about renal transplantation will also be taught to the trainee.

b. Evaluation of Medical Knowledge - The trainee's medical knowledge of nephrology topics will be assessed by the following:
1. The trainee's ability to answer directed questions and to participate in didactic sessions, attending rounds and in clinics.
2. The trainee's presentations of assigned topics and their display of understanding of the topic.
3. That the trainee understands pathophysiology, differential diagnosis and management issues of the various aspects of nephrology; this will evaluate their application of information learned didactically to actual patient care.
4. The trainee’s enthusiasm and motivation for learning.

IV. Core Competency 3: Professionalism
a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
2. The trainee should be willing to accept errors and determine how to avoid them in the future.
3. The trainee should always be responsible and reliable.
4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
5. The trainee must maintain a professional appearance at all times.

V. **Core Competency 4: Interpersonal and Communication Skills**
   a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should learn when to consult a sub-specialist for evaluation and management of a patient with renal disease.
      2. The trainee should be able to fully and properly present the consult cases to the attending staff.
      3. The trainee should be able to develop a rapport with the patients and take patient preferences and concerns into consideration at all times.
      4. The trainee should provide effective education and counseling to patients.
      5. The trainee should keep proper records in patient’s charts.
      6. The trainee must communicate any patient problems to the attending staff in a timely manner.

VI. **Core Competency 6: Systems-Based Practice**
   a. Objectives and Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should improve the utilization of good communication with other health services/professionals like nurses, nutritionists, therapists, surgeons, and administrative staff.
      2. The trainee should improve in the practice of cost effective medicine.
      3. The trainee will assist in determining the root cause of any error identified and methods for avoiding future recurrence.
      4. The trainee will assist in development of systems improvement if problems are identified.

VII. **Core Competency 7: Practice Based Learning Improvement**
    a. Objectives and Evaluation - The trainee’s performance will be evaluated on their willingness and ability to attain the following objectives:
       1. The trainee should use feedback and self-evaluation to improve their performance.
       2. The trainee should read the required material and articles provided to enhance learning.
       3. The trainee should use medical literature search tools in the library and elsewhere to find appropriate articles related to relevant cases.

VIII. **Educational Materials**
    a. Mandatory Reading
       1. Section on Renal Diseases in Harrison’s Principles of Family Medicine
       2. Section on Renal Diseases in Cecil’s Textbook of Medicine
    b. Suggested Readings
1. Relevant section in MKSAP booklets on Nephrology.
2. A collection of articles on various Nephrology topics will be provided to the trainee at the start of the rotation. They are expected to read as many of these as possible.
3. The trainee is also encouraged to read current medical literature/text from the medical library and programs such as “Up-To-Date,” in (Nephrology topics/Hypertension).

IX. Evaluation
   a. Trainee Evaluation
      1. Faculty will give constructive criticisms/suggestions at all times and will provide mid-rotation evaluation to the trainee as well.
      2. At the end of the rotation, faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to Nephrology.
   b. Program Evaluation
      1. The trainee will fill out an evaluation of the Nephrology rotation at the end of the month.
      2. Any constructive criticism or suggestions towards improving or enhancing any part of the Nephrology training program will be welcome.

X. Feedback
   a. The trainee will get frequent, regular feedback with regard to their performance during the nephrology rotation.
   b. Faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is done at the end of the rotation.

Nephrology

3.28 Pediatrics

Educational Purpose:
To provide the trainee with family centered patient care that is developmentally and age appropriate, compassionate, and effective for the treatment of health problems and the promotion of health.

The trainee will demonstrate competency in their ability to:

- Diagnose and manage pediatric problems encountered.
- Manage pediatric emergencies.
- Provide general care of the newborn in the hospital and office setting.
- Provide well childcare up to and including adolescence.
The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods:
   a. Gathering Data from History or Interview. Conduct effective interviews with parents and children at all developmental stages.
      1. Demonstrate skill in the use of appropriate strategies and techniques for communicating with children of varying ages and developmental levels.
      2. Obtain a clinical history using a logical sequence of appropriate questions.
      3. Obtain complete and accurate data by using a combination of open-ended and closed-ended questions, avoiding the use of questions that are presumptive, leading or multiple in construct. Use segment summaries to clarify answers obtained.
      4. Manage the flow of an interview by avoiding interruptions and using silence, re-direction and transitions appropriately.
   b. Establish rapport by using all, or a combination of the following elements:
      1. A comfortable seating and room arrangement
      2. Good eye contact
      3. Open body language
      4. Appropriated facial expression and tone of voice
      5. Reflection and legitimization
      6. Offering partnership, support and encouragement
   c. Open an interview with an inclusive introduction and greeting (acknowledging everyone in the room and finding out how they are related to the patient), to call the patient by name during the interview, and to close the interview gracefully.
   d. Recognize when it might be appropriate to ask people to leave the room (e.g., when you might be asking sensitive questions and there is a non-family member in the room), and ask them to leave in a sensitive manner.
   e. Demonstrate awareness of cultural and religious or spiritual differences, and avoid questioning styles and/or responses that might be construed as judgmental or insensitive.

II. Core Competency 5: Patient Care: Gathering Data by Physical Examination. Perform an appropriate physical exam, demonstrating technical proficiency and sensitivity to the needs of the child and parent, as well as the clinical situation.
   a. Demonstrate successful verbal and physical strategies for conducting physical examinations in children of different ages, with attention to each of the following components:
      1. Age and developmental stage (e.g., modify physical and verbal approach to diminish fears and demystify exam using: lap exam,
sequence other than head to toe, age-appropriate vocabulary for play, distraction and explanation, respect for modesty by ensuring privacy)

2. State (e.g., auscultate heart first in a sleeping infant, warm hands and instruments prior to examination, use light touch prior to firm touch)

3. Temperament (e.g., proceed slowly and cautiously when approaching a "slow-to-warm-up" child)

4. Parent-child relationship (e.g., enlist office personnel to adequately restrain child if parent unable or unwilling)

5. Previous frightening medical encounters (e.g., adjust pace and sequence to diminish anxiety for child with history of painful procedures)

6. Acuity of illness or symptoms (e.g., adjust pace, sequence, maneuvers to minimize exacerbation of symptoms)

b. Recognize when clinical situations require a complete examination and when a focused examination is more appropriate; perform the appropriate maneuvers and sequence to address each circumstance adequately.

c. Display sensitivity to the needs of the child and parent/guardian when performing physical examinations by adapting approach/components of examination to setting and clinical situation (e.g., concerns arising from fears; modesty; privacy or confidentiality needs; significant pain, distress or illness; ethnic, cultural, religious/spiritual or health beliefs; language barriers; sensory, physical or mental impairments).

d. Perform a thorough and systematic, comprehensive examination in premature and term infants, older infants, toddlers, preschoolers, school-age children and adolescents, incorporating each of the following elements:

1. Use appropriate infection control including hand washing, and gown, glove, mask when appropriate.

2. Use observation effectively as a tool to gather important data about child health, development and parent-child interaction.

3. Focus attention on important content areas during the examination as suggested by the child's age, chief complaint, other aspects of the medical history, or acuity of illness.

4. Demonstrate technical proficiency for each step of the exam, including proper use of instruments.

5. Demonstrate technical proficiency for obtaining measurements and vital signs and evaluate results in terms of age and gender-related developmental progression of normal values.

6. Discuss and clarify examination maneuvers, instruments and findings with parents, using vocabulary that is appropriate to their educational background and language, and verify their comprehension.

7. Identify and distinguish between physical examination findings for all major organ systems that are normal for age, common variations of normal, age-related "benign" pathology (e.g.,
caput/cephalohematoma of the newborn), and borderline abnormal, or common and important abnormal. Discuss findings in terms of anatomy and physiology in a way that patients and parents can understand.

8. Establish, discuss, and gain agreement for a follow-up plan and timeframe for investigation of borderline abnormal findings.

9. Demonstrate examination strategies and maneuvers to pursue and confirm abnormal findings, establish, discuss and gain agreement for further diagnostic or therapeutic workup and management.

10. Record examination findings accurately and use correct medical terminology.

c. Health Promotion and Screening. Provide comprehensive health care promotion, screening and disease prevention services to infants, children, adolescents and their families in the ambulatory setting.

1. Perform health promotion (well child care) visits at recommended ages based on nationally recognized periodicity schedules (e.g., AAP Health Supervision Guidelines, Bright Futures, and GAPS).

2. Perform a family centered health supervision interview.
   a) Define family and identify significant family members and other significant caretakers and what role they play in the child's life.
   b) Identify patient and family concerns.
   c) Discuss health goals for the visit with the patient and family.
   d) Prioritize agenda for the visit with the patient and family.
   e) Elicit age appropriate information regarding health, nutrition, activities, and health risks.


4. Identify risks to optimal developmental progress (e.g., prematurity, SES, family/genetic conditions, etc.).

5. Order or perform and interpret additional age-appropriate screening procedure, using nationally recognized periodicity schedules and local or state expectations (e.g., newborn screening, lead, hematocrit, hemoglobin for sickle cell, blood pressure, cardiovascular risk assessment, vision, hearing, dental assessment, reproductive-related concerns).

6. Order or perform appropriate additional screening procedures based on patient and family concerns (e.g., sports involvement, positive family history for specific health condition, behavioral concerns, depression, identified risk for lead exposure).

7. Perform age appropriate immunizations using nationally recognized periodicity schedules.
8. Provide age-appropriate anticipatory guidance to parent(s) or caregiver(s), and child or adolescent, according to recommended guidelines (e.g., AAP TIPP program, Bright Futures, GAPS), on topics including:
   a) Promotion of healthy habits (e.g. Physical activity, reading, etc.)
   b) Injury and illness prevention
   c) Nutrition
   d) Oral health
   e) Age appropriate medical care
   f) Promotion of social competence
   g) Promotion of positive interactions between the parent and infant/child/adolescent
   h) Promotion of constructive family communication, relationships and parental health
   i) Promotion of community interactions
   j) Promotion of responsibility (adolescence)
   k) Promotion of school achievement (middle childhood, adolescence)
   l) Sexuality (infancy, early and middle childhood, adolescence)
   m) Prevention of substance use/abuse (middle childhood, adolescence)
   n) Physical activity and sports
   o) Interpretation of screening procedures
   p) Prevention of violence

9. Demonstrate practical office strategies that allow provision of comprehensive and efficient health supervision (e.g., share tasks with office staff; develop and use structured records, computerized information, websites, questionnaires, patient education handouts, books, videos; develop office policies for such things as consent and confidentiality, request for transfer of medical records, school information).

10. Discuss logistical barriers to the provision of health supervision care (e.g., financial, social, environmental, health service, insurance systems) and discuss strategies to overcome these for specific families.

III. Patient Education and Counseling
   a. Develop skills in promoting a therapeutic alliance with patients and families by providing counseling, guidance, and patient education in areas important to child health and disease.
b. Provide parents with appropriate anticipatory guidance, based on age, gender, risk factors, and developmental stage of the child, in order to enhance function, maintain health, and prevent disease and injury.

c. Provide effective education via written, visual, and hands-on techniques (e.g., demonstrations, models, handouts, videotapes, group learning sessions), selecting an educational method that is tuned to the patient's or family's learning style, language limitations, knowledge level, cultural background, and emotional state.

**GOAL:** Utilize common diagnostic tests and imaging studies appropriately in the outpatient department.

1. Demonstrate understanding of the common diagnostic tests and imaging studies used in the outpatient setting, by being able to:
   a. Explain the indications for and limitations of each study.
   b. Know or be able to locate age-appropriate normal ranges (lab studies).
   c. Apply knowledge of diagnostic test properties, including the use of sensitivity, specificity, positive predictive value, negative predictive value, likelihood ratios, and receiver operating characteristic curves, to assess test utility in clinical settings.
   d. Recognize cost and utilization issues.
   e. Interpret the results in the context of the specific patient.
   f. Discuss therapeutic options for correction of abnormalities.

2. Use appropriately the common laboratory studies in the Continuity Clinic and Outpatient setting:
   a. CBC with differential, platelet count, RBC indices.
   c. Hemoglobin A1C
   d. Cholesterol
   e. Renal function tests.
   f. Tests of hepatic function (PT, albumin) and damage (liver enzymes, bilirubin).
   g. Serologic tests for infection (e.g., hepatitis, HIV).
   h. CRP, ESR.
   i. Routine screening tests (e.g., neonatal screens, lead).
   j. Wet preps and skin scrapings for microscopic examination, including scotch tape test for pinworms.
   k. Tests for ova and parasites
   l. Thyroid function tests.
   m. Culture for bacterial, viral, and fungal pathogens, including stool culture.
   n. Urinalysis.
   o. Gram stain.
   p. Developmental, behavioral and depression screening tests.
3. Use the common imaging, diagnostic or radiographic studies when indicated for patients evaluated in Continuity Clinic or the Outpatient Pediatric Clinic:
   a. Plain radiographs of the chest, extremities, abdomen, skull, sinuses.
   b. CT, MRI, angiography, ultrasound, nuclear scans (interpretation not expected) and contrast studies when indicated.
   c. Bone age films.
   d. Electrocardiogram and echocardiogram.
   e. Skin test for tuberculosis.
4. Recognize normal and abnormal findings at tracheostomy, gastrostomy, or central venous catheter sites, and demonstrate appropriate intervention or referral for problems encountered.

**GOAL:** Describe the following procedures, including how they work and when they should be used; competently perform those commonly used by the pediatrician in practice.

1. Breast pump use
3. Medication delivery: inhaled
4. PPD: placement
5. Pulmonary function tests: peak flow meter

**GOAL:** Describe the following tests or procedures, including how they work and when they should be used; competently perform those commonly used by the pediatrician in practice.

1. ADHD home and school questionnaires
2. Behavioral screening questionnaire
3. Developmental screening test
4. Hearing screening
5. PPD: interpretation
6. Scoliosis, scoliometer
7. Tympanometry evaluation: interpretation
8. Vision screening

**Core Competency 2: Medical Knowledge.** Understand the scope of established and evolving biomedical, clinical, epidemiological and social-behavioral knowledge needed by a pediatrician; demonstrate the ability to acquire, critically interpret and apply this knowledge in patient care.

**GOAL:** Evaluate and manage common signs and symptoms associated with the practice of pediatrics in the Continuity Clinic and Primary Care Pediatric Outpatient Department.

1. Evaluate and manage the following signs and symptoms that present in the context of health care promotion:
a) **Infancy:** malpositioning of feet, hip clicks, skin rashes, birthmarks, jitteriness, hiccups, sneezes, wheezing, heart murmur, vaginal bleeding and/or discharge, foul smelling umbilical cord with/without discharge; undescended testicle, breast tissue, breast drainage, malpositioning of feet, malrotation of lower extremities, developmental delays, sleep disturbances, difficulty feeding, dysconjugate gaze, failure to thrive, frequent infections, abnormal head shape or size, evidence of abuse or neglect, abdominal masses, abnormal muscle tone

b) **General:** Acute life-threatening event (ALTE), constitutional symptoms, excessive crying, failure to thrive, fatigue, fever, weight loss or gain, dental caries, excessive thumb-sucking or pacifier use, sleep disturbances, difficult behaviors, variations in appetite, variations in toilet training, overactivity, somatic complaints, poor school performance, attention problems, fatigue, masturbation, anxiety, violence.

c) **Cardiorespiratory:** Apnea, chest pain, cough cyanosis, dyspnea, heart murmur, hemoptysis, hypertension, inadequate respiratory effort, respiratory failure, rhythm disturbance, shortness of breath, stridor, syncope, tachypnea, wheezing.

d) **Dermatologic:** Congenital nevus and other birth marks, ecchymoses, edema, paleness, petechiae, pigmentary changes, purpura, rashes, urticaria, vascular lesions, foul smelling umbilical cord.

e) **EENT:** Acute visual changes; dysconjugate gaze; conjunctival injection; ear or eye discharge; ear, throat, eye pain, edema, epistaxis; nasal foreign body; hoarseness; stridor.

f) **Endocrine:** growth disturbance, short stature, heat or cold intolerance, normal and abnormal timing of pubertal changes, polydipsia, polyuria.

g) **GI/Nutrition/Fluids:** Abdominal pain, mass or distention; ascites; constipation; dehydration; diarrhea; dysphagia; encopresis; hematemesis; inadequate intake of calories or fluid; jaundice; melena; obesity; rectal bleeding; regurgitation; vomiting.

h) **Genitourinary/Renal:** Change in urine color, dysuria, edema, enuresis, frequency, hematuria, oliguria, and pain referable to the urinary tract, scrotal mass, pain or edema, trauma to urinary tract or external genitalia, undescended testicle, enuresis.

i) **GYN:** Asymmetry of breast development, abnormal vaginal bleeding, pelvic or genital pain, vaginal discharge or odor; vulvar trauma or erythema, delayed onset of menses, missed or irregular periods.

j) **Hematologic/Oncologic:** Abnormal bleeding, bruising, hepatosplenomegaly, lymphadenopathy, masses, pallor.

k) **Musculoskeletal:** Malpositioning of feet, malpositioning of legs, hip clicks, abnormal gait, abnormal spine curvature, arthritis or arthralgia, bone and soft tissue trauma, limb or joint pain, limp, variations in alignment (e.g., intoeing).
l) **Neurologic**: Delays in developmental milestones, ataxia, change in sensorium, diplopia, headache, head trauma, hearing concerns, gait disturbance, hypotonia, lethargy, seizure, tremor, vertigo, visual disturbance, weakness.

m) **Psychiatric/Psychosocial**: Acute psychosis, anxiety, behavioral concerns, conversion symptoms, depression, hyperactivity, suicide attempt, suspected child abuse or neglect.

**GOAL**: Recognize and manage common childhood conditions presenting to the Continuity Clinic and Primary Care Pediatric Outpatient Department.

1. Evaluate and manage the common conditions and situations presenting in the context of health promotion visits.

   a) **Infancy**: Breast feeding, bottle feeding, colic, congenital hip dislocation, constipation, strabismus, colic, parent-infant interactional issues, sleep problems, child care decisions, separation protest, stranger anxiety, failure to thrive, recurrent respiratory and ear infections, positional foot deformities, rashes, teething, injury prevention and safety.

   b) **General**: Colic, failure to thrive, fever, overweight, iron deficiency, lead exposure, strabismus, hearing problems, child care decisions, well-child and well adolescent care (including anticipatory guidance), parental issues (financial stress, divorce, depression, tobacco, alcohol or substance abuse, domestic violence, inadequate support networks).

   c) **Allergy/Immunology**: Allergic rhinitis, angioedema, asthma, food allergies, recurrent infections, serum sickness, urticaria.

   d) **Cardiovascular**: Bacterial endocarditis, cardiomyopathy, congenital heart disease (outpatient management of minor illnesses), congestive heart failure, heart murmurs, Kawasaki disease, palpitations, rheumatic fever.

   e) **Dermatology**: Abscess, acne, atopic dermatitis, cellulitis and superficial skin infections, impetigo, molluscum, tinea infections, viral exanthems, verruca vulgaris, other common rashes of childhood and adolescence.

   f) **Endocrine/Metabolic**: Diabetes mellitus, diabetes insipidis, evaluation for possible hypothyroidism, growth failure or delay, gynecomastia, hyperthyroidism, precocious or delayed puberty.

   g) **GI/Nutritional**: Appendicitis, bleeding in stool, constipation, encopresis, foreign body ingestion, gastroenteritis, gastroesophageal reflux, hepatitis, inflammatory bowel disease, nutritional issues, obesity, pancreatitis.

   h) **GU/Renal**: Electrolyte and acid-base disturbances (mild), enuresis, glomerulonephritis, hematuria, Henoch Schonlein purpura, nephrotic syndrome, obstructive uropathy, proteinuria, undescended testicles, UTI/pyelonephritis.

   i) **Gynecologic**: Genital trauma (mild), labial adhesions, pelvic inflammatory disease, vaginal discharge or foreign body.
j) **Hematology/Oncology**: Abdominal and mediastinal mass (initial work up), anemia, hemoglobinopathies, leukocytosis, neutropenia, thrombocytopenia.

k) **Infectious Disease**: Cellulitis, cervical adenitis, dental abscess with complications, initial evaluation and follow-up of serious, deep tissue infections, laryngotracheobronchitis, otitis media, periorbital and orbital cellulitis, pharyngitis, pneumonia (viral or bacterial), sinusitis, upper respiratory tract infections, viral illness, recurrent infections.

l) **Musculoskeletal**: Apophysitides, femoral retro- and anteversion, fractures, growing pains, hip dysplasia, limp, metatarsus adductus, sprains, strains, tibial torsion.

m) **Pharmacology/Toxicology**: Common drug poisoning or overdose, ingestion avoidance (precautions).

n) **Neurology/Psychiatry**: Acute neurologic conditions (initial evaluation), behavioral concerns, discipline issues, temper tantrums, biting, developmental delay, seizures (evaluation and adjustment of medications), ADHD, learning disabilities, substance abuse.

o) **Pulmonary**: Asthma, bronchiolitis, croup, epiglottitis, pneumonia; sinusitis, tracheitis, viral URI and LRI.

p) **Surgery**: Initial evaluation of patients requiring urgent referral, pre- and post-op evaluation of surgical patients (general, ENT, ortho, urology, neurosurgical, etc.).

**Core Competency 3: Interpersonal and Communication Skills.** Demonstrate interpersonal and communication skills that result in information exchange and partnering with patients, their families and professional associates.

**GOAL:** Effectively and empathically communicate with children and families.

1. Understand and use the following methods during communication with children and families:

   a) Strive to identify and respond to the child and family's learning style.

   b) Consider the developmental stage of patient and family.

   c) Adapt language and concepts to the educational level of the family.

   d) Take into account cultural, ethnic, and socioeconomic issues.

   e) Deal effectively with language barriers.

   f) Take into account hearing, speech, or vision impairments.

   g) Be sensitive to health beliefs and religious or spiritual issues.

   h) Recognize personal factors in the physician that may influence interaction (e.g., personal biases and prejudices, sleep deprivation, home or family issues).
2. Formulate a plan for each visit by thoughtfully considering the goals of the encounter with the family or patient.

3. Understand and communicate effectively and empathically with a patient or family in these special circumstances:
   a) New patient and/or family members (e.g., clarify role and expectations)
   b) Dealing with the "difficult" patient or family
   c) Talking with families with language barriers or different cultural and religious/spiritual perspectives
   d) Talking with patients or families with "endless concerns"
   e) Talking with patients or families who are non-adherent with medical therapy to understand their perspective and obstacles to adherence, clarify their understanding of the treatment plan, and manage barriers collaboratively
   f) Screening and assessing substance abuse issues with patients
   g) Discussing domestic violence or other abuse issues with patients

**GOAL: Patient Education and Counseling.** Develop skills in promoting a therapeutic alliance with patients and families by providing counseling, guidance, and patient education in areas important to child health and disease.

1. Provide parents with appropriate anticipatory guidance, based on age, gender, risk factors, and developmental stage of the child, in order to enhance function, maintain health, and prevent disease and injury.

2. Provide effective education via written, visual, and hands-on techniques (e.g., demonstrations, models, handouts, videotapes, group learning sessions), selecting an educational method that is tuned to the patient’s or family’s learning style, language limitations, knowledge level, cultural background, and emotional state.

3. Summarize the key topics or issues at the end of the session, and verify that the patient or parent understands the information presented.

4. Identify and facilitate access to appropriate community health care resources for parents, including support groups.

**GOAL: Professional Communication and Collaboration.** Communicate and collaborate effectively as part of a functional team with physicians, other health professionals, staff, and students.

1. Communicate and work effectively with:
   a) Members of an interdisciplinary health care team.
   b) Other health care professionals, including those in the community and complementary and alternative medicine providers who are treating the patient.
   c) Specialists (when functioning as the referring physician).
   d) Referring physicians and primary care providers (when functioning as a specialist in the care of children).
c) Support and administrative staff.

f) Medical students.

2. Work collaboratively as a member of the health care team.
   a) Know the various roles of team members and utilize their skills appropriately.
   b) Work effectively with team members by establishing mutually agreed upon goals, roles and procedures (decision making, role and goal negotiation, addressing team differences and conflicts)
   c) Communicate effectively with members of the team
   d) Demonstrate an appreciation of and respect for the contribution of each team member
   e) Demonstrate skill in avoiding and reducing interpersonal conflict
   f) Serve as a team member or team leader in the appropriate situations

3. Communicate effectively in the following contexts:
   a) Brief oral case presentations (e.g., at morning report/check-in, inpatient work rounds, clinic visits; phone contacts with primary provider or consultants).
   b) Written, dictated, and computerized medical records (accurate, complete, timely, legal).
   c) Letters of referral.
   d) Consultation reports.
   e) Oral presentations to healthcare professionals

**GOAL: Use of Consultants.** Use consultations and referrals effectively in a variety of settings.
1. Demonstrate appropriate use and selection of specialists/consultants in inpatient, outpatient, and community settings.

**GOAL:** Maintain accurate, legible, timely, and legally appropriate medical records in the continuity and general ambulatory settings

**Core Competency 7: Practice Based Learning Improvement.**
Demonstrate knowledge, skills and attitudes needed for continuous self-assessment, using scientific methods and evidence to investigate, evaluate, and improve one's patient care practice.

**GOAL:** Accept feedback appropriately and act on areas identified for improvement
1. Identify resources for up-to-date information related to general pediatrics (e.g., journals, texts, tapes, computer databases, continuing education courses, online resources, etc.).
2. Locate, appraise, and assimilate evidence from scientific studies related to one's patients' health problems.
3. Seek and incorporate feedback and self-assessment into a plan for professional growth as well as provide constructive feedback to others.

**GOAL:** Access medical information efficiently, evaluates it critically and applies it appropriately to patient care.
1. Identify resources for up-to-date information related to general pediatrics (e.g., journals, texts, tapes, computer databases, continuing education courses, online resources, etc.)
2. Locate, appraise, and assimilate evidence from scientific studies related to one's patients' health problems.

**GOAL:** Develop effective strategies for teaching students, colleagues.
1. Identify in each teaching encounter your educational objectives and the learners' educational needs; use this information to direct your selection of content and teaching methods.
2. Use a variety of teaching techniques effectively, such as:
   a) Bedside teaching
   b) Teaching during work rounds
   c) Lectures or case-based discussions using multimedia presentation methods
   d) Role modeling for learners
   e) Written instruction
3. Provide learners with sensitive, timely and constructive feedback, and evaluate their performance based on pre-defined criteria, using evaluation methods that match the performance task.

**Core Competency 3: Professionalism.** Demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity.

**GOAL:** Develop responsible and productive work habits encompassing the broad responsibilities of a competent pediatrician.
1. Assume appropriate responsibility and make responsible decisions when carrying out one's duties.
   c. Be punctual in keeping appointments with supervisors, colleagues, patients, and other members of the healthcare team.
   d. Maintain responsibility for patient care when going off duty until suitable coverage is secured. Transfer information and responsibility of care effectively at the time of sign out and change of service
   e. Perform duties such as completing charts, dictating discharge summaries, returning calls, and making referrals in a timely manner
   f. Take responsibility for one's own errors
   g. Organize work and manage time productively
   h. Demonstrate a positive attitude in dealing with work-related problems
2. Delegate patient care duties to other members of the healthcare team appropriately and work collaboratively to ensure that the patient's needs are met.

**GOAL:** Demonstrate personal accountability to the well being of patients (e.g., following-up lab results, writing accurate and concise notes, and seeking answers to patient care questions, advocate for patients, takes ownership for patient care) in the continuity and general ambulatory setting.

1. Demonstrate humanistic health care by integrating biological, psychosocial, legal, ethical, and cultural or religious/spiritual aspects of patient management into one's data gathering, diagnostic, therapeutic and patient education/counseling activities.
2. Demonstrate a willingness to advocate for children and their families.
3. Delegate patient care duties to other members of the healthcare team appropriately and work collaboratively to ensure that the patient's needs are met. Demonstrate commitment to honesty, confidentiality, and respect for patients and families.
4. Demonstrate commitment to honesty, confidentiality, and respect for patients and families.

**GOAL:** Demonstrate sensitivity to and respect for patients', colleagues and ancillary staff members' culture, ethnicity, age, gender and disabilities.

**GOAL:** Adhere to ethical and legal principles while providing care in the critical care setting.

**Core Competency 6: Systems-Based Practice.** Understand how to practice high quality health care and advocate for patients within the context of the health care system.

**GOAL: Practice Management.** Understand the importance of effective practice management for high-quality, efficient health care delivery.

1. Demonstrate awareness of office management issues, including:
   a) Billing and collection procedures
   b) Communication and patient education
   c) Compliance with regulations (OSHA, CLIA, HIPAA, etc.)
   d) Computer systems for billing and data tracking
   e) Cost effectiveness of care and productivity
   f) Efficient office design and patient flow
   g) Personnel utilization, supervision, and management
   h) Quality assessment and performance improvement including utilization review and case management
   i) Risk management and liability
   j) Scheduling for patient care
   k) Scope of practice, including procedures and office laboratory
   l) Telephone management
m) Demonstrate the use of a framework for managing a telephone interaction, which includes the ability to:

1) Apply clinical judgment or standardized algorithms in the management of an acute illness to make a triage decision about appropriate level of care needed by the patient (e.g., "See immediately," "See the next day for an outpatient visit," or "Manage at home with appropriate advice.")

2) Put the current concern or complaint in the context of the patient's chronic course and determine an appropriate course of action

3) Communicate necessary information clearly and confirm that the caller understands the guidelines for recognizing worsening illness, agrees with the disposition, and can adhere to the recommended treatment and follow-up plan

4) Document the telephone interaction accurately, efficiently and with appropriate detail

**GOAL:** Recognize and advocate for families who need assistance to deal with systems complexities, such as lack of insurance, multiple medication refills, multiple appointments with long transport times, or inconvenient hours of service.

**GOAL:** Identify and use appropriately standardized guidelines for diagnosis and treatment of conditions common to outpatient care.

1) Educational methods used:
   a. Direct patient care
   b. Pre-Clinic conferences
   c. APL Conferences

2) Evaluation tools used:
   b) Observed patient encounter with checklist
c) Review of Patient logs
d) Intern conference with faculty evaluation
e) 360-degree evaluation: Nursing
f) 360-degree evaluation: Patient Satisfaction
g) Biannual faculty evaluation of performance and progress towards competencies
h) Billing and Coding Exercise
i) Procedure Log

3.29 Pulmonary & Critical Care Medicine

**Educational Purpose:**
The trainees will be provided with the knowledge and skills to manage pulmonary diseases.
To have the trainees learn to diagnose and manage patients with commonly seen acute and chronic pulmonary diseases, and for them to know when to seek pulmonary subspecialty consultations.

The trainee will demonstrate competency in their ability to:

- Perform a preoperative pulmonary assessment.
- Diagnose and manage common pulmonary diseases.
- Understand the role of osteopathic manipulation in the treatment of pulmonary disease.

a. History.
   i. Dyspnea: exertional, positional, rest;
   ii. Cough: productive, dry, character, frequency, pattern changes, color, quantity of sputum;
   iii. Wheezing, stridor;
   iv. Environmental exposures;
   v. Past history of lung or functional disorder;
   vi. Previous pulmonary testing;
   vii. Snoring, hypersomnia;
   viii. Hemoptysis;
   ix. Voice changes;
   x. Chest pain.

b. Physical exam.
   i. Extrapulmonary findings in lung disease:
   ii. Cyanosis;
   iii. Clubbing;
   iv. Chest configuration;
   v. Respiration patterns:
   vi. Cheyne-Stokes;
   vii. Kussmaul;
   viii. Accessory muscle use/abdominal paradox;
   ix. Thoracic structural abnormalities;
   x. Detection and character of crackles, wheezes, rhonchi, post-tussive crackles, tubular breath sounds;
   xi. Pleural friction rub;
   xii. Differentiation of effusion from consolidation with percussion in multiple positions, egophony, ("e" to "a");
   xiii. Subcutaneous emphysema;
   xiv. Diaphragmatic immobility.

c. Basic concepts.
   i. LEVEL I
      1. Aspiration pneumonitis;
2. Lung abscess/pneumonia/bronchitis/colonization;
3. Hypersensitivity pneumonitis;
4. Bronchiolitis/tracheitis;
5. Allergic bronchopulmonary aspergillosis;
6. Infiltrate with eosinophilia;
7. Emphysema/chronic bronchitis/asthma;
8. Pulmonary embolism/infarction;
9. Bronchopulmonary hemorrhage;
10. Sleep apnea;
11. Pulmonary contusion/rib fracture/burns/drowning;
12. Pneumothorax;
13. ARDS;
14. Atelectasis;
15. Basic physiology of respiration;
16. Pulmonary function testing;
17. Rheumatoid lung and other connective tissue disorders;
18. Cor pulmonale.

ii. LEVEL II
1. Mediastinitis/tumors;
2. Empyema;
3. Alveolar proteinosis/BOOP;
4. Desquamative interstitial pneumonitis;
5. Eosinophilic granulomatosis;
6. Sarcoidosis;
7. Churg-Strauss syndrome/vasculitis;
8. Wegener's granulomatosis;
9. Goodpasture's syndrome;
10. Fungal/TB granulomatosis;
11. Foreign body;
12. Hemosiderosis;
13. Cystic fibrosis;
14. Flail chest;
15. Primary pulmonary hypertension.

d. Diagnostics/therapeutics.

iii. LEVEL I
1. Ventilator management/physiology/weaning parameters/modes/adjustments/trouble shooting;
2. Arterial blood gas performance and interpretation;
3. Pleural biopsy: assist;
4. Thoracentesis;
5. Simple spirometry;
6. Pleural fluid analysis;
7. Sputum induction;
8. Direct fluorescent Legionella antibody in sputum/urine;
9. Gram stain;
10. Basic hypersensitivity testing;
11. Endotracheal intubation;
12. Chest tube drainage;
13. Lung scan/gallium scan;
14. Pre-operative evaluation;
15. Osteopathic structural evaluation.

iv. LEVEL II
1. Bronchoscopy/biopsy/lavage;
2. Fluoroscopy;
3. MRI/CT of chest;
4. Lung biopsy or aspiration;
5. Pulmonary angiography;
6. Cardiopulmonary stress testing;
7. Complete pulmonary function testing with methycholine challenge;
8. Tracheotomy;
9. Mediastinoscopy;
10. Lung transplantation protocol.

e. Health maintenance.
   i. Smoking cessation;
   ii. Immunizations;
   iii. Rehabilitation;
   iv. Support groups;
   v. Screening exams.

f. Core Competency 1: Osteopathic Concepts
   i. Thoracic pump;
   ii. Rib raising techniques;
   iii. Diaphragmatic release techniques;
   iv. Appropriate chest physiotherapy on ventilated patients

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
a. The trainee will receive individual instruction by the pulmonary attendings through seeing patients in the pulmonary outpatient clinic and the inpatient consults service.
   1. Each outpatient will be evaluated by the trainee, and then discussed and seen with the staff pulmonologist. The trainee will complete a thorough visit note on every outpatient seen and this will be completed and countersigned by the staff pulmonologist with whom the patient was seen.
   2. All pulmonary inpatient consults will be seen and a consultation
note completed by the trainee. The case will then be discussed with the pulmonary attending that would be seeing the patient along with the trainee. Appropriate bedside teaching will take place at that time and ultimately the attending faculty will complete the consultation note.

3. The trainee will be carrying out daily follow up rounds on the consult service and writing notes accordingly. This will take place under the immediate supervision of the pulmonary attending.

b. The rotation will provide the environment and resources for the trainee to acquire knowledge in the indications for and interpretation of:

1. Pulmonary function tests to assess respiratory mechanics and gas exchange, including spirometry, flow volume loops, lung volumes, diffusion capacity, airways resistance, and arterial blood gases. Towards this goal one half day per week will be spent along with the trainee in the review and interpretation of all pulmonary function tests performed the previous week.

2. Diagnostic and therapeutic procedures, including their indications, performance and interpretation will be discussed with the trainee.

3. Radiological imaging procedures including chest x-rays, computed axial tomograms of the chest and ventilation/perfusion lung scans will be individually reviewed with the trainee.

II. Core Competency 5: Patient Care

a. Objectives - The pulmonary rotation will provide the educational environment and resources to allow the trainee to learn to care for patients with acute and chronic pulmonary disorders in both the outpatient and Hospitals setting.

b. Practical Skills - At the completion of their rotation, the trainee would have gained the ability to properly perform a clinical history, including a thorough review of the patients occupational exposure, a review of systems with emphasis on respiratory symptoms and a thorough physical exam with emphasis on pulmonary findings and be adept at interpretation of radiologic imaging procedures and basic pulmonary function tests.

c. Procedural Skills - The trainee will be taught the indications and performance of common procedures related to the pulmonary specialty. These will include thoracentesis and needle biopsy of pleura.

d. Attitudes and Values

1. The trainee should gain insight and appreciation of the psychosocial effects of acute and chronic pulmonary illnesses.

2. The trainee will improve in the utilization of and communication with the Public Health Services and other professionals including the microbiologists, radiologists, pathologists and chest surgeons.

3. The trainee will learn the importance of preventive medicine in routine health care and specifically in the area of tuberculosis, lung
cancer and C.O.P.D.
4. The trainee will become familiar with dealing with the difficulties of disease management within different age groups, different socioeconomic, educational and cultural backgrounds that are seen.
5. The trainee will improve in the use of cost-effective medicine.

III. Core Competency 2: Medical Knowledge
a. Objectives - These objectives will be taught in relation to specific patients whenever possible in the clinic or on the consult service. Otherwise they will be discussed in the didactic sessions:
   1. Pulmonary infections, including fungal infections, and those in the immuno-compromised host.
   2. Tuberculosis, including all aspects of management, epidemiology and prevention.
   3. Obstructive lung diseases including asthma, bronchitis, emphysema and Bronchiecstasy.
   4. Malignant diseases of the lung, pleura and mediastinum, both primary and metastatic.
   5. Pulmonary vascular disease with emphasis on pulmonary embolism.
   6. Pleuro-pulmonary manifestations of systemic diseases with emphasis on collagen vascular diseases.
   7. Respiratory failure, including the acute respiratory distress syndrome.
   8. Occupational and environmental lung disease.
10. Disorders of the pleura and mediastinum, including pneumothorax and empyema
11. Sleep-induced disorders of breathing.

IV. Core Competency 3: Professionalism
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   1. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
   2. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
   3. The trainee must be responsible and reliable at all times.
   4. The trainee must always consider the needs of patients, families, colleagues, and support staff.
   5. The trainee must maintain a professional appearance at all times.

V. Core Competency 4: Interpersonal and Communication Skills
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
1. The trainee should learn when to call a subspecialist for evaluation and management of a patient with a pulmonary disease.
2. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
3. The trainee must be able to establish a rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.
4. The trainee should provide effective education and counseling for patients.
5. The trainee must write organized and legible notes.
6. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. Core Competency 6: Systems-Based Practice
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
1. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, ophthalmologist, physical therapist, surgeon, and nuclear medicine specialist.
2. The trainee should improve in the use of cost effective medicine.
3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
4. The trainee will assist in development of systems’ improvement if problems are identified.

VII. Core Competency 7: Practice Based Learning Improvement
a. Objectives
1. The trainees will receive frequent informal feedback from the attending physician in regards to their performance during their rotation. The trainees will be informed about the results of their evaluation, and input will be requested from the trainee in regard to means of improving on their experience. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation. The trainee should read the required material and articles provided to enhance learning.
2. The trainee should read the required material and articles provided to enhance learning.
3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Educational Materials
a. Mandatory Reading
1. Section on Pulmonary diseases in Harrison’s Principles of Family Medicine.
2. Basics of Pulmonary Function Interpretation.
   b. Medical Literature – A select collection of current review articles and clinical guidelines that address pulmonary issues will be provided.
   c. Pathology - All surgical specimens obtained by the staff pulmonologist will be reviewed along with the trainee in the Pathology Laboratory.

IX. Evaluation
   a. Trainee Criteria for Evaluation
      1. The general quality of care provided by the trainee to pulmonary patients in different settings.
      2. The fund of knowledge in basic pulmonary medicine achieved by the trainee during the rotation as evidenced by the understanding of patient problems displayed by the trainee in discussions with the staff.
   b. Program Evaluation - The trainee will fill out an evaluation of the pulmonary rotation at its conclusion.

Pulmonary & Critical Care Medicine

3.30 Rheumatology*

Educational Purpose:
The trainee will have the opportunity to acquire expertise in the evaluation and management of rheumatologic disorders. The trainee will learn about the practice of rheumatology in an ambulatory and hospital setting.

Format: The implementation of this curriculum will be longitudinal throughout the trainee's experience and may include block experiences in specialty offices that focus on rheumatic conditions and will be integrated into the schedule of conferences and other teaching modalities, such as monographs, films, and consultations. Assessment will be made of a trainee's competency with diagnostic and therapeutic procedures. The trainee should gain hands-on experience by being involved in management of this group of diseases that emphasizes disability prevention and patient self-management skills.

The trainee will demonstrate competency in their ability to:

- Perform diagnostic, therapeutic, and rehabilitative examination and treatment of the rheumatologic patient competently
- Optimize treatment plans with consultation of the local rheumatologist and arthritis resources that include local, state, and federal agencies
- Demonstrate comprehensive, culturally competent communication with each patient and his or her family in order to ensure clear understanding of the diagnosis, treatment, and rehabilitation
• Recognize that the treatment of rheumatologic diseases requires a multidisciplinary approach and, when necessary, may require urgent referral and consultation to provide optimal patient care and decrease disability
• Practice a multidisciplinary approach for rheumatologic patients that emphasizes the collaborative use of mental health professionals, physical therapy, and patient self-management skills
• Recognize and emphasize the importance of preventive medicine and physical activity prescriptions that ultimately decrease the disability attributable to rheumatologic disease
• Practice lifelong learning that incorporates diagnostic and therapeutic

I. **Core Competency 1: Osteopathic Concepts**  
a. Range of motion therapy;  
b. Myofascial release, especially in fibromyalgia;  
c. Counter strain techniques for fibromyalgia

II. **Core Competency 5: Patient Care**  
a. The basic elements of a rheumatic assessment  
b. Development of a differential diagnosis based on the pattern of joint and soft tissue involvement, such as symmetrical small joints, nonsymmetrical large joints, and axial skeleton  
c. The ordering of appropriate laboratory tests based on initial evaluation and interpretation of the results  
d. Joint and bursal aspirations and interpretation of results for crystal, inflammatory, or infectious causes  
e. The ordering of appropriate radiographic views of involved joints and interpretation of results with emphasis on soft tissue changes and early erosive changes  
f. Evaluation of limitations in activities of daily living and effect on social and psychological status of the patient  
g. Recognition of urgent joint conditions, such as the “red hot joint,” and performance of appropriate synovial fluid aspiration and analysis  
h. Treatment of rheumatologic conditions and the monitoring of the laboratory, physical exam, and potential side effects in consultation with a rheumatologist  
i. The use of many modalities for pain control (including oral pharmacologic agents, physical therapy, acupuncture, and intra-articular and soft tissue aspirations and injections)  
j. The utilization of traditional treatment modalities (including physical therapy, splinting devices, and assistive or offloading devices)  
k. Communication to the patient and family regarding the proposed investigation, treatment, and community resources available to promote understanding and compliance for optimal patient care  
l. A focused history, musculoskeletal exam, and laboratory evaluation to evaluate
disease progression
m. The inclusion of a multidisciplinary approach to the treatment of rheumatologic
conditions and appropriate referral to orthopedic surgeons, rheumatologists,
physiatrists, psychologists or psychiatrists, nutritionists, and physical and
occupational therapists

III. Core Competency 2: Medical Knowledge
The trainee will demonstrate the ability to apply knowledge of:
a. Anatomy and physiology of the normal musculoskeletal system and the
immunologic processes that contribute to the pathogenesis of rheumatic disease
b. The appropriate focused history for joint and soft tissue symptoms, screening, a
complete musculoskeletal examination, functional assessment, and use of
laboratory and imaging modalities:
   1. Indications for and interpretation of arthrocentesis
   2. Indications for and interpretation of tissue biopsy results
   3. Indications for arthroscopy
c. The clinical presentation, diagnostic criteria, and initial treatment for various
rheumatologic conditions, with special emphasis on osteoarthritis, gout,
rheumatoid arthritis, lupus erythematosus (LE), and polymyalgia rheumatic
   1. Arthralgia/Arthritis
      i. Osteoarthritis (OA), including primary and secondary
      ii. R Rheumatoid arthritis (RA) with manifestations of articular, extra-
          articular, and juvenile forms
      iii. Spondyloarthritis
          1) Ankylosing spondylitis
          2) Reiter disease
          3) Psoriatic arthritis
          4) Arthritis associated with inflammatory bowel disease
      iv. Infections that cause direct and indirect forms of arthritis
          1) Acute rheumatic fever
          2) Subacute bacterial endocarditis
          3) Postdysenteric
    v. Crystal-induced arthropathies
        1) Gout
        2) Acquired
        3) Calcium pyrophosphate dehydrate (pseudogout)
        4) Hydroxyapatite deposition
    vi. Neoplasms that cause arthropathies
    vii. Drug-induced
    2. Connective tissue disorders
        i. LE with various presentations (including systemic, discoid, and drug-
           induced)
        ii. Scleroderma with various presentations (including localized, systemic,
           and drug-/toxin-induced)
iii. Polymyositis and dermatomyositis and their relationship to connective tissue disorders, as distinguished from drug-induced myositis

iv. Sjögren syndrome (primary and secondary)
v. Polymyalgia rheumatic
vi. Antiphospholipid syndrome

3. Vasculitis
i. Polyarteritis nodosa
ii. Microscopic polyangiitis
iii. Hypersensitivity angitis
   1) Serum sickness
   2) Henoch-Schönlein purpura

viii. Granulomatous arteritis
   1) Wegener granulomatosis
   2) Giant cell (temporal) arteritis

ix. Kawasaki disease
x. Behçet disease

4. Regional rheumatic pain syndromes
i. Bursitis
ii. Tendinitis and tendinosis
iii. Low back pain
iv. Costochondritis
v. Chondromalacia patellae
vi. Compression
   1) Peripheral entrapment (e.g., carpal tunnel)
   2) Radiculitis and radiculopathy
   3) Spinal stenosis

vii. Raynaud pheonomenon
viii. Complex regional pain syndrome

5. Other
i. Osteopenia and osteoporosis
ii. Osteomalacia
iii. Paget disease
iv. Avascular necrosis
v. Relapsing panniculitis (Weber-Christian disease)
vi. Erythema nodosum
vii. Sarcoidosis
viii. Adult Still disease  
ix. Fibromyalgia and chronic fatigue syndrome

6. The indications. Laboratory and exam monitoring, potential side effects, and contraindications of pharmacologic agents for analgesia, disease modification, immunosuppression, and anti-inflammation  
i. List the mechanisms of the different disease-modifying agents (including antimalarials, sulfasalazine, minocycline, and gold salts)  
ii. List the mechanism of action of different immunosuppressive agents, including penicillamine, cytotoxic agents such as methotrexate, and biologic agents such as anti-tumor necrosis factor and interleukin-1 (IL-1) receptor antagonists  
iii. List the indications for use of local and systemic preparations of corticosteroids in different rheumatic conditions  
iv. Describe the use of uricosuric agents for prevention of gouty attacks and the use of abortive agents in acute attacks  
v. Describe the role of antibiotics in the treatment of rheumatic conditions  
vi. List the various medications and special circumstances for each agent in the treatment of osteoporosis

7. The use of rehabilitation services for joint mobilization and physical conditioning, and modalities for different stages of rheumatologic conditions to promote function and prevent physical disability

8. A multidisciplinary approach to the treatment of rheumatologic conditions that utilizes expert resources (including a rheumatologist, a physiatrist, a physical and occupational therapist, an orthopedic surgeon, and a mental health provider) for optimal patient care

9. Complementary therapies and modalities available for rheumatic conditions (including supplements, manipulation therapy, and acupuncture)

10. Disability prevention in rheumatologic conditions, which includes appropriate general health maintenance with attention to necessary vaccinations, appropriate weight maintenance with nutrition and exercise counseling, and attention to controlling other comorbid medical conditions.

IV. **Core Competency 3: Professionalism**

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

1. Recognition of the increased health care utilization and potential disability of rheumatic diseases
2. Support of each patient to reach his or her maximum function with minimal disability
3. Taking into account the direct and indirect costs of rheumatic diseases (including treatment, supportive care, and burden for the patient's family)
4. Recognition of how family, psychological, and environmental variables impact health status

*Effective 07/01/2016*  
The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
5. Endorsement of the multidisciplinary approach for the control of rheumatic disease and promotion of function
6. Recognition that each patient’s cultural background can impact proposed treatment plans and future disability

V. Core Competency 4: Interpersonal and Communication Skills
   a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should learn when to call a subspecialist for evaluation and management of a patient with rheumatologic disease.
      2. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
      3. The trainee must be able to establish a rapport with the patients and listen to the patient’s complaints to promote the patient’s welfare.
      4. The trainee should provide effective education and counseling for patients.
      5. The trainee must write organized and legible notes.
      6. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. Core Competency 6: Systems-Based Practice
   a. Objective & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
      1. The trainee should improve in the utilization of and communication with many health services and professionals such as the rheumatologist, the nurse clinician, physical therapist, and surgeon.
      2. The trainee should improve in the use of cost effective medicine.
      3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
      4. The trainee will assist in development of systems’ improvement if problems are identified.

VII. Core Competency 7: Practice Based Learning Improvement - The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives.
    a. Objectives
       1. The trainees should use feedback and self-evaluation in order to improve performance.
       2. The trainee should read the required material and articles provided to enhance learning.
       3. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Educational Material
a. Mandatory Reading
   1. Section on rheumatology in Rakel’s
   2. Section of rheumatology in Cecil’s Textbook of Medicine

b. Suggested Reading
   1. MKSAP booklet on Rheumatology

c. Pathology - the trainee and staff rheumatologist will review all synovial fluid aspirations, synovial biopsy or any pathology pertaining to rheumatology with the pathologist.

IX. Evaluation
   a. Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to rheumatology.
   b. Program Evaluation
      1. The trainee will fill out an evaluation of the rheumatology rotation at the end of the month.
      2. Any constructive criticism, improvements, or suggestions to further enhance the training in rheumatology are welcome at any time.

X. Feedback
   a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rheumatology rotation. The trainee will
be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rheumatology rotation.

b. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.31 Urgent and Emergent Care*

Educational Purpose:
The trainee will learn about the practice of emergency medicine in a busy medical center. The rotating trainee will be taught prioritization of care and triage. The trainee will learn how to interact with ambulance and other emergency service personnel. The trainee will learn the basic approach to common emergencies, traumatic, medical, pediatric and adult.

To provide educational experiences that will expand their knowledge and skills in the management of emergent patients.

Format: Trainees will have the opportunity to concentrate time spent in the emergency department on evaluation and management of patients who have presentations atypical of other outpatient experiences. Knowledge and skill acquisition will be supplemented through additional lectures or course work, including Advanced Burn Life Support (ABLS), ACLS, Advanced Life Support in Obstetrics (ALSO), Advanced Trauma Life Support (ATLS), Pediatric Advanced Life Support (PALS), and other such courses.

The trainee will demonstrate competency in their ability to:

- Demonstrate an ability to rapidly gather and assess information pertinent to the care of patients in an urgent and emergent situation, and develop treatment plans appropriate to the stabilization and disposition of these patients.
- Identify the indication and perform procedures as appropriate for the stabilization of the patient in an urgent and emergent care setting.
- Acquire the requisite skills in appropriate utilization of the resources available in the urgent and emergent care setting, including laboratory, radiology, ancillary services, and consultations with specialists (including transfer to a higher level of care).
- Demonstrate an ability to learn from experience, perform self-analysis of practice patterns, and participate in peer review of practice patterns.
- Use a professional and caring manner and sensitivity to cultural and ethnic diversity to appropriately inform and educate the patient and family, and to elicit their participation in medical decision making.
The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Core Competency 1: Osteopathic Principles**
   b) Osteopathic principles
      i.

II. **Core Competency 2: Medical Knowledge**
   a) Basic principles of surgical diagnosis:
      1. Basic surgical anatomy
      2. Wound physiology, care, and healing processes
      3. Clinical assessment, including history, physical examination, laboratory evaluation, and differential diagnosis of key signs and symptoms of surgical conditions
      4. Invasive versus noninvasive diagnostic tests
   b) Anesthesia
      v. Premedication
      vi. Agents and routes of administration
      vii. Resuscitation methods
   c) Recognition of surgical emergencies
      ix. Respiratory
         1. Airway obstruction
         2. Chest trauma
            a. Flail chest
            b. Hemothorax
            c. Pneumothorax
         3. Circulation
            a. Hypovolemia
               i. Gastrointestinal bleeding
               ii. Traumatic blood loss
         4. Acute abdomen
            a. Perforated viscus
            b. Intestinal obstruction
            c. Incarcerated hernia
            d. Mesenteric ischemia
            e. Appendicitis
            f. Diverticulitis
         5. Soft tissue
            a. Necrotizing
            b. Thermal injuries
         6. Trauma
            a. Advanced Trauma Life Support
         7. Common surgical procedures
            a. Appendectomy
b. Cholecystectomy
c. Herniorrhaphy
d. Colectomy
e. Hemorrhoidectomy – surgical or simple banding
f. Arterial bypass
g. Varicose vein procedures
h. Thyroidectomy and thyroid nodules
i. Parathyroidectomy

8. Ethical, legal, and socioeconomic considerations
   a. Informed consent
   b. Quality of life
   c. Cultural sensitivity
   d. End-of-life issues

9. Preoperative assessment
   a. Recognition of appropriate surgical candidates
   b. Surgical risk assessment
   c. Comorbid diseases
   d. Antibiotic prophylaxis
   e. Patient preparation (bowel, medication, schedule, etc.)

10. Intraoperative care
    a. Basic principles of asepsis and sterile technique
    b. Patient monitoring
    c. Fluid management
    d. Blood requirements
    e. Temperature control
    f. Use of basic surgical instruments

11. Postoperative care
    a. Routine
       i. Wound care
       ii. Patient mobilization
       iii. Nutrition management
       iv. Pain management
       v. Suctions and drains

12. Common complications
    a. Fever workup and management
       i. Wound dehiscence
       ii. Urinary retention
       iii. Hemorrhage
       iv. Pneumonia
       v. Atelectasis
       vi. Fluid overload
       vii. Transfusion reaction
       viii. Thrombophlebitis
ix. Pulmonary embolism
x. Oliguria
xi. Respiratory insufficiency
xii. Ileus
xiii. Infection
xiv. Shock

2. Outpatient surgery
   a. Patient selection
   b. Procedural sedation and analgesia
   c. Postoperative observation principles
   d. Follow-up care

3. Office care of common condition
   a. Lumps, bumps, and abscesses
   b. Simple lacerations
   c. Superficial burns
   d. Common methods of anesthesia

4. Adjunctive and long-term care of organ donors and recipients
5. Adjunctive and long-term care of bariatric surgical patients
6. Recognition and care of surgical wounds
7. Penetrating wounds
8. Avulsion crush, or shear injury wounds
9. Bite wounds

III. Core Competency 3: Professionalism
   a) An ability to communicate effectively and compassionately with patients and families
   b) An ability to communicate effectively with physicians and other health care professionals and to work effectively in a team
   c) A capacity to work effectively and efficiently to assess the patient according to the urgency of the patient's problem
   d) An awareness of the importance of cost containment and the need to appropriately utilize medical resources
   e) An awareness of the role of the emergency department in disaster planning for a community
   f) An understanding of the role of the family physician in disaster planning, training, and integration into the various government and private agencies responding to natural and man-made disasters.

IV. Core Competency 5: Patient Care
   In the appropriate setting, the trainee should demonstrate the ability to independently perform or appropriately refer:
   a) Airway management
      1. Heimlich maneuver
      2. Ensuring airway patency and the use of advanced airway techniques
         a. Bag-valve mask ventilation
b. Oral endotracheal intubation in children and adults, including rapid sequence intubation
c. Laryngeal mask airway (LMA)
d. Esophageal obturator airway
3. Needle thoracentesis and tube thoracostomy
4. Initiation of mechanical ventilation
5. Cricothyroidotomy

b) Anesthetic techniques, including appropriate assessment and monitoring
1. Regional and digital nerve blocks
2. Procedural sedation and analgesia, including intravenous and alternate routes
c) Hemodynamic techniques
1. Arterial catheter insertion and blood gas sampling
2. Central venous access (e.g., jugular, femoral, subclavian)
3. Venous cutdown
4. Intravenous infusion
d) Diagnostic and therapeutic procedures
1. Control of epistaxis (anterior and posterior packing)
2. Peritoneal tap and lavage
3. Lumbar puncture
4. Arthrocentesis
5. Pericardiocentesis
6. Nasogastric intubation
7. Thoracentesis
c) Skeletal procedures
1. Spine immobilization and traction techniques
2. Fracture and dislocation immobilization techniques
3. Fracture and dislocation reduction techniques
4. Initial management of traumatic amputation
f) Other
1. Repair of skin lacerations (including plastic closure)
2. Management of wounds
3. Management of foreign bodies in the skin and body orifices
4. Mass casualty triage
5. Multiple patient management
6. Grief and loss counseling
7. Critical incident stress debriefing
8. Management of acute cardiorespiratory arrest in all age groups and implementation of the skills of ACLS to lead a team resuscitative effort

V. Educational Materials
VI. Evaluation

b) Trainees will be evaluated in the performance in the following manner:

1. Patient evaluations will be reviewed with the attending physicians.
2. Patient presentations and conference presentations will be reviewed.
3. Procedures done by the trainee will be documented giving the indications, outcomes, diagnoses, level of competence and assessment by the supervisor of the ability of the trainee to perform it independently.
4. Mid-rotation evaluation session between the faculty members working with the trainee and the ED service attending for the month.

b. Feedback - Trainees will receive feedback with respect to achieving the desired level of proficiency and working out ways in which they can enhance their performance when the desired level of proficiency has not been achieved. Evaluation and feedback will occur during the rotation. In addition, we are developing a real time evaluative tool for trainee performance. It is anticipated that this will improve feedback.

3.32 Ophthalmology*

Educational Purpose:
The trainee will learn about the practice of ophthalmology in a busy medical center. The trainee will be taught prioritization of care and triage. The trainee will learn how to interact with ophthalmologist and other office personnel. The trainee will learn the basic approach to conditions of the eye.

Format: Implementation of this training will be attained in the ophthalmology outpatient setting and didactics. Family medicine trainees will have the opportunity to provide direct patient care under supervision, with emphasis on common treatable problems, prevention of
deterioration, and ocular emergencies. Trainees planning to provide care in communities where consultation resources are not readily available may wish to seek additional training.

The trainee will demonstrate competency in their ability to:

- Display an understanding of eye anatomy, common causes and treatment of acute and chronic visual loss, indications for screening examinations in the general population and in patients with systemic disease, and the ability to perform basic vision screening
- Demonstrate an understanding of the impact of ocular illness and dysfunction on patients and their families
- Demonstrate an understanding of the ophthalmic consultant’s role, including the different responsibilities of ophthalmologists, optometrists, and opticians
- Recognize his or her own practice limitations and seek consultation with other health care providers when necessary to provide optimal patient care

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Core Competency 1: Osteopathic Principles**
   a) The trainee will demonstrate the ability to apply knowledge of:
      i. Normal anatomy, physiology, and aging of the eye and ocular function

II. **Core Competency 2: Medical Knowledge**
   a) The trainee will demonstrate the ability to apply knowledge of:
      i. Normal anatomy, physiology, and aging of the eye and ocular function
      ii. Psychological and adaptive needs of patients with chronic ocular deterioration
      iii. Effects of drugs and toxins on ocular function and disease
      iv. Effects of ocular drugs on systemic function
      v. Ocular manifestations of systemic disease
      vi. Understanding of ocular disability in elderly patients and the importance of regular assessment and maintenance of functional capacity
      vii. Ocular complications of systemic illness
      viii. Guidelines for appropriate vision evaluation (including recommended time between evaluations) from birth to senescence
      ix. Initial diagnosis, management, and appropriate referral criteria for common eye problems
         1. Refractive errors
            i) Nearsightedness (myopia)
ii) Farsightedness (hyperopia)
iii) Presbyopia
iv) Astigmatism

2. Skin and adnexal disorders
   i) Infections
      (1) Hordeolum
      (2) Preseptal cellulitis
      (3) Orbital cellulitis
      (4) Dacryocystitis
   ii) Inflammation
      (1) Graves disease
      (2) Chalazion
   iii) Eyelid disorders
      (1) Entropion and extropion
      (2) Ptosis
      (3) Blepharitis
   iv) Benign tumors
      (1) Milia
      (2) Papilloma
      (3) Keratoacanthoma
      (4) Nevus
      (5) Dermoid
      (6) Xanthelasma
   v) Malignant tumors
      (1) Basal cell carcinoma
      (2) Squamous cell carcinoma
      (3) Lymphoma
      (4) Malignant melanoma
      (5) Retinoblastoma

3. Conjunctival disorders
   i) Conjunctivitis
      (1) Viral conjunctivitis
      (2) Herpes simplex conjunctivitis
      (3) Herpes zoster conjunctivitis and keratitis
      (4) Bacterial conjunctivitis
      (5) Allergic conjunctivitis
   ii) Conjunctival nevus
      (1) Pterygium
      (2) Pinguecula
   iii) Conjunctival tumors

4. Corneal diseases
   i) Superficial trauma and infection
5. Corneal abrasion (including those caused by contact lenses)
6. Keratitis
7. Corneal ulcers
   ii) Dry eye and associated diseases
8. Iritis
   (i) Unequal pupils
   (ii) Afferent pupillary defect
   (iii) Adie syndrome
   (iv) Horner syndrome
9. Cataracts
10. Glaucoma
    i. Acute angle-closure glaucoma
    ii. Open-angle glaucoma
11. Retinal disease
    i. Associated with visual loss
       (1) Central retinal vein occlusion
       (2) Branch retinal vein occlusion
       (3) Central retinal artery occlusion
       (4) Retinal detachment and vitreous hemorrhage
    ii. Associated with medical conditions
       (1) Hypertension
       (2) Diabetes mellitus
       (3) Migraine headache
    iii. Macular degeneration
    iv. Age-related changes
12. Optic nerve disorder
13. External muscular disorders
    i. Cranial nerve palsies
14. Trauma
    i. Blunt
    ii. Penetrating
x. Appropriate indications for special procedures in ophthalmology and ophthalm-radiology
1. Fluorescein angiography
2. Ocular ultrasound
3. Visual field testing
4. Magnetic resonance imaging (MRI) and computed tomography (CT) of the eye
xi. Indications, contraindications, limitations, and follow-up care of elective eye procedures, including the spectrum of refractive surgery, cosmetic surgery, and procedures (including the procedures of lens transplant and laser keratotomy)
xii. Prevention of eye injury and vision loss

III. Core Competency 3: Professionalism
a) A supportive and compassionate approach to the care of patients who have ocular disease, especially in cases of deteriorating vision
b) Recognition of the effects of loss of visual function
c) The importance of support systems in the health of patients who have ocular disease
d) An understanding of the ophthalmic consultant’s role, including the different responsibilities of ophthalmologists, optometrists, and opticians

IV. Core Competency 5: Patient Care
The trainee will demonstrate the ability to independently perform or appropriately refer:
a) Perform specific procedures and interpret results
   i. Tests of visual acuity, visual fields, and ocular motility
   ii. Direct ophthalmoscopy
   iii. Flashlight examinations
   iv. Fluorescein staining of the cornea
   v. Tonometry
   vi. Slit-lamp examination
b) Perform physical examination in patients of all ages, with emphasis on understanding normal neurologic and motor responses, as well as appearance
c) Localize the problem and generate a differential diagnosis and management plan
d) Formulate a rational plan for investigation and management, including assessment of severity and the need for immediate expert assistance
e) Formulate a plan for management, investigation, and acquisition of expert advice, with an awareness of the potential risks, costs, and value of information that can be obtained
f) Manage and recognize the prevalent and treatable diseases listed in the "Knowledge" section of this guideline, with consultation as appropriate
g) Manage and coordinate psychosocial and family issues, including long-term care of debilitating ocular conditions, necessary environmental adaptation, and use of community resources
h) Use appropriate diagnostic tests and medications
   i. Mydriatics
   ii. Topical anesthetics
   iii. Corticosteroids
   iv. Antibiotics
   v. Glaucoma agents

V. Educational Materials


VI. Evaluation

a) Trainees will be evaluated in the performance in the following manner:

1. Patient evaluations will be reviewed with the attending physicians.
2. Patient presentations and conference presentations will be reviewed.
3. Procedures done by the trainee will be documented giving the indications, outcomes, diagnoses, level of competence and assessment by the supervisor of the ability of the trainee to perform it independently.
4. Mid-rotation evaluation session between the faculty members working with the trainee and the teaching attending for the month.

c. Feedback - Trainees will receive feedback with respect to achieving the desired level of proficiency and working out ways in which they can enhance their performance when the desired level of proficiency has not been achieved. Evaluation and feedback will occur during the rotation. In addition, we are developing a real time evaluative tool for trainee performance. It is anticipated that this will improve feedback.

3.33 Geriatrics*

**Educational Purpose:** Trainees will learn about the principles of aging and become proficient in the application of this information. Trainees will learn to recognize, understand, and manage certain geriatric syndromes. The trainee will become proficient in the diagnosis, management, and evaluation of certain common diseases, disorders and health concerns of the elderly.

**Format:** This curriculum will be taught during both focused and longitudinal experiences throughout the residency program. Physicians who have demonstrated skills in caring for the elderly and who have a positive attitude toward the elderly will be available to act as role models to the trainee and will be available to give support and advice to individual trainees.
regarding the management of their own patients. A multi-disciplinary approach coordinated by the family physician is an appropriate method for structuring teaching experiences. Individual teaching and small group discussion will help promote appropriate attitudes.

The trainee will be responsible for caring for elderly patients and have opportunities to act as decision maker and case manager. Each trainee’s panel of patients will include a significant number of elderly patients, including healthy elderly patients and those with minor health problems, the chronically ill, the critically ill, the acutely ill, and the injured. The trainee will be required to have experience providing continuing care for elderly patients in the ambulatory setting, the home, the hospital, and assisted living facilities.

The trainee will demonstrate competency in their ability to:

- Be able to perform comprehensive, standardized geriatric assessments and develop short- and long-term treatment plans.
- Be able to optimize treatment plans based on knowledge of local geriatric care resources, including local, state, and federal agencies.
- Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and governmental agencies.
- Demonstrate the ability to communicate effectively with the patient, as well as the patient’s family and caregivers, to ensure the diagnosis is clearly understood and the treatment plan is developed collaboratively.
- Recognize their practice limitations and seek consultation with other health care providers when necessary to provide optimal care.

I. **Core Competency 1: Osteopathic Concepts**

   i. Primary use of muscle energy techniques, fascial release and counter strain rather than high velocity thrust;

   ii. Goal is to maintain mobility and functional status rather than to focus on reversal of dysfunction;

   iii. Posture and strengthening exercises to maintain mobility and reduce energy expenditure.

II. **Core Competency 5: Patient Care**

   The trainee will demonstrate the ability to independently perform or appropriately refer:

   a. Basic elements of geriatric assessment, including the standardized methods for assessing physical, cognitive, emotional, and social functioning as appropriate

   b. Screening examinations for mental status, depression, and functional status including activities of daily living (ADL) and instrumental activities of daily living (IADL)

   c. Physical diagnosis, including:

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1. Mobility, gait, and balance assessments
2. Recognition of normal and abnormal signs of aging
3. Preoperative assessment
4. Obtain a comprehensive history and mental status examination, utilizing all available sources of information
5. Evaluation of the appropriate use of assistive devices (e.g. canes, walkers, wheel or power chairs)

   d. Conduct an efficient and comprehensive physical examination in the following venues: office, hospital, and nursing home settings. The physician should be mindful of the patient's modesty and mobility

   e. Appropriate selection, interpretation, and performance of diagnostic procedures

   f. Appropriate house calls and coordination of home care

   g. Develop problem lists in practical, clinical, functional, psychological, and social terms

   h. Set appropriate priorities and limitations for investigation and treatment

   i. Communicate with the patient and / or caregivers the proposed investigation and treatment plans in a way that promotes understanding, adherence and appropriate attitudes

   j. Communicate hope and empathy

   k. Counsel patients about age-related psychological, social, and physical stresses and changes of the normal life cycle of aging, dying, and death

   l. Coordinate a range of services appropriate to the patient's needs and support systems

   m. Integrate factors of the patient's family life, home life, and general lifestyle into the diagnostic and therapeutic process

   n. Appropriate use of critical care resources which includes dealing with ethical issues, including advance directives, decision-making capacity, euthanasia, assisted suicide, health care rationing, and palliative and end-of-life care

III. Core Competency 2: Medical Knowledge

   The trainee will demonstrate the ability to apply knowledge of:

   a. Normal underlying physiologic changes due to aging in the various body systems

      1. Diminished homeostatic abilities

      2. Altered metabolism and effects of drugs

      3. Physiology of aging in various organ systems

   b. Normal psychological, social, and environmental changes of aging

      1. Reactions to common stresses such as retirement, bereavement, relocation, and ill health

      2. Changes in family relationships that affect health care of the elderly

   c. Unique modes of presentation for care, including atypical presentations of specific diseases in elderly patients

   d. Risks and adverse outcomes in geriatric care
1. Polypharmacy
2. Iatrogenic illness
3. Immobilization and its consequences
4. Over-dependency
5. Inappropriate institutionalization
6. Non-recognition of treatable illness
7. Over-treatment
8. Inappropriate use of technology
9. Unsupported family

e. Means for promoting health and health maintenance through screening for and assessment of risk factors
f. Services available to promote rehabilitation or maintenance of an independent lifestyle for elderly people, thus increasing their ability to function in their existing family, home, and social environments
g. Indications and benefits of the house call in the assessment and management of elderly patients
h. Characteristics of the various types of long-term care facilities and alternative housing available to the elderly
i. Specific regulations for patient care in long-term facilities
j. Financial aspects of health care of the elderly understanding local, state, and federal programs that assist the elderly to finance the cost of their health care
k. Means to actively promote health in the elderly through exercise, nutrition, and psychosocial counseling
l. Elder abuse and neglect
m. Community resources, including those used to help patients maintain independence
n. Evaluation of the functional status of the elderly patient

1. Problems that are characteristic of older patients or that differ significantly in presentation and/or management in order adults
   1. Special senses: hearing and vision loss, speech disorders, taste, vestibular, and proprioceptive
   2. Respiratory: pneumonia and other respiratory infections
   3. Cardiovascular: hypertension, congestive heart failure, myocardial infarction, thromboembolism, temporal arteritis, cerebral vascular accident, transient ischemic attacks, and postural hypotension
   4. Oral Conditions: caries, periodontal disease, tooth loss and denture care, oral-pharyngeal cancers, and oral-systemic linkages
   5. Gastrointestinal: dentition problems, acute abdomen, malnutrition, constipation, and fecal impaction
   6. Genitourinary: incontinence, urinary tract infections, bacteriuria, and sexual dysfunction
   7. Musculoskeletal: degenerative joint disease, fractures, contractures, osteopenia / osteoporosis, podiatric problems, falls, decubiti, and
pressure ulcers
8. Neurological: delirium, dementia (e.g., Alzheimer’s disease), altered mental status, dizziness, tremor, memory loss, gait disorders, and sleep disorders
9. Metabolic: dehydration, diabetes, hypothyroidism, medication-induced illness, malnutrition, anemia, hypothermia, and malignancies
10. Psychosocial: abuse (physical, financial, and psychological), alcoholism and other substance abuse, grief reactions, depression, psychological effects of illness, pain, terminal care, malnutrition, and failure to thrive
11. Dermatologic: xerosis, cutaneous neoplasms, skin manifestations of internal illness, blistering diseases, and environmental and traumatic lesions

IV. Core Competency 3: Professionalism
The trainee will demonstrate attitudes that encompass:

a. Awareness of the effects that attitudes and stereotypes related to aging, disability, and death can have on the care of elderly patients.
b. Empathy and compassion towards the elderly and assisting them to cope with inevitable decline and loss.
c. The promotion of the patient’s dignity through self-care and self-determination.
d. Recognition of the importance of family and home in the overall lifestyle and health of patients.
e. An understanding of appropriate limitation of investigation and treatment for the benefit of the patient.
f. An awareness of the importance of a multidisciplinary approach to the enhancement of individualized care.
g. Accessibility to and accountability for his or her patients.
h. An awareness of the importance of limiting cost when treating elderly patients.
i. An awareness of the benefits, limitations, and appropriate use of advance directives, living wills, and durable powers of attorney.

V. Core Competency 4: Interpersonal and Communication Skills
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   1. The trainee should learn when to refer to a geriatrician for evaluation and management of a patient with geriatric disease.
   2. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.
   3. The trainee must be able to establish a rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.
4. The trainee should provide effective education and counseling for patients.
5. The trainee must write organized and legible notes.
6. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. Core Competency 6: Systems-Based Practice
a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:
   1. The trainee should improve in the utilization of and communication with many health services and professionals such as the nutritionist, the nurse clinician, podiatrist, ophthalmologist, physical therapist, occupational therapist, speech therapist, and pharmacist.
   2. The trainee should improve in the use of cost effective medicine.
   3. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.
   4. The trainee will assist in development of systems’ improvement if problems are identified.

VII. Core Competency 7: Practice Based Learning Improvement
a. Objectives
   1. The trainee will learn the importance of continued scholarship in the areas of principles of aging. Reference to geriatric texts and journals will be utilized.
   2. The trainee will learn to recognize his or her own limitations and request appropriate consultation and support.
   3. The trainee will learn the importance of staying abreast of the medical literature addressing the various diseases and problems of the elderly.

b. Evaluation of Practice Based Improvement - The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives.
   1. The trainee should use feedback and self-evaluation in order to improve performance. 2. The trainee should read the required material and articles provided to enhance learning.
   2. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Educational Materials
a. Mandatory Reading
   1. Section on geriatric disease in Rakel’s; AND,
   2. Section on geriatric disease in Cecil’s Textbook of Medicine

b. Suggested Reading
2. MKSAP booklet on Geriatrics

IX. Evaluation

  a. Evaluations will be similar to that utilized in other areas of the Family Medicine training program and will have both formal and informal components. The formal evaluations will consist of written evaluations by attending physicians on each trainee when they are in various settings such as the ambulatory clinic and nursing home. Informal evaluations are based on interactions that the trainees have with faculty members.

  b. Program Evaluation

      1. The trainees will fill out an evaluation of the geriatric rotation at the end of the month.

      2. Any constructive criticism, improvements, or suggestions to further enhance the training in geriatrics are welcome at any time.

X. Feedback

  a. Trainees should receive feedback on their knowledge in geriatrics from a number of sources. This can come from the attending or other members of the team such as the therapists, pharmacists, and nurses. Finally, the trainees receive feedback about their knowledge in geriatrics by assessing their performance when various lectures and board reviews are given, as well as when they take the in-training examination.

  b. The trainee will obtain feedback on the acquisition of skills from interactions with attending physicians, trainees and nurses during their rotations. Trainees may also assess their attainment of certain skills by comparing their progress with that espoused in the geriatric lecture series.
c. Faculty in the form of evaluations as well as meetings will also provide feedback with the trainee.

**Geriatrics**

### 3.34 Medical Genetics*

**Educational Purpose:** Trainees will learn about the principles of medical genetics and become proficient in the application of this information. Trainees will learn to recognize, understand, and manage certain genetic syndromes. The trainee will become proficient in the diagnosis, management, and evaluation of certain common diseases, disorders and health concerns.

**Format:** Implementation of this curriculum will include longitudinal and didactic experience throughout residency training. Physicians who have expertise in medical genetics will be available for conferences and electives for resident physicians. Consideration of genetic diagnoses in the differential diagnosis of common and complex diseases will be made during obstetrics, pediatric, and adult medicine training rotations, as well as during patient care in the family medicine center.

The trainee will demonstrate competency in their ability to:

- Perform an appropriate family history and identify patients who have a personal medical condition and/or family history that indicates the risk of a genetically linked disorder, and provide appropriate counseling
- Effectively interview patients in order to obtain information about relevant genetic, environmental, and behavioral risk factors
- Understand the important social and psychological implications health-related genetic information can have for individuals and families
- Recognize his or her limitations and seek consultation with other medical genetics health care professionals as needed
- Properly use family medical history tools and/or genetics pedigree charts, including a three-generation family history (e.g., [www.hhs.gov/familyhistory/](http://www.hhs.gov/familyhistory/))

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I. **Core Competency 1: Osteopathic Concepts**
   a. 
   b. 

II. **Core Competency 5: Patient Care**

   The trainee will demonstrate the ability to independently perform or appropriately refer:
   a. Gather genetic family history information (including an appropriate multigenerational family history)
b. Identify patients who would benefit from genetic services
e. Explain basic concepts of probability, disease susceptibility, and the influence of genetic factors on maintenance of health and development of disease
d. Seek appropriate assistance from and refer to appropriate genetics experts and peer support resources
e. Obtain current information about genetics for self, patients, and colleagues
f. Utilize new information technologies effectively to obtain current information about genetics
g. Participate in professional and public educational discussions about genetics from the perspective of a family physician
h. Provide culturally appropriate information about the potential risks, benefits, and limitations of genetic testing
i. Educate patients about the range of emotions they and/or family members may experience as a result of receiving genetic information
j. Safeguard the privacy and confidentiality of the genetic information of patients
k. Inform patients of potential limitations of maintaining privacy and confidentiality of genetic information
l. Educate patients about availability of genetic testing and/or treatment for conditions seen frequently in practice, such as the following:
   i. BRCA1/BRCA2 testing for hereditary breast and ovarian cancer
   ii. Fluorescence in situ hybridization (FISH) analysis in the newborn nursery
   iii. Preconception counseling for carrier disease states
   iv. Risk scoring and focused testing for disease states (e.g., cancers that might or might not respond to treatments such as chemotherapy)
   v. Screening for cardiogenetic anomalies such as hypertrophic cardiomyopathies, lipid genetics, and coronary artery disease (CAD) risk states, as well as long QT syndrome, if appropriate
m. Provide patients with an appropriate informed consent process to facilitate decision making related to genetic testing
n. Educate patients about direct-to-consumer (DTC) genome-wide association study (GWAS) testing as a risk stratification strategy, and its benefits and risks

III. Core Competency 2: Medical Knowledge

The trainee will demonstrate the ability to apply knowledge of:

a. Basic human genetics terminology, principles of human and medical genetics, and basic patterns of biological inheritance and variation (both within families and within populations)

b. The importance of the three-generation family history in assessing predisposition to disease, highlighting the difference between a pedigree and genogram

c. The role of genetic factors in health maintenance and disease prevention
d. The difference between clinical diagnosis of disease and identification of genetic predisposition to disease

e. The role of behavioral, social, and environmental factors that modify or influence genetics in the manifestation of disease

f. The influence of ethnicity, culture, related health beliefs, and economics in determining the ability of the patient to use genetic information and services

g. The potential physical and/or psychosocial benefits and risks of genetic information for individuals in the context of the family and community

h. The range of genetic approaches to treatment of disease (including pharmacogenomics and gene therapy)
i. The indications and resources for genetic testing and referral to genetic specialists

j. The history of misuse of human genetic information (i.e., eugenics)
k. The ethical, legal, and social issues related to genetic testing and recording of genetic information regarding:

i. Screening for genetic abnormalities

ii. Prenatal/preconception testing

iii. Presymptomatic genetic testing

iv. Carrier testing for genetic disorders

v. Confidentiality (Genetic Information Nondiscrimination Act of 2008 [GINA])

vi. Risk assessment

vii. Responsibility to inform

viii. Discrimination issues (e.g., insurance coverage, employment)

ix. Informed consent

x. Paternity determinations

IV. Core Competency 3: Professionalism

The trainee will demonstrate attitudes that encompass:

a. Recognition of the philosophical, theological, cultural, and bioethical perspectives influencing use of genetic information and services

b. An appreciation for the sensitivity of genetic information, and the need for privacy and confidentiality while delivering genetic education and counseling fairly; accurately; without coercion or personal bias; and with sensitivity to the patients’ and families’ culture, knowledge, and language level

c. Recognition of the importance of the family physician, the medical geneticist, and the genetics team as collaborators in the evaluation, diagnosis, and treatment of patients tested and referred for genetic consultation

d. Recognition of ethical, social, cultural, religious, and ethnic issues and situations in which personal values and biases pertaining to these issues may affect or interfere with care provided to patients

V. Core Competency 4: Interpersonal and Communication Skills

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee’s responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
i. The trainee should learn when to refer patient for evaluation and management of a patient to medical genetics.

ii. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.

iii. The trainee must be able to establish rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.

iv. The trainee should provide effective education and counseling for patients.

v. The trainee must write organized and legible notes.

vi. The trainee must communicate any patient problems to the staff in a timely fashion.

VI. **Core Competency 6: Systems-Based Practice**

a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

   i. The trainee should improve in the utilization of and communication with many health services and professionals.

   ii. The trainee should improve in the use of cost-effective medicine.

   iii. The trainee will assist in determining the root cause of any error which is identified and methods for avoiding such problems in the future.

   iv. The trainee will assist in development of systems’ improvement if problems are identified.

VII. **Core Competency 7: Practice Based Learning Improvement**

a. Objectives

   i. The trainee will learn the importance of continued scholarship in the areas of principles of aging. Reference to geriatric texts and journals will be utilized.

   ii. The trainee will learn to recognize his or her own limitations and request appropriate consultation and support.

   iii. The trainee will learn the importance of staying abreast of the medical literature addressing the various diseases and problems relating to medical genetics.

b. Evaluation of Practice Based Improvement - The trainee’s performance will be evaluated on their willingness and ability to obtain the following objectives.

   i. The trainee should use feedback and self-evaluation in order to improve performance.

   ii. The trainee should read the required material and articles provided to enhance learning.

   iii. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VIII. Educational Materials

a. Mandatory Reading
i. Section on medical genetics in Rakel's; AND,
ii. Section on medical genetics in Cecil’s Textbook of Medicine

b. Suggested Reading
12. MKSAP booklet on Medical Genetics

IX. Evaluation

a. Evaluations will be similar to that utilized in other areas of the family medicine residency training program and will have both formal and informal components. The formal evaluations will consist of written evaluations by attending physicians on each trainee when they are in various settings such as the ambulatory clinic and on in-patient service. Informal evaluations are based on interactions that the trainees have with faculty members.

b. Program Evaluation

i. The trainees will fill out an evaluation of the medical genetics at the end of the month.

ii. Any constructive criticism, improvements, or suggestions to further enhance the training in medical genetics are welcome at any time.

X. Feedback

a. Trainees will receive feedback on their knowledge in genetics from a number of sources. This can come from the attending or other members of the team.
Finally, the trainees will receive feedback about their knowledge in genetics by assessing their performance when various lectures and board reviews are given, as well as when they take the in-training examination.

b. The trainee will obtain feedback on the acquisition of skills from interactions with attending physicians, trainees and nurses during their rotations. Trainees may also assess their attainment of certain skills by comparing their progress with that espoused in the genetics lecture series.

c. Faculty in the form of evaluations as well as meetings will also provide feedback to the trainee.

3.35 Medical Informatics*

**Educational Purpose:** Trainees will learn about the principles of medical informatics and become proficient in the application of this information.

**Format:** Curriculum implementation will include both focused and longitudinal experiences throughout the residency program. Didactic lectures and journal clubs should be augmented with instruction regarding principles of the physician-patient-computer relationship in daily practice. The model of care should shift from a reactive, individual model to a proactive, population-based model through technology application. Communication should be emphasized as integral to the effective use of information. Ready access to computer and information resources in the clinical care, administrative, and teaching environments should be provided. An efficient and responsive technical support infrastructure should be in place, in addition to a faculty “champion” to direct medical informatics training within the program. A baseline needs assessment at matriculation should lead to appropriate practical training in computer skills literacy through tutorials, and group and/or one-on-one instruction. Avoid applying technology for its own sake and intimidating those who are anxious about technology. Departments should also measure and report educational outcomes to promote evidence-based approaches to high quality medical informatics training for family medicine residents across the nation.

The trainee will demonstrate competency in their ability to:

- Demonstrate basic computer literacy, utilization, and safety, in addition to effective use of office productivity and communication software tools
- Efficiently use appropriate information resources and tools available to support clinical decision making at the point-of-care and to promote lifelong professional learning and enrichment
- Exhibit understanding of the ways in which medical informatics and information technology can be applied to the continuum of care delivery in order to improve efficiency, quality, and safety
• Access specific, relevant clinical information by performing and appropriately refining database searches through use of necessarily focused medical terminology and concepts
• Access, enter, and retrieve data related to patient care, and efficiently and accurately document clinical encounters, plans of care, and medical decision making via available clinical information systems

I. Core Competency 1: Osteopathic Concepts
   a.
   b.

II. Core Competency 2: Medical Knowledge
   The trainee will demonstrate the ability to apply knowledge of:
   a. Information resources and support tools available to aid in clinical decision making and to promote patient education and lifelong learning for clinicians
   b. Basic components of computer systems and networks, and the nature of computer-human interfaces as they impact patient care
   c. Fundamentals of data modeling and database systems (including the definition and application of controlled vocabularies and structured versus unstructured data types)
   d. Policies and procedures to ensure the security and confidentiality of patient information and the integrity of computer systems and networks
   e. Application of aggregation and analysis of clinical data for improving care quality and patient outcomes
   f. Benefits and limitations of computer hardware and software systems
   g. New technologies that may be used in clinical practice to improve clinician efficiency, effectiveness, and productivity
   h. The importance of technology tools to actively engage and involve the patient before, during, and after the visit
   i. Simulation technologies to aid in clinician training

III. Core Competency 3: Professionalism
   The trainee will demonstrate attitudes that encompass:
   a. The encouragement of other members of the care team to develop comfort with and competency in the use of clinically relevant technologies
   b. Recognition of the importance of health care professional involvement in the planning, selection, design, and implementation of information systems, and participation in systems change processes and utility analysis at the point-of-care
   c. Awareness of the impact of implementing technology to facilitate medical practice and participating in policy and procedural development related to medical informatics
   d. Recognition of the relevance of aggregation and analysis of clinical data for improving care quality and patient outcomes
e. Recognition of computer hardware and software system limitations and the need for continual learning in informatics skills, applications, and knowledge as technology continues to advance rapidly
f. Recognition of personal knowledge deficits in evidence-based medicine and commitment to perpetual curiosity and inquiry to resolve them
g. Understanding of the impact of information systems on clinical workflow and communication within multidisciplinary teams
h. An upholding of legal and ethical standards related to data security, confidentiality, and patients’ right to privacy
i. Recognition of the importance of accuracy, integrity, and completeness of the medical record, and commitment to playing a critical role in maintaining patient information

IV. **Core Competency 4: Interpersonal and Communication Skills**

   a. Objectives & Evaluation - The trainee will be evaluated on their ability to demonstrate the following objectives:

      i. The trainee should learn when to refer patient for evaluation and management of a patient to medical genetics.

      ii. The trainee should be able to clearly present the consultation cases to the staff in an organized and thorough manner.

      iii. The trainee must be able to establish rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.

      iv. The trainee should provide effective education and counseling for patients.

      v. The trainee must write organized and legible notes.

      vi. The trainee must communicate any patient problems to the staff in a timely fashion.

V. **Core Competency 6: Systems-Based Practice**

   a. Demonstrate basic computer literacy, utilization, and safety (including keyboarding, navigation of operating systems; connection; and use of peripheral devices, data storage, and backup)

   b. Retrieve information by performing and appropriately refining database searches using logical (Boolean) operators in a manner that reflects understanding of medical language and terminology, and the relationships among medical terms and concepts

   c. Access, evaluate, grade, and synthesize data, information, and knowledge from multiple sources and apply to clinical practice and professional development

   d. Evaluate Internet-based health materials for quality, accountability, reliability, and validity, and use multiple information sources to gather evidence for clinical decision making at the point-of-care and for professional learning and enrichment

   e. Direct patients to credible online medical information and services, and use information management systems for patient education
f. Use all technology tools to augment the patient experience, and be skilled at managing the physician-patient-computer triangle

g. Access, enter, and retrieve data related to patient care, and efficiently and accurately document clinical encounters, plans of care, and medical decision making via available clinical information systems

h. Collaborate with other clinicians and support staff via networks across multiple sites and contexts using email, discussion lists, news groups, teleconferencing, and related communication technologies

i. Effectively use office productivity and communication software, including:

   i. Word processing
   ii. Presentation (including multimedia)
   iii. Spreadsheet
   iv. Database
   v. Web browsers
   vi. Email, instant messaging, video conferencing, and other digital messaging tools
   vii. Ancillary devices: monitors, diagnostic and imaging tools for multimedia inclusion in the record
   viii. Social media: effective and secure use to effectively manage one’s online reputation, support practices, and help patients deal with their acute and chronic conditions
   ix. Wide array of digital tools to continuously monitor personal and practice-wide quality metrics to enhance the quality of care

j. Evaluate and incorporate new applicable technologies for clinical practice and training, including mobile technologies, tablets, simulation technologies, and online educational tools

k. Participate in design of data collection tools for practice decision making, record keeping, and participation in quality management/improvement initiatives related to clinical data in practice

l. Evaluate security effectiveness and parameters of systems for protecting patient information and ensuring confidentiality

VI. Core Competency 7: Practice Based Learning Improvement

a. Objectives

   i. The trainee will learn the importance of continued scholarship in the areas of principles of aging. Reference to geriatric texts and journals will be utilized.

   ii. The trainee will learn to recognize his or her own limitations and request appropriate consultation and support.

   iii. The trainee will learn the importance of staying abreast of the medical literature addressing the various diseases and problems relating to medical genetics.

b. Evaluation of Practice Based Improvement - The trainee’s performance will be evaluated on their willingness and ability to obtain the following
objectives.
   i. The trainee should use feedback and self-evaluation in order to improve performance.
   ii. The trainee should read the required material and articles provided to enhance learning.
   iii. The trainee should use the medical literature search tools in the library to find appropriate articles related to interesting cases.

VII. Educational Materials

VIII. Evaluation
   a. Evaluations will be similar to that utilized in other areas of the family medicine residency training program and will have both formal and informal components. The formal evaluations will consist of written evaluations by attending physicians on each trainee when they are in various settings such as the ambulatory clinic and on in-patient service. Informal evaluations are based on interactions that the trainees have with faculty members.
   b. Program Evaluation
      i. The trainees will fill out an evaluation of the medical genetics at the end of the month.
      ii. Any constructive criticism, improvements, or suggestions to further enhance the training in medical genetics are welcome at any time.

IX. Feedback
   a. Trainees will receive feedback on their knowledge in genetics from a number of sources. This can come from the attending or other members of the team. Finally, the trainees will receive feedback about their knowledge in genetics by assessing their performance when various lectures and board reviews are given, as well as when they take the in-training examination.
   b. The trainee will obtain feedback on the acquisition of skills from interactions with attending physicians, trainees and nurses during their rotations. Trainees may also assess their attainment of certain skills by comparing their progress with that espoused in the genetics lecture series.
   c. Faculty in the form of evaluations as well as meetings will also provide...
feedback to the trainee.

3.36 Neurology

**Educational Purpose:**
To provide the trainees with formal intensive instruction and clinical experience

To provide the opportunity to acquire expertise in the evaluation and management of neurological diseases

The trainee will demonstrate competency in their ability to:

- Diagnose and manage common disorders of the nervous system.
- Understand the role osteopathic manipulation plays in the management of neurologic disorders.

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a. History.
   i. Nature of dysfunction and mode of onset;
   ii. Toxins or other environmental exposures;
   iii. Trauma/infections;
   iv. Activities of daily living;
   v. Family history.

b. Physical exam.
   i. Complete cranial nerve evaluation;
   ii. Muscular tone, strength, fasciculations, wasting;
   iii. Reflex testing, clonus, Babinski, Chaddock, Bing;
   iv. Cerebellar testing;
   v. Gait observation;
   vi. Sensory testing to include pain, light touch, temperature,
   vii. Irritative, position, neglect;
   viii. Mental status exam.

c. Basic concepts.
   i. Cephalgia: tension, vascular, cluster;
   ii. Vertigo;
   iii. CNS infections, hemorrhage, trauma, edema;
   iv. Concussion, epidural and subarachnoid hematoma;
   v. Seizures: status epilepticus, classification, evaluation, indications for treatment;
   vi. Coma;
   vii. Cerebrovascular disease: CVA, TIA, RIND, stroke in evolution, intracranial; hemorrhage and aneurysms;
viii. Fluent and non-fluent aphasia;
ix. Dementia: multi-infarct, metabolic, Alzheimer's, degenerative, toxic;
x. Meningitis, encephalitis;
xi. Movement disorders: Parkinsonism, tardive dyskinesia, essential and secondary tremor;
 xii. Multiple sclerosis;
 xiii. Muscular dystrophies;
xiv. Polyneuropathy, mononeuritis, myasthenia gravis, Guillain Barre;
xv. Neuro-ophthalmology: normal fundus, papilledema, Marcus Gunn pupil;
xvi. Syncope;
xvii. Pituitary adenoma;
xviii. Spinal cord compression, corda equina syndrome;
xix. Primary and secondary brain tumors;
d. Diagnostics/therapeutics.
i. Lumbar puncture;
ii. EEG assist;
iii. Cerebral angiography interpretation;
iv. CT/MRI scanning interpretation;
v. Myelography: assist;
vi. Evoked potentials interpret;
vii. EMG assist;
viii. Doppler ultrasound of carotids interpret;
ix. Osteopathic structural exam.
e. Health promotion.
i. Psychosocial support;
ii. Genetic counseling.
f. **Core Competency 1: Osteopathic Concepts**
i. Focus on secondary structural changes and spasm with myofascial release, counter strain, and mobility therapy;
ii. Cervical myofascial release for tension cephalgia;
iii. Short leg syndrome therapy

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods - Trainees will receive individual instruction by neurology physicians while interviewing patients at the outpatient clinics, and the private office, and in the consultation services.
   a. Trainees will see a wide variety of patients from various ages, social economic, educational, and cultural backgrounds.
   b. Trainees will evaluate patients and will discuss findings by staff neurologists. Trainees must complete a thorough progress note on every outpatient and the neurology staff in charge of the patient must countersign this.
c. Trainees will initially see the inpatient consults, and gather information from chart, radiology and laboratory reports. Trainees then will discuss all this information with the staff neurologists as part of the bedside teaching round. Trainees will follow these patients as their own until patients are released.

d. The neurology staff will give teaching lectures weekly. There is a basic neuro imaging review.

c. Trainees will be responsible for reviewing one general Neurology topic per week and giving a short presentation during the morning lecture.

II. Core Competency 5: Patient Care

a. Objectives

1. Interpreting the significance of neurological symptoms.
2. Performing a neurological examination.
3. Interpreting the signs obtained in the examination.
4. Localization of diseases process in the nervous system.
5. Integration of symptoms and signs into neurological syndromes and recognizing neurological illnesses.
7. Learning the basis of neuro imaging (CT scan, MRI), and electro diagnostic studies (EEG's and EMG's).
8. Utilizing laboratory data to complete topographic and etiologic diagnoses.
10. Formulating plan for investigation and management.
12. Understanding main neurological manifestations of systemic diseases.
13. Identifying emergencies and need for expert assistance.

b. Evaluation of Patient Care - Trainee will be evaluated using the following criteria:

1. Completeness and accuracy of medical interviews and physical examination.
2. Thoroughness of the review of available medical data obtained from patients.
3. Performance of appropriate procedures on patients.
5. Appropriateness of diagnosis and therapeutic decisions.
7. Consideration of patient’s preferences in making therapeutic decisions.
8. Completeness of medical charting.

c. At the completion of the rotation trainees should be able to manage neurological disease such as epilepsy, migraine headaches, vertigo, dizziness,
strokes, dementia, Parkinson’s disease, multiple sclerosis, amyotrophic lateral sclerosis, neuropathies, head and spinal cord injuries and neurological complication of systemic diseases. These skills are acquired in the inpatient consultation service, inpatients, and outpatient visits.

III. **Core Competency 2: Medical Knowledge**

a. **Objectives** - These objectives will be taught through didactic sessions, and at bedside teaching.

1. Classification, pathogenesis, diagnosis, complications and treatment of Epilepsy (seizure disorder)
   a. Syncope
   b. Headache
   c. Vertigo/dizziness
   d. Stroke
   e. Brain and spinal tumors
   f. Head and spinal injuries
   g. Dementia
   h. Parkinson’s disease
   i. Multiple sclerosis
   j. Motor neuron disease
   k. Infection diseases of the nervous system
   l. Neuropathies
   m. Diabetic neuropathies
   n. Acute and chronic inflammatory demyelinating neuropathies
   o. Toxic neuropathies
   p. Toxic neuropathies
   q. Neuropathies due to systemic diseases
   r. Neuromuscular junction diseases
   s. Myopathies
   t. Hereditary
   u. Acquired

2. Neurological complications of systemic diseases

3. Adverse effects, pharmacokinetics and pharmacodynamics
   Antiepileptic drugs Anti-parkinson drugs Immunomodulator IV Immunoglobulins Antihypertensive medicines Psychotropic medicines Neurotropic medicines Anticoagulant medicines

b. **Evaluation of Medical Knowledge** - Trainees’ medical knowledge of Neurology will be assessed by their ability to:

1. Answer specific questions and to participate in didactic sessions.
2. Properly present assigned topics (these will be examined for completeness, accuracy, organization, and trainee’s understanding of the subject).
3. Apply the learned information in patient care setting.
4. Give more than their share and demonstrate interest, and
enthusiasm in learning.

IV. **Core Competency 3: Professionalism**
   a. Objectives and Evaluation - Trainees will be evaluated on their ability to demonstrate the following objectives:
      1. Development of ethical behavior and humanistic qualities of respect, compassion, integrity, and honesty.
      2. Willing to acknowledge errors & determine how to prevent them in the future.
      3. Responsibility and reliability at all times.
      4. Consideration of needs from patients, families, colleagues and support staff.
      5. Professional appearance at all times.

V. **Core Competency 4: Interpersonal and Communication Skills**
   a. Objectives and Evaluation
      1. Trainees should be able to decide when to call another specialist for evaluation and management on a patient with a neurological disease.
      2. Trainees should be able to clearly present the problem to the consultant and ask a precise question to the consultant.
      3. Trainees should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, empathy, and rapport with patients and family to promote the patient's welfare.
      4. Trainees should provide effective education and counseling to patients.
      5. Trainees must write organized and legible notes.
      6. Trainees must communicate to the staff in a timely fashion any problem or conflict that arouse during interaction with the patients.

VI. **Core Competency 6: Systems-Based Practice**
   a. Objectives and Evaluation
      1. Trainees should gain insight into and appreciation of the psychosocial effects of chronic illness.
      2. Trainees should enhance their utilization of communication with many health services and professionals such as nutritionists, nurse clinicians, physician assistants, social workers podiatrist, ophthalmologist, physical therapist, surgeon, and radiologist and nuclear medicine specialist.
      3. Trainees should learn the importance of preventive medicine in routine health care and specifically in the area of neurological disease management.
      4. Trainees should be knowledgeable on the use of cost effective medicine.
      5. Trainees will assist in development of systems of improvements to correct identified problems.
VII. **Core Competency 7: Practice Based Learning Improvement**
a. Performance will be judged by ability to:
   1. Use feedback and self-evaluation to improve performance.
   2. Read the required material from textbook, journals and handouts.
   3. Use medical literature search tools at the library and through online to find appropriate articles that apply to interesting cases.

VIII. **Educational Material**
a. Mandatory Reading
   4. Section on Neurology in Cecil’s Textbook of Medicine.
   5. All handouts provided through the course

b. Suggested Reading
   1. The Neurologic Examination. Russell De Yong.
   2. Patten J. Neurological differential diagnosis. Springer
   4. Medical Literature: A collection of updated review articles will also be provided which address all basic areas of Neurology. Trainees are strongly encouraged to read as many of these articles as possible. In addition trainees are encouraged to read basic neurological journals such as Neurology, Archives of Neurology and Annals of Neurology.

c. Neuro imaging: There is a formal instruction to interpret of neuro imaging techniques with teaching cases provided by the Department of Radiology.

IX. **Evaluation**
a. Trainees Evaluation - The Faculty will fill out the standard Evaluation Form using the criteria for evaluations as delineated above to grade the trainees’ performance in each category of competency.

b. Program Evaluation - The trainees will fill out an evaluation of the Neurology rotation at the end of the month. This will include constructive criticism for improvement; or suggestions to further enhance training.

X. **Feedback** - Trainees should receive frequent (generally daily) feedback in regards to their performance during the rotation. Trainees will be informed about the results of the evaluation process and input will be requested from trainees in regards to their evaluation of the Neurology rotation. There will be a formal evaluation and verbal discussion with the trainee at the end of the rotation.

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3.37 **Community Medicine**

**Educational Purpose:**

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
To provide the trainee, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will enhance their knowledge and skills in health promotion disease prevention, including appropriate strategies such as immunizations, healthful lifestyle changes, and other community related programs.

The trainee will demonstrate competency in their ability to:

- Utilize community resources to assist in the management of patients.
- Understand the role of local health departments in the management of patients.
- Utilize evidence-based principles to determine appropriate strategies for care.
- Identify modifiable risk factors for the prevention of disease.
- Understand how physicians’ personal behavior affects the patient’s perception of them as a role model for responsibility in their own health.
- Understand the importance of patient education in the area of injury prevention, especially motor vehicle accidents, accidents in the home, sports injuries, and domestic violence.
- Understand the role of and utilize Hospice in the care of the dying patient.
- Understand the importance of recognizing cultural diversity among the patient population and within the community.

3.38 General Surgery*

Educational Purpose:
The trainee will be able to recognize the importance of collaboration between the family physician and the surgeon as partners in the evaluation of surgical patients and the decision-making process regarding their care. Develop awareness of the principles involved in differentiating the causative origin of clinical symptoms that result in the need for medical and/or surgical intervention. Recognize the concerns and anxieties of the patient and the patient’s family members regarding the potential for surgical intervention.

FORMAT:
Care of the surgical patient is an important part of the education and practice of family physicians. Although few family physicians perform major surgeries, many assist during major surgical procedures. Family physicians are called upon by their surgical specialist colleagues to evaluate patients for surgery, make preoperative and perioperative recommendations for care, and assist in the postoperative medical management of patients. Family physicians are often asked to help their patients understand their appropriateness for surgery and the risks and benefits of surgical procedures. Some patients may turn to their family physician to help them understand the exact nature of a surgical procedure.
Importantly, family physicians need to know how to appropriately refer patients for surgery, particularly in emergent or life-threatening situations.

The trainee will demonstrate competency in their ability to:

- Be able to perform a surgical assessment and develop an appropriate treatment plan
- Coordinate ambulatory, inpatient, and institutional care across health care providers, institutions, and agencies
- Demonstrate the ability to communicate effectively with the patient, as well as with the patient’s family and caregivers, to ensure that the diagnosis and treatment plan are clearly understood
- Demonstrate the ability to communicate effectively with the surgeon supervisor/consultant about the patient’s symptoms, physical findings, test results, and proposed plan of care
- Recognize his or her practice limitations and seek consultation with other health care providers when necessary to provide optimal care

I. Core Competency 1: Osteopathic Principles
   b) Osteopathic principles
      ii)

II. Core Competency 2: Medical Knowledge
   a) Basic principles of surgical diagnosis:
      i. Basic surgical anatomy
      ii. Wound physiology, care, and healing processes
      iii. Clinical assessment, including history, physical examination, laboratory evaluation, and differential diagnosis of key signs and symptoms of surgical conditions
      iv. Invasive versus noninvasive diagnostic tests
   b) Anesthesia
      i. Premedication
      ii. Agents and routes of administration
      iii. Resuscitation methods
   c) Recognition of surgical emergencies
      i. Respiratory
         1. Airway obstruction
         2. Chest trauma
            a. Flail chest
            b. Hemothorax
            c. Pneumothorax
      3. Circulation
         a. Hypovolemia
            i. Gastrointestinal bleeding
            ii. Traumatic blood loss
      4. Acute abdomen
a. Perforated viscus  
b. Intestinal obstruction  
c. Incarcerated hernia  
d. Mesenteric ischemia  
e. Appendicitis  
f. Diverticulitis  

5. Soft tissue
   a. Necrotizing  
b. Thermal injuries  

6. Trauma
   a. Advanced Trauma Life Support  

7. Common surgical procedures
   a. Appendectomy  
b. Cholecystectomy  
c. Herniorrhaphy  
d. Colectomy  
e. Hemorrhoidectomy – surgical or simple banding  
f. Arterial bypass  
g. Varicose vein procedures  
h. Thyroidectomy and thyroid nodules  
i. Parathyroidectomy  

8. Ethical, legal, and socioeconomic considerations
   a. Informed consent  
b. Quality of life  
c. Cultural sensitivity  
d. End-of-life issues  

9. Preoperative assessment
   a. Recognition of appropriate surgical candidates  
b. Surgical risk assessment  
c. Comorbid diseases  
d. Antibiotic prophylaxis  
e. Patient preparation (bowel, medication, schedule, etc.)  

10. Intraoperative care
    a. Basic principles of asepsis and sterile technique  
b. Patient monitoring  
c. Fluid management  
d. Blood requirements  
e. Temperature control  
f. Use of basic surgical instruments  

11. Postoperative care
    a. Routine  
       i. Wound care  
       ii. Patient mobilization  

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iii. Nutrition management
iv. Pain management
v. Suctions and drains

12. Common complications
   (a) Fever workup and management
      i. Wound dehiscence
      ii. Urinary retention
      iii. Hemorrhage
      iv. Pneumonia
      v. Atelectasis
      vi. Fluid overload
      vii. Transfusion reaction
     viii. Thrombophlebitis
      ix. Pulmonary embolism
     x. Oliguria
     xi. Respiratory insufficiency
     xii. Ileus
     xiii. Infection
     xiv. Shock

2. Outpatient surgery
   a. Patient selection
   b. Procedural sedation and analgesia
   c. Postoperative observation principles
   d. Follow-up care

3. Office care of common condition
   a. Lumps, bumps, and abscesses
   b. Simple lacerations
   c. Superficial burns
   d. Common methods of anesthesia

4. Adjunctive and long-term care of organ donors and recipients

5. Adjunctive and long-term care of bariatric surgical patients

6. Recognition and care of surgical wounds

7. Penetrating wounds

8. Avulsion crush, or shear injury wounds

9. Bite wounds

III. Core Competency 5: Patient Care

In the appropriate setting, the trainee should demonstrate the ability to independently perform or appropriately refer:
   a) Preoperative assessment
   b) Surgical risk evaluation, including assessment of medication use
      1. Surgical risk evaluation
      2. Physical assessment
      3. Radiographic assessment
4. Noninvasive diagnostic procedures
5. Invasive diagnostic procedures
   a. Paracentesis
   b. Nasogastric lavage
   c. Peritoneal lavage
   d. Thoracentesis
   e. Bladder aspiration
   f. Central venous access (central venous pressure, Swan-Ganz catheter)
   g. Venous cutdown
   h. Arterial puncture and catheterization
   i. Needle aspiration and biopsy technique

c) Recognition of need for emergent surgical techniques
   1. Cricothyroidotomy
   2. Needle thoracostomy
   3. Pericardiocentesis

d) Intraoperative skills
   1. Preparation and draping of operative field
   2. First assist at major surgery
   3. Basic use of surgical instruments
   4. Incision and dissection
   5. Exposure and retraction
   6. Hemostasis
   7. Estimation of blood loss
   8. Fluid replacement
      a. Wound closure
      b. Technique selection (ligature, staples, adhesives)
      c. Suture selection
      d. Drains
      e. Dressings

c) Postoperative care
   1. Suture removal
   2. Dressing changes
   3. Drain removal

f) Minor surgical techniques
   1. Local anesthesia
   2. Simple excision
   3. Incision and drainage of cysts and abscesses
   4. Aspiration
   5. Foreign body removal
   6. Minor burns
   7. Vasectomy
   8. Cauterization and electrodesiccation
9. Skin biopsy (punch, shave, excisional)
10. Wound debridement
11. Enucleation and excision of external thrombotic hemorrhoid
12. Nail surgery
13. Cryosurgery (liquid nitrogen)

g) Counseling about advance directives, organ donations, and end-of-life issues
h) Recognition and treatment of venous stasis ulcers, arterial ulcers, and neuropathic ulcers
i) Grading and treatment of decubitus ulcers

IV. Educational Materials


V. Evaluation

a) Trainee Evaluation - The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to endocrinology.
b) Program Evaluation
   a. The trainees will fill out an evaluation of the endocrine rotation at the end of the month.
   b. Any constructive criticism, improvements, or suggestions to further enhance the training in endocrinology are welcome at any time.
c) Feedback
   a. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the endocrinology rotation.
   b. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the endocrinology rotation.
   c. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done
at the end of the rotation.

3.39 Dermatology *

**Educational Purpose:**
The trainee will be able to recognize the importance of collaboration between the family physician and the dermatologist as partners in the evaluation of patients with disorders of the skin. The trainee will develop awareness of the principles involved in differentiating the clinical symptoms that result in the need for medical and/or surgical intervention. Timely referral is essential in challenging cases that require specialized treatment modalities more commonly performed by a dermatologist. Family physicians play a key role in promoting behaviors to prevent skin cancers and other skin diseases while ensuring the future health of the skin, our body’s largest organ.

**FORMAT:** This curriculum will include structured experience (both focused and longitudinal) throughout the residency program. Physicians who have demonstrated skill in caring for skin conditions will act as teachers and role models by advising trainees to manage their own patients. Attending physicians will demonstrate proper technique while allowing trainees to actively participate in procedures in order to achieve competency.

The trainee will demonstrate competency in their ability to:

- Provide compassionate and culturally appropriate patient care that recognizes the effect of skin problems on the patient and emphasizes the importance of comprehensive preventive care
- Diagnose and treat common skin diseases proficiently and adeptly perform common dermatologic procedures
- Utilize diagnostic and evidence-based treatment guidelines, as well as maintain up- to-date knowledge and usage of evolving dermatologic treatment
- Communicate effectively with the patient so that dermatologic diagnosis and treatment is provided in a nonjudgmental, caring manner
- Incorporate knowledge of the dermatology specialty in order to determine which problems can be managed by a family physician and how to coordinate needed referrals to specialty providers

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**I. Core Competency 1: Osteopathic Principles**

1. Osteopathic principles

   i.

**II. Core Competency 2: Medical Knowledge**
The trainee will demonstrate the ability to apply knowledge of:
a) Classification and terminology of skin disorders – description of primary and secondary lesions.
b) Diagnosis of common dermatologic disorders based on history, topography, and morphology
c) Management of common skin disorders
   i. Acne
   ii. Actinic keratosis
   iii. Alopecia and hair disorders
   iv. Bacterial infections
   v. Bites and stings (mammals, spiders, reptiles, ticks, and insects)
   vi. Infestations (lice, scabies, bedbugs, schistosome cercarial dermatitis, myiasis)
   vii. Contact dermatitis
   viii. Cutaneous viral infections and exanthems
   ix. Exzema and atopic dermatitis
   x. Fungal skin infections
   xi. Hyperpigmentation and hypopigmentation
   xii. Lichen planus and bullous/vesicular diseases
   xiii. Nail disorders
   xiv. Nevi
   xv. Rosacea
   xvi. Skin ulcers and pressure sores
   xvii. Dermatologic manifestations of sexually transmitted infections (STIs)
   xviii. Seborrheic dermatitis
   xix. Psoriasis
   xx. Urticaria and drug eruptions
d) Prevention of skin diseases
c) Skin manifestations of systemic diseases
f) Prevention, recognition, and management of common skin cancers (including basal cell carcinoma, squamous cell carcinoma, Kaposi sarcoma, and melanoma)
g) Pharmacology of skin medications.

III. Core Competency 5: Patient Care

The trainee will demonstrate the ability to independently perform:
a) History and physical examination appropriate for skin conditions
b) Preventive skin examination
c) Biopsy of skin lesions
   1. Punch biopsy
   2. Shave biopsy
   3. Excisional biopsy
d) Scraping and microscopic examination
e) Use of dermoscopy to complement physical examination

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f) Injection
   1. Local anesthesia
   2. Steroids

g) Incision and drainage

h) Destruction of lesions
   1. Cryosurgery
   2. Electrodesiccation
   3. Curettage

i) Choice of suturing materials and skin surgery instruments

j) Skin closure techniques including: non-suturing techniques (e.g., benzoin and Steri-Strips, skin glues); simple interrupted; simple continuous; vertical and horizontal mattress; layered closures; and subcuticular suturing

k) Principles and practice of wound care, including use of occlusive dressings

l) Counseling and anticipatory guidance for dermatologic disorders.

IV. Educational Materials


V. Evaluation

   a) Trainee Evaluation
      1. The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the six competencies as related to endocrinology.

   b) Program Evaluation
      1. The trainees will fill out an evaluation of the endocrine rotation at the end of the month.
      2. Any constructive criticism, improvements, or suggestions to further enhance the training in endocrinology are welcome at any time.

VI. Feedback

   a) The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the endocrinology rotation.

   b) The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the endocrinology rotation.
c) The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.40 Office Laboratory Medicine*

Educational Purpose:
To prepare the trainee for entry into the health care environment

Format: Implementation of this curriculum will include both focused and longitudinal experience throughout residency. Physicians who have demonstrated skill in use of an office laboratory will be available to act as role models to the trainees, to give support and to offer advice.

If the trainee wishes to meet CLIA certification requirements, additional implementation will be necessary. The minimal educational experience required by CLIA is 20 hours of didactic and laboratory workshops. It is suggested that the experience be divided into approximately 15 hours of didactic training and at least five hours of laboratory skills. The 15 hours of didactic time could meet the CLIA certification for laboratory director if the following times are allocated:

- Regulations: 1 hour
- Physical plant: 1 hour
- Testing systems and equipment: 3 hours
- Quality assurance: 3 hours
- Quality control: 3 hours
- Laboratory personnel: 2 hours
- Written policies, procedures, and individual performance responsibilities: 2 hours

The guidelines will be accomplished on a longitudinal basis or through an in-depth, intense experience utilizing family medicine and laboratory educators.

The trainee will demonstrate competency in their ability to:

- Be able to perform and interpret common tests done in the laboratory setting and be able to teach these skills to other individuals.
• Know the significance of quality control in the office lab, including the importance of 
documentation.
• Understand the basic principles of laboratory tests, including method selection, 
method verification, sensitivity, specificity, precision, accuracy, and bias.
• Be knowledgeable in the cost considerations of office laboratory testing.
• Demonstrate knowledge of CLIA-88 regulations with both an understanding of the 
requirements for waived testing and an ability to follow the manufacturer’s 
instructions in order to obtain reliable test outcomes.
• Recognize other national and state regulations which factor into running an office 
laboratory.
• Understand one’s role as a potential laboratory director, including qualifications, 
responsibilities, and the role in the relationship with others working in the lab.

The trainees will obtain competency in all of the above goals by meeting the following 
criteria:

I. Core Competency 2: Medical Knowledge
a) The physician’s role in the office lab, both as one who uses the lab and as a 
potential director of a lab
b) Ways in which point-of-care testing can improve the quality of patient care 
over traditional testing, e.g., INR testing, transcutaneous bilirubin levels
c) The limits of a positive or negative test result in the diagnosis of a disease
d) The risks and benefits of performing lab tests, including negative outcomes 
and costs associated with ordering unnecessary lab tests
e) The resources which should be available when considering a new test
f) The importance of documentation, especially as it relates to quality control in 
the laboratory setting
g) Financial considerations in lab testing including coding, billing, and insurance 
reimbursement
h) The medical director’s role in proficiency testing with an external quality 
control process and the importance of internal quality control

II. Core Competency 3: Professionalism
In the appropriate setting, the trainee should demonstrate the ability to 
independently perform or appropriately refer:
a) Use and care of the microscope
b) Skin scrapings
c) Vaginal smears (fern testing, vaginal pH, KOH/wet prep)
d) Blood draws
e) Urinalysis
f) Gram stain testing
g) Immunochemical assays
h) Fecal occult testing
i) Other point-of-care tests, including:
1. HbA1C
2. INR
3. Troponin
4. Glucose
5. Transcutaneous bilirubin
6. Pregnancy
7. Hemoglobin
8. Urine drug screening

j) Discussion of test and test results

III. Educational Materials

1. Centers for Disease Control and Prevention. Good laboratory practices for waived testing sites: survey findings from testing sites holding a certificate waiver under the Clinical Laboratory Improvement Amendments of 1988 and Recommendations for Promoting Quality Testing. MMWR 2005 Nov;54(No. RR-13);1-25.
7. Center of Laboratory Accreditation (COLA). http://www.cola.org

ii. Evaluation

a) Trainee Evaluation

1. The faculty will fill out the standard evaluation form using the criteria for evaluations as delineated above to grade the trainee in each of the seven competencies

b) Program Evaluation

1. The trainees will fill out an evaluation of the rotation at the end of the month.
2. Any constructive criticism, improvements, or suggestions to further enhance the rotation are welcome at any time.

c) Feedback

1. The trainee should receive frequent (generally daily) feedback in regards to his or her performance during the rotation.
2. The trainee will be informed about the results of the evaluation process, and input will be requested from the trainee in regards to his or her evaluation of the rotation.

3. The faculty is encouraged to use feedback throughout the rotation. A formal evaluation and verbal discussion with the trainee is to be done at the end of the rotation.

3.41 Practice Management

Educational Purpose:
To prepare the trainee for entry into the health care environment

The trainee will demonstrate competency in their ability to:

- Enter into contractual arrangements with health care systems.
- Understand issues of medical jurisprudence.
- Understand community systems and agencies that enter into aspects of health care.
- Understand risk management.
- Understand principles of office management.
- Understand the principles of reimbursement, and coding, including coding for osteopathic manipulative treatment.
- Understand the differences of Group Practice versus Private Practice versus Employment as part of a hospital system.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. The trainee’s continuity of care training site experience to illustrate the basic economic principles of medical practice.
      1. Timely statements indicating the volume of patients seen
      2. Revenue generated per patient visit
      3. Gross Charges
      4. Contractual adjustments
      5. Balance billing
      6. Overhead costs
      7. Prorated economic data

II. Structured Curriculum
   a. Personal and practice financial management education
      1. Debt consolidation
      2. Student loan repayment
      3. Retirement planning
4. Financial planning

Practice Management

3.42 Practice-Based Learning and Improvement*

Educational Purpose:
To give the trainees formal instruction and the opportunity to acquire expertise in epidemiology, bibliography retrieval and assessment of medical literature.

Format: Implementation of this practice-based learning and improvement (PBLI) Curriculum Guideline will be longitudinal throughout the trainee's training experience, with increasing emphasis in the latter half of the residency program. Conferences and other teaching activities will be integrated into the core PBLI topics. Trainees will also gain an awareness of community/cultural resources needed for sustained improvement. Implementing the PBLI curriculum provides an opportunity for interdisciplinary work in both inpatient and outpatient settings. Trainees may also partner with external resources to ensure that PBLI is valid to their own practice and to those with whom they are practicing. For trainee quality improvement projects to be successful, barriers and strengths must be fully explored in order to best understand needs and move forward. With this background, the trainee will have hands-on experience leading at least one performance improvement initiative during the three years of training. Improvement projects based in collaboration with clinic staff and quality management professionals in the community (e.g., family medicine center [FMC], hospital, community at large) will provide paths to PBLI competency.

At the completion of residency training, the trainee will be able to:

- Demonstrate the ability to investigate and evaluate his or her care of patients
- Identify strengths, deficiencies, and limits in his or her medical knowledge and expertise
- Appraise and assimilate scientific evidence
- Continuously improve patient care on the basis of constant self-evaluation and lifelong learning

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. The trainee will receive instruction through conferences by librarian and physicians and outside speakers in epidemiology, bibliography retrieval and assessment of medical literature.
   b. The trainee will also obtain insight in epidemiology, bibliographic retrieval...
and assessment of medical literature through articles discussed with staff on their rotations.

c. The trainee will gain expertise in epidemiology, bibliographic retrieval and assessment of medical literature during their experiences in research and through the conferences they will give.

II. Core Competency 2: Medical Knowledge

a. The principles of evidence-based medical decision making
   1. Methods of rating evidence
   2. Basic statistical measures
   3. Quality of clinical trials
   4. Limitations of evidence-based medicine (EBM)

b. Sources of evidence-based medical literature
   1. Point-of-care tools providing filtered EMB information (e.g., Family Physicians Inquiries Network [FPIN] Clinical Inquiries, DynaMed, First Consult, Up-to-Date, Bandolier)
   2. Tools providing unfiltered information (e.g., MEDLINE)

c. Systems-based practice
   1. Teams: formation, management, role as leader and facilitator
   2. Care coordination
   3. Cost-benefit analysis
   4. Patient advocacy
   5. System consultant
   6. System evaluator

d. History of medical quality improvement
   1. Medical errors and patient safety issues
   2. Review of previous quality improvement project outcomes
   3. American Board of Family Medicine (ABFM) and American Osteopathic Board of Family Practitioners (AOBFP), Institute for Clinical Systems Improvement (ICSI), Institute for Healthcare Leadership, Institute for Healthcare Improvement (IHI), American Academy of Family Physicians (AAFP), Institute of Medicine (IOM), Occupational Safety and Health Administration (OSHA)

e. Deming’s PDSA Cycle of continuous quality improvement, including the FOCUS-PDSA model
   1. Find, organize, clarify, understand, select (FOCUS)
      a. Find an opportunity for improvement through discussion with process participants
      b. Organize key players, select leader, and agree on a mission statement
      c. Clarify current understanding of the process
      d. Understand what the team is trying to improve; identify measurable outcomes; study variance and perform root-cause analysis
c. *Select a strategy for continued improvement or a part of the process to change*

2. Plan, do, study, act (PDSA)
   a. Plan – identify one small improvement to the process; establish goals and intended outcomes
   b. Do – implement the process and collect data for analysis
   c. Study – assess the impact of improvements
   d. Act – if successful, implement the change on a broader scale. If not, reevaluate the process and make changes, and determine whether to try a different approach.

3. Performance improvement (PI) tools
   a. Traditional Deming-style tools
      a. Pareto charts, run charts, statistical process control charts, scatter diagrams, flowcharts, cause-and-effect (Ishikawa) diagrams, control charts, bar charts
   b. Toyota-style/Lean tools
      a. Process maps
      b. A3 diagrams
      c. 5 Whys
      d. Visual controls
         i. 5S system (sort, straighten, shine, standardize, sustain)
         ii. Kanbans

4. Role of information systems and informatics in performance improvement
   a. Sources of data/information
      a. External organizations: National Committee for Quality Assurance (NCQA), Institute for Healthcare Improvement (IHI), Institute of Medicine (IOM), The Joint Commission (TJC)
      b. NCQA Healthcare Effectiveness Data and Information Set (HEDIS) criteria
      c. Centers for Medicare & Medicaid Services (CMS, formerly Health Care Financing Administration [HCFA]) peer review organizations (PRO)
      d. Patent accounting systems
      e. Health plan reports
      f. Hospital data systems
      g. External sources (e.g., county health departments, peer review organizations)
   b. Use of information system in process redesign
      a. Electronic health records that follow the four rules of work design
b. Patient registries for chronic disease management

III. **Core Competency 4: Interpersonal and Communication Skills**

   a. The trainee will gain insight and appreciation of the uses for clinical epidemiology and critical assessment of medical literature.
   b. The trainee will be able to assess the validity of published evidence.
   c. The trainee will improve in the use and communications with many health services and professionals.

IV. **Core Competency 3: Professionalism**

   a. Use PI methodology to identify a clinical process, analyze practice, and implement change, with a goal of performance improvement
   b. Coordinate team-based care
   c. Locate, appraise, and assimilate evidence from scientific studies in order to improve patient care
   d. Utilize resources and provide resources to patients in clinical practice
   e. Awareness that performance improvement (PI) tools and methods improve patient care
   f. A valuing of teamwork for PI initiatives
   g. Commitment to improving health care delivery
   h. Ongoing effort to identify the best evidence available for each clinical issue faced
   i. Understanding that the available evidence may not directly answer a clinical question
   j. Willingness to advocate for evidence-based care of patients


VI. Feedback - Each trainee will receive frequent feedback regarding his or her performance in all areas. Among more valuable examples are feedback given by attending staff in clinics and inpatient services, monthly written evaluation of attending staff, comments and lectures.

**Practice-Based Learning and Improvement**

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**3.43 Case Management/UM-QM/Quality Improvement**

**Educational Purpose:**
During residency training, practiced-based learning occurs on a daily basis in patient care and education, teaching rounds, morning report, clinics, outpatient services, chart reviews, informal talks, review of charts by Quality Resource Management and Quality Improvement Services. The trainees will also be required each year to review their continuity patient charts for quality of care. The purpose is to improve the quality of medical care given by the trainee through many modalities such as mentoring, self-assessment, 360° evaluations, and structured conferences.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Principal Teaching Methods**
a. The residency program strives to develop the following lifelong learning habits (learning never ends). Trainees will learn the ability to understand the patient’s health needs, the needs of their families, respecting the patient’s confidentiality, improvement of the patient care skills, appropriate inpatient and outpatient care, need for keeping up with the literature, avoiding inappropriate tests and consults, avoiding unnecessary or risky procedures which are of marginal or no benefit to the patient. The costs of doing or not doing certain tests, procedures, unnecessarily short/long hospital stays should be considered.
b. The trainees will have the opportunity to improve their interview techniques, physical examination skills, clinical assessments, proper use of lab tests and personnel, recording of differential diagnosis and plan of management. They will also be taught good bedside manners, proper record keeping (time, procedure notes, consults), and timeliness.
c. They will learn appropriateness, inappropriateness, benefits, and risks of various exams, tests, and procedures. The appropriate methods for obtaining proper consents, writing do not resuscitate notes, proper process for transfer to other patient care facilities, and documentation of use of restraints will be taught.
d. During this month rotation each year the trainees will review inpatient records with Case Managers and Medical Legal/Risk. Additionally the trainee will review their own inpatient records and outpatient record in their continuity clinic panel and fill in a chart which documents the completeness of their primary care and preventative medicine procedures ordered for each patient.

II. Core Competency 2: Medical Knowledge & Core Competency 5: Patient Care

a. The trainee will assist in determining the root cause of any error, which is identified, and methods for avoiding such problems.
b. The trainee will assist in development of systems’ improvement if problems are identified.
c. Procedures
   1. During the three years of residency training, trainees will have ample opportunity to learn about indications, contraindications, complications, and interpretation of the following procedures and tests: intravenous lines, central lines, lumbar punctures, bone marrow aspiration and bone marrow biopsies, paracentesis, thoracentesis, foley catheters, nasogastric tubes, arterial blood gases, plain x-rays, contrast radiography, ultrasound, CAT-scans, and MRI scans.
   2. More specialized procedures or additional procedures will be taught/practiced/interpreted in some particular rotations or electives. Examples include: Swan-Ganz catheterization in
ICU/CCU, flexible sigmoidoscopy, esophagogastroduodenoscopy in gastroenterology, etc.

d. Practice Skills - Trainees will be evaluated continually by supervising attending staff and senior trainees as well as the consultants, nursing, and QRM personnel. The following will be assessed, deficiencies identified, and means of improvement will be pointed out:

1. Histories and physicals/bedside manners
2. Politeness, respect to the patient/patient confidentiality
3. Assessment of patient health
4. Development of a management plan
5. Need for admission
6. Need for continued care
7. Discharge planning
8. Follow up care
9. Purpose and use of supporting staff, lab facilities, nursing home, and hospice care
10. Cost effectiveness, usefulnes, limitations, benefits, and alternatives of invasive or non-invasive procedures

III. **Core Competency 4: Interpersonal and Communication Skills & Documentation Skills**

a. The trainee should improve in the utilization of and communication with many health services and professionals.
b. The trainee must be able to establish a rapport with the patients and listens to the patient’s complaints to promote the patient’s welfare.
c. The trainee should provide effective education and counseling for patients.
d. The trainee must be able to effectively communicate with colleagues and support staff.
e. The trainee must write organized and legible notes.
f. The trainee must communicate any patient problems to the staff in a timely fashion.

IV. Ethics

a. The trainee should use feedback and self-evaluation in order to improve performance.
b. The trainee should learn when to call the ethics committee for end of life issues.
c. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
d. The trainee must always consider the needs of patients, families, colleagues, and support staff.
e. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
f. The trainee must be responsible and reliable at all times.
g. The trainee must maintain a professional appearance at all times.
V. Educational Material - During the ward, ICU/CCU or outpatient experience, didactic teaching, teaching at bedside, attending physician rounds, consultations, morning report and conferences are the major ways of improving the quality of care provided.

VI. Evaluation
   a. This is an ongoing process, which starts at the beginning of residency and continues through graduation. The major means of evaluation are constant evaluation of quality of care by attending staff and supporting staff.
   b. Practiced based medicine and improvement goals will be discussed at the trainees’ meetings with their advisors and the program director. The trainees will be expected to improve their abilities from year to year. The trainees’ performance on their continuity clinic patient preventative medicine practices will be evaluated annually and methods for improvement discussed with them.
   c. Identifiable problems
      1. Once an actual or potential problem has been identified a determination will be made as to whether it will be assessed prospectively, concurrently or retrospectively. Possible areas that will be evaluated for problems include:
         a. All readmissions within 30 days of prior admission and ending in death
         b. Abnormal lab studies not addressed by trainees
         c. Patients refusing treatment/leaving AMA
         d. Hospitals induced events like drug reactions or transfusion reactions and patient injuries
         e. Deaths
         f. Cardiac or respiratory arrests while patient is hospitalized for other reasons
         g. Complications of procedures
         h. Response to consultation
            i. Sub-therapeutic/toxic dosing of medications
            j. Inappropriate medication prescriptions
            k. Patient care (histories and physicals, tests, procedures, progress notes, consultations) and interpersonal skills (peers, supporting staff, supervisors).
      2. Appropriate action will be implemented to eliminate or reduce the identified issue. These include:
         a. Medical staff educational programs
         b. Implementation of new/revised policy or procedure
         c. Staffing changes
         d. Equipment or facility changes
         e. Practitioner counseling/guidance as needed
         f. Peer action.
d. M & M Conference - M&M conferences are held at least quarterly with faculty and house staff in attendance. An appropriate case(s) is/are chosen which has/have potential learning objectives and presented by the house staff. The house staff will be evaluated on their presentation and their presentation skills of the M & M conference. The house staff will learn through examples non-optimal patient outcomes due to known complications, potential errors, or systems problems. The root cause will be identified and possible actions to avoid future events will be discussed.

e. QA and Risk Management Talks - Quality assessment meetings are held at least quarterly with faculty and house staff in attendance. Coordinators maintain minutes. Reports from various committees (e.g. Tissue and transfusion, pharmacy and therapeutics, infection control and medical records) are reviewed and recommendations made.

VII. Feedback - Each trainee will receive frequent feedback regarding his or her performance in all areas. Among more valuable examples are feedback given by attending staff in clinics and inpatient services, monthly written evaluation of attending staff, comments and lectures. Concurrent and retrospective reviews of medical records are conducted on a regular basis and focused review of individual cases, identified patterns or trends are also done from time to time.

3.44 Professionalism

Educational Purpose:
To give the trainee’s formal intensive instruction and clinical experience in making ethical decisions as related to patient care and to understand and practice in a professional manner.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. Instruction is provided by a core series of lectures through the year.
   b. During the intensive care rotation, issues of ethics that come up serve as opportunities to instruct and review the knowledge base in ethics.
   c. The trainees are encouraged to read the medical ethics section of their medicine textbook.

II. Core Competency 2: Medical Knowledge
   a. The trainee should read the required material and articles provided to enhance learning.
   b. The trainee will assist in determining the root cause of any error, which is identified, and methods for avoiding such problems.
   c. The trainee should use the medical literature search tools in the library to
find appropriate articles related to interesting cases.
d. The trainee will assist in development of systems’ improvement if problems are identified.
c. The trainee will learn the prognostic side of medical ethics.
   1. Definitions and concepts of medical futility
   2. The persistent vegetative state
   3. Post-anoxic brain injury
   4. APACHE data on prognosis versus number and duration of organ failures
   5. Medical and ethical issues related to the feasibility of domiciliary care for seriously ill persons, issues of medical and social suitability for hospice care.
f. Trainees will learn the social side of medical ethics.
   1. The extent and limits of the patient's right to self-determination
   2. Informed Consent
   3. The right to refuse treatment, limitations on that right in the case of children, ethical and legal implications in the case of the patient leaving "against medical advice”.
   5. The ethical and legal basis for the family's right to "substituted judgment," for a patient unable to decide for himself.
   6. Ethical and legal issues relating to medical decisions to be made for permanently incompetent persons.
   7. Ethical and legal issues related to abuse of patients by their friends or relatives.
g. The trainee will learn the limits to care.
   1. Limits to care as posted in "living wills" "do not resuscitate."
   2. The ethical and legal basis for decision to withdraw life support
   3. The legal definition of brain death.
h. The trainee will learn about conflict of interest - Ethical problems related to temptations.

III. Core Competency 4: Interpersonal and Communication Skills & Documentation Skills
   a. The trainee must be able to establish a rapport with the patients and listen to the patient’s complaints to promote the patient’s welfare.
b. The trainee should provide effective education and counseling for patients.
c. The trainee must write organized and legible notes.
d. The trainee must communicate any patient problems to the staff in a timely fashion.
e. The trainee should improve in the utilization of and communication with many health services and professionals.

IV. Ethics
a. The trainee should use feedback and self-evaluation in order to improve performance.
b. The trainee should learn when to call the ethics committee for end of life issues.
c. The trainee should continue to develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
d. The trainee must always consider the needs of patients, families, colleagues, and support staff.
e. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
f. The trainee must be responsible and reliable at all times.
g. The trainee must maintain a professional appearance at all times.
h. The trainee should improve in the use of cost effective medicine.

V. Educational Materials
   a. Mandatory Reading - Sections on Ethics, Decision Making, and Economic Issues in Rakel's.
   b. Suggested Reading
      1. The American College of Physicians Ethics Manual

VI. Evaluation
   a. On each rotation, the trainee's compassion and integrity and ethical approach to medicine are part of the evaluation.
   b. The faculty advisor plays an important role in using trainee evaluations from other rotations to see how the trainee is developing as an ethical person.
   c. Annual meetings with the Program Director at the time of the annual trainee evaluation provide an opportunity to emphasize and reinforce the trainee's development as an ethical and compassionate physician with sound knowledge of medical ethics.

VII. Feedback - The trainee should receive frequent feedback in regards to his or her performance during the rotation in regards to the ethical and professional approach to medical care. The trainee will be informed about the results of the evaluation process and input will be requested from the trainee in regards to his or her evaluation.

Professionalism

3.45 Systems-Based Practice

Educational Purpose:
LEGAL MEDICINE - Trainees will learn to identify factors, which precipitate medical malpractice lawsuits. Trainees will learn risk management measures, which will minimize the risk of being sued. The trainee will understand the significance of documentation in relation
to its effect on medical malpractice. The trainee will know what to expect should a malpractice lawsuit be brought against him/her.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. **Principal Teaching Methods**
   a. Lectures, conferences, seminars
   b. Case studies
   c. Faculty instruction in clinical settings

II. **Knowledge Objectives**
   a. The trainee should provide effective education and counseling for patients.
   b. The trainee will become proficient at obtaining 'Informed Consent'.
   c. They will learn to avoid actions which might lead to anger, distrust, or, inappropriate expectations from the patient.
   d. The trainee will learn an appreciation for our judicious system and defense attorneys.
   e. Trainees will learn to recognize factors that might serve to precipitate a malpractice lawsuit.
   f. Trainees will identify such factors and, when possible, prevent or minimize their effects.
   g. The trainee will understand the various parties involved in a lawsuit.
   h. The trainee will learn the proper steps to take when notified of a potential lawsuit.
   i. The trainee will learn the various components of pre-trial, trial and post-trial events.
   j. The trainee will learn proper preparation for himself, assistance for his attorney and provide, when appropriate, suggestions for defense experts, literature, etc.
   k. The trainees will learn appropriate conduct during depositions and in the courtroom.

III. **Core Competency 4: Interpersonal and Communication Skills & Documentation Skills**
   a. Demonstrate open communication and honesty with patients.
   b. The trainee should improve in the utilization of and communication with many health services and professionals.
   c. The trainee will learn respect for the patient and learn to communicate in a manner, which the patient can fully comprehend.
   d. The trainee will learn how documentation or the lack thereof can help or adversely affect a malpractice lawsuit.
   e. The trainee will demonstrate appropriate documentation and will learn inappropriate forms of communication (such as open disagreement in front of the patient or "finger pointing" in the chart).
f. The trainee will demonstrate proper documentation by including appropriate details of date and time, the patient's understanding and attitude towards the situation, and what information was given to the patient.
g. The trainee should understand that his written word is his best defense in a medical malpractice situation.

IV. Ethics
a. The trainee will learn proper conduct and empathy towards patients.
b. Trainees will develop appropriate relationships between themselves, their patients and staff.
c. The trainee must always consider the needs of patients, families, colleagues, and support staff.
d. The trainee should continuously develop their ethical behavior and the humanistic qualities of respect, compassion, integrity, and honesty.
e. The trainee must be willing to acknowledge errors and determine how to avoid future similar mistakes.
f. The trainee must be responsible and reliable at all times.
g. The trainee must maintain a professional appearance at all times.

V. Educational Material - A series of lectures will be provided for the trainees. These will include a yearly Legal Workshop for Physicians with required attendance as well as bi-annual lectures provided by the defense attorneys of the institution.

VI. Evaluation - Trainees will be asked to express their opinions of the lecture series to the Program Director. Preceptors are asked on a monthly basis to evaluate trainees rotating on their team in such areas as Patient Relationships and Record keeping. M & M Conferences will be held on a regular basis to point out problems in documentation, inappropriate actions or treatment, etc.

VII. Feedback - Attendance will be taken at each lecture. The trainee will be notified on a monthly basis if attendance is satisfactory. Inappropriate conduct, witnessed by attendings during the year, will be documented and will then be brought to the attention of the Program Director.

3.46 Case Management, Billing, Coding & Reimbursement

Educational Purpose:
To train the trainee in current managed care systems with regard to DRG coding, reimbursements, length of stay issues, and denials.

The trainees will obtain competency in all of the above goals by meeting the following criteria:

I. Principal Teaching Methods
   a. In both the first and third years, the trainees will meet with a case manager
for small group presentation, which gives an overview of inpatient practices.
b. During all three years, the trainee will attend at least one day of case
management rounds and daily ICU case management rounds per week.
c. The trainee will attend lectures provided by the personnel in the outpatient
billing department to learn outpatient billings and coding practices.

II. Knowledge Objectives
a. Understand the meaning of DRG and CPT coding.
b. Become familiar with the current managed care systems.
c. Become familiar with the methods of reimbursement in the inpatient and
outpatient settings.
d. Understand Length of Stay and how it ties to reimbursement issues.
e. Learn common reasons for denials and what can be done to prevent them.
f. Understand how improved documentation impacts on reimbursement.
g. The trainee should read the required material and articles provided to
enhance learning.
h. The trainee will improve in using case managers and social workers to
facilitate discharge planning.

III. Core Competency 4: Interpersonal and Communication Skills &
Documentation Skills
a. The trainee must be able to establish a rapport with the patients and listen
to the patient’s complaints to promote the patient’s welfare.
b. The trainee should provide effective education and counseling for patients.
c. The trainee must communicate any patient problems to the staff in a timely
fashion.
d. The trainee will learn to write organized and legible notes.
e. The trainee will learn to improve documentation to increase reimbursement.
f. The trainee should improve in the utilization of and communication with
many health services and professionals.

IV. Ethics
a. The trainee should use feedback and self-evaluation in order to improve
performance.
b. The trainee should put into practice the suggested changes in order to
improve coding and billing of services.
c. The trainee should continue to develop their ethical behavior and the
humanistic qualities of respect, compassion, integrity, and honesty.
d. The trainee must always consider the needs of patients, families, colleagues,
and support staff.
e. The trainee must be willing to acknowledge errors and determine how to
avoid future similar mistakes.
f. The trainee must be responsible and reliable at all times.
g. The trainee must maintain a professional appearance at all times.
h. The trainee should improve in the use of cost effective medicine.

V. Evaluation - Trainees will be asked to complete a written evaluation of their time
spent with the case manager and the coders. Attendings are asked, on a monthly basis, to evaluate trainees rotating on their teams in systems based practice.

The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.
4 CONTINUITY CLINIC

Goals: To create a Family Medicine Clinic experience designed to provide trainees with a continuity of care experience. The continuity clinic will facilitate the diagnostic and therapeutic skills of physicians in training utilizing patients encompassing the total health care of the individual and the family. This includes the physiological, emotional, cultural, economic, psychological and environmental factors as they relate to the disease process.

4.1 Overview

Rotation Goals & Objective:
The continuity care clinical experience will begin by focusing on the acquisition of a small panel of patients under the supervision of the family medicine attending physician. The attending physician will help the trainee identify a panel of patients for whom the trainee will assume greater and greater responsibility throughout the longitudinal care experience. This will facilitate continuity of care. A requirement of the longitudinal curriculum will be that the trainee must acquire responsibility for patients at different stages of lifecycle. In addition, efforts will be made to insure that each trainee’s panel represents variance in patient characteristics such as gender, socioeconomic status, and ethnicity.

The goals of this experience for the trainee are:
1. Gain an appreciation for the primary care practitioner’s role as the physician on first contact who delivers holistic, family-oriented, comprehensive and continuous medical care to those patients entering the health care system;
2. Develop greater confidence in providing quality medical care in ambulatory settings;
3. Understand family systems concepts, the impact that family functioning and psychosocial factors have on health and illness, and the importance of involving the family in the treatment of the patient in order to provide effective overall health care;
4. Appreciate the use of computers to access current medical literature to complete learning as well as information about community resources for utilization in case management, disease prevention, health maintenance, and patient education;
5. Enhance diagnostic, interpersonal communications, procedural, OMT, and practice management skills to improve patient care;
6. Increase knowledge about the etiology, appropriate intervention and treatment, and possible complications of diseases and conditions commonly presented by patients and their families in the primary care setting;
7. Gain better understanding of the moral, ethical, political, legal, economic, and minority health issues affecting the practice of Family Medicine; and,
8. Nurture a sense of responsibility for lifelong learning in medicine and the advancement of the osteopathic profession through scholarly endeavors and community service.

Upon completion of the residency, the trainee will be able to:

1. Complete a thorough osteopathic assessment of a patient, determine the need for manipulative medicine, and perform osteopathic manipulative techniques;
2. Demonstrate knowledge of the indications, contraindications, interactions, pharmacokinetic, side effects, and special instructions to patients for drugs commonly prescribed for patients seen in a medical practice;
3. Demonstrate the ability to perform common clinical procedures, tests and skills;
4. Construct a differential diagnosis and develop a treatment or management plan for diseases commonly presented by patients seen in a medical practice;
5. Demonstrate knowledge of the prevention, diagnosis, treatment and management of conditions commonly presented by patients seen in a medical practice;
6. Evaluate problems commonly presented by patients seen in a medical practice;
7. Recognize and respond appropriately to patients presenting with issues/concerns commonly encountered in a medical practice;
8. Demonstrate knowledge of the ethical, moral, and social challenges that may confront the patient, family, or physician when dealing with health care issues;
9. Demonstrate knowledge of the role of family dynamics in the delivery of health care;
10. Assess a patient’s living conditions (e.g., environment, family members, health related behavior, etc.) and their impact on treatment strategies and medical care for the patient;
11. Identify community support agencies and how they can be utilized by the physician in his/her preventive care/health promotion efforts with patients and their families;
12. Develop preventive medicine and health maintenance protocols for patients based on current information sources and utilize patient education skills and compliance monitoring skills in the process of implementing those protocols with patients;
13. Demonstrate interpersonal communication skills with patients and their families to build rapport and facilitate a positive physician-patient relationship;
14. Utilize computers as a tool to enhance learning in the clinical setting;
15. Identify and provide patient education information and preventive care strategies appropriate to the primary care setting, and;
16. Demonstrate an understanding of medical record documentation.

The trainees will be supervised by a board certified physician. Cases will be discussed and all charts will be reviewed. The trainee will be exposed to a broad spectrum of medical diagnoses and will be taught to apply the concepts of disease prevention and health maintenance.
Trainees are required to maintain an ambulatory log that will be maintained in each trainee’s personnel file through New Innovations. These logs must contain a patient identifier, diagnosis and the activity and/or procedure performed on each visit.

Number of patients seen per half day period, will be as follows:

- PGY 1 = 2 new patient; 4 existing patients (1 – ½ day clinic per week for a total of 52 ½ day clinics)
- PGY 2 = 2 new patients; 6 existing patients
- PGY 3 = 2 new patients; 8 existing patients

Trainees will be evaluated on a semi-annual basis using the 360° evaluation process. Trainees will be evaluated by their attending physician, clinic staff and their patients.

The trainee will be exposed to osteopathic concepts, behavioral and psycho social aspects of medical care, medical ethics, medical-legal implications and practice management throughout the course of their training through lectures and discussions.

Trainees will be notified of the patient’s admission and will follow their patient’s admission throughout the course of the patient’s stay.

The attending physician will evaluate the trainee on their ability to perform a comprehensive history and physical examination, including structural examination for somatic dysfunction, pelvic exam, rectal exam, breast exam and male genital exam.

### 4.2 Teaching Objectives

Trainees will learn skills required to:

1. Deliver osteopathic care to patients in an ambulatory setting;
2. Manage effectively a normal caseload during a scheduled day;
3. Develop medical practice management skills;
4. Increase his/her expertise in:
   a. Methods of referring patients
   b. Methods of counseling
   c. Providing patient education
   d. Delivery of osteopathic manipulative treatment
   e. Diagnosis and treatment of patients in all age groups
   f. Providing preventative measures for a varied patient population
   g. Diagnosing and managing medical and surgical problems
5. Develop a thorough understanding of family oriented care;
6. Become familiar with the evaluation of industrial injury and criteria for returning to work;
7. Become familiar with the basic guidelines for reporting communicable diseases;
8. Become familiar with the use of community resources in total patient care;
9. Learn how to be a part of a health care team; and,
10. Demonstrate team leadership skills.

4.3 Trainee Patient Schedules

Trainees are expected to progressively expand their patient base and clinical skills with advancing academic year. As such, their individual clinic schedules will vary by postgraduate year as follows:

<Note these represent approximate Schedules and may vary on individual trainee and patient needs>

<table>
<thead>
<tr>
<th>Time</th>
<th>PG-1</th>
<th>PG-2</th>
<th>PG-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>Overview</td>
<td>Overview</td>
<td>Overview</td>
</tr>
<tr>
<td>1:15</td>
<td>New Patient / Consult</td>
<td>Recheck</td>
<td>Recheck</td>
</tr>
<tr>
<td>1:30</td>
<td>#</td>
<td>Recheck</td>
<td>Recheck</td>
</tr>
<tr>
<td>1:45</td>
<td>#</td>
<td>Recheck</td>
<td>New Patient / Consult</td>
</tr>
<tr>
<td>2:00</td>
<td>#</td>
<td>Recheck</td>
<td>#</td>
</tr>
<tr>
<td>2:15</td>
<td>Recheck</td>
<td>New Patient / Consult</td>
<td>Recheck</td>
</tr>
<tr>
<td>2:30</td>
<td>New Patient / Consult</td>
<td>#</td>
<td>Recheck</td>
</tr>
<tr>
<td>2:45</td>
<td>#</td>
<td>#</td>
<td>New Patient / Consult</td>
</tr>
<tr>
<td>3:00</td>
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<td>#</td>
</tr>
<tr>
<td>3:15</td>
<td>#</td>
<td>#</td>
<td>Recheck</td>
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<tr>
<td>3:30</td>
<td>Recheck</td>
<td>#</td>
<td>Recheck</td>
</tr>
<tr>
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</tr>
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<td>Recheck</td>
<td>Recheck</td>
</tr>
<tr>
<td>4:15</td>
<td>Chart Completion</td>
<td>Chart Completion</td>
<td>Chart Completion</td>
</tr>
</tbody>
</table>

### Time Allotments

<table>
<thead>
<tr>
<th>Time Allotments</th>
<th>New Patient/Consult</th>
<th>Recheck</th>
<th>Procedures</th>
<th>Annual Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effective 07/01/2016</td>
<td>The Hospital at its option, may change, delete, suspend or discontinue portions of this manual at any time without prior notice. It is the trainee's responsibility to obtain the most current version of this manual. A current copy of this manual is available in the Medical Education Department. Any changes in this manual shall apply to existing as well as future trainees.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.4 Continuity Clinic Evaluation

Trainees will be evaluated quarterly with respect to participation in didactic sessions, quality of charting, overall progress in clinic, attitude, professionalism and procedural skills. The trainee will provide evaluations of preceptors and constructive feedback for the preceptors and staff at this time as well.

The 360° continuity clinic evaluation is conducted at least twice each year by the Family Medicine Residency Clinic trainer(s). The evaluation form is presented as a model, which utilizes the accrediting body’s core competency requirements.

Trainer(s) should discuss the evaluation with the trainee, highlighting strengths and weaknesses and pointing out areas that can be improved. The evaluation process should be an opportunity for teaching by the trainers resulting in personal and professional growth by the trainee. Serious deficiencies need to be documented along with a plan for improvement.

A scoring grid is provided for those programs that have multiple trainers in their ambulatory clinic who each fill out an evaluation. The grid serves to illustrate to the trainee how their performance has been rated by several supervisors and adds some validity to the evaluation when there is agreement in scores.

The accrediting body has adopted the six core competencies with an additional section for Osteopathic Concepts. This evaluation, along with the Trainee Patient Evaluation, groups the questions into categories based on these competencies. While there is considerable overlap between the competencies, this format serves to illustrate how we are evaluating these items while acting as a guideline for shaping our curriculum.

Medical knowledge and patient care issues are still paramount, but a successful physician needs more than good knowledge. Assessment of professionalism and interpersonal communication is often difficult, especially since the evaluating physician sees the trainee in only one context.

A 360° evaluation compiles subjective information from several sources to obtain a ‘well rounded’ view of the trainee. Evaluation forms may be filled out by the trainee’s patients and peers, as well as by clinic staff. The clinic supervisor may
decide how many evaluations to solicit, with the understanding that three (3) or more evaluations from each source will likely provide better data.

The scoring grid may be used to compile the results of all the evaluations and will act as a valuable resource to promote personal growth and change in our trainees. A discussion between the clinic supervisor and the trainee concerning these results is an essential part of this process.

4.5 Clinic Didactics

Teaching during clinic sessions occurs informally with discussion of various Family Medicine topics as they pertain to the diagnoses of the patients seen in the clinic. Trainee notes are reviewed by the supervising clinic attending physicians and teaching points are reviewed with the trainee.

4.6 Charting

Charting will be in standard SOAP format. Additionally, clinical trials/research will be conducted from the Family Medicine Clinic with additional documentation requirements being requested of the participating trainee/preceptor. All charting by trainees are reviewed and countersigned by the trainee’s teaching attending and are completed during the assigned clinic. All charting will be completed prior to vacations or graduation.

Feedback regarding the trainee’s documentation will occur during the clinic session and a compiled for inclusion in the trainee’s annual performance review will be made.

4.7 Clinic “After Hours”

After hours the Chief Family Medicine Trainee or attending physician in conjunction with the Clinic Director will arrange coverage. Schedules will be created and distributed on a monthly basis. The hours of Family Medicine Clinic call are 5 p.m. – 9 a.m. Documentation of patient calls is mandatory. Call Logs will be distributed to trainees for maintaining this documentation with copies placed on the patient chart. Calls requiring more detailed documentation will be dictated on the hospital stat dictation line and a message left at the clinic indicating the patient name, phone number and direction to the staff to obtain the dictated notation. If calling from your private phone, remember to first dial *67 to block caller ID.
4.8 Procedures

Trainees will develop proficiency in various procedures. The preceptor will supervise all procedures performed in the Family Medicine Clinic. The trainee is responsible for staffing and performing the procedure under the direct supervision of the attending physician, notification of the attending 24-hours prior to the procedure and dictation of procedure documentation.

Trainees are required to document procedures performed in the trainee tracking system. Each procedure shall be forwarded to the supervising physician to document level of competency.

4.9 Vacation/Time Off from Clinic

All vacation requests will be filed in compliance with Medical Education Policy with a copy being provided to the Family Medicine Clinic by the trainee at least 4 weeks prior to the requested time. Any canceled clinic days, require 2 weeks advanced notice and will be made up by the trainee in discussion with the Clinic Director and staff. The only exception is emergencies, which require immediate notification of the Clinic Director.

Return to the beginning of the Manual
5  CLINICAL EXPECTATIONS

5.1  Electives

PGY-1 - Elective must be chosen at the beginning of the program year. Electives may be out-of-house, but if so, should be in a specialty area not available in-house. Electives must be within other Harnett Health Graduate Medical Education Programs. You must be available to take call at 6:30 p.m. if on an outside elective. Out of town electives will not be allowed. The Program Director, in conjunction with the Director of Medical Education must approve all electives at least three months in advance.

PGY-2 and above - Elective must be chosen at the beginning of the program year. Electives may be out-of-house, but if so, must be with an affiliated training institution. The Program Director and the Director of Medical Education must approve all electives at least three months in advance.

Harnett Health requires all rotations to be arranged at the beginning of the academic year.

Prior to any elective rotations, the trainee MUST confirm the elective with the Administrative Director of Medical Education to ensure all requirements for the elective have been met, i.e. affiliation agreements, if applicable; trainee program requirements are met.

5.2  Floor Coverage

When a nursing floor requires a physician for a specific patient problem, coverage is as follows:

1. The PGY-1 that is covering Emergent Floor calls as designated in the monthly call schedule packet.
2. The House Staff Physician designated on patient’s chart as following this patient. This includes all services, i.e. Surgery, EENT, IM, and OB etc.
3. The Attending Physician of record.

Emergent coverage is designated in the monthly call schedule.

5.3  Night Coverage

Night coverage is 7 p.m. to 7 a.m. Weekend nights coverage is 7 p.m. to 7 a.m., Friday; and Saturday and Sunday are 24-hour shifts; 7 AM to 7 AM.
Night PGY-1 must immediately notify the operator regarding which PGY-1 is covering which specific area, if changes in the printed call coverage have occurred.

Night PGY-1s are expected to participate in all a.m. lectures throughout the year.

The attending physician on call is responsible for the admission, and must be contacted by the house officer. Attending physicians are encouraged to call the house officer prior to each admission. PGY-1s should participate in admissions and discuss cases with the admitting trainee.

Use your discretion, but it is always better to call than NOT call if there are any questions. Attending physicians are responsible for their patients and want to be informed of significant changes in their status.

All procedures are to be performed by a trainee who has been “signed off” by their program director to perform the procedure. Prior to being “signed-off”, trainees must have attending or senior trainee supervisor the procedure.

If you feel uncomfortable and/or feel you are in trouble, DO NOT get in over your head - ANTICIPATE. You should notify the appropriate trainee on call in these situations and/or the attending physician for the patient.

5.4 Response to Floor Calls

Trainees shall respond as soon as possible during the day or night when called to see a patient.

Instructions for giving medications and treatments may be given over the phone to the nurses only when the trainee cannot report in person. Subsequently, he/she must respond when able and write all orders on the chart and sign and date. In addition, the trainee must write a progress note on all patients requiring orders and evaluation.

During the hours 7 a.m. to 7 p.m., floor call is directed to the trainee directly caring for the patient. In their absence, the attending physician for the patient will be contacted. During the hours 7 p.m. to 7 a.m., floor call is directed to the trainee assigned to nights. Patients will be seen ACCORDING TO HIGHEST PRIORITY FIRST. When handling a floor call, review the chart, pay attention to age, race, why the patient is here, what procedures have been done, vitals, and lab studies, then go see the patient. If indicated, do not be afraid to ask for a set of fresh vital signs. Then it is your responsibility to write the orders and a progress note (SOAP format). Finally, it is your responsibility to follow-up with the orders until you are sure the problem is solved, keep the attending notified of the patient’s status.
5.5 Rounds

The trainee should make rounds on all assigned cases each morning and write his/her progress notes at that time. The trainee will make rounds with the attending staff and specifically with the staff member to whom he/she is assigned, on a daily basis. He/she will receive instruction, information, advice, suggestions and assistance from the staff that thus contributes to his/her bedside teaching. Prior to rounds, the trainee should report to the attending physician all patients who present any new or unusual symptoms, unforeseen developments, emergencies or any dissatisfaction expressed by patients in regard to treatment, food, nursing, surroundings, or annoyances. After each patient visit, the house officer must make appropriate notes in the patient's chart.

Assigned patients are to be visited as soon as possible after admission regardless of the hour. The attending physician is to be called at this time and be notified of the patient’s condition.

5.6 Admission

The admission process is presently set up to:

1. Provide the attending physician with name of the trainee who is responsible for the admission at the time the admission is being called to the hospital. The attending physician can then, prior to the patient getting to the hospital, notify the responsible trainee with information that is essential to facilitate the evaluation of the patient; such as labs, X-rays already done, severity of patients condition, consults, or other physicians who need to be notified.
2. Provide a more service-oriented admission process.
3. Provide for trainees performing admissions, not just H & P’s.
4. Provide more intern and trainee supervision of students.
5. Improve communication between the house staff and the attending physician.
6. Improved patient care and avoid untimely evaluation of severely ill patients.

In order for the Admitting Department to appropriately assign your patient to the correct trainee, they need to know:

1. The admitting physician’s name.
2. The preliminary diagnosis and unit of admission.
3. Consulting physician(s) and levels of participation.

After seeing the patient, the trainee doing the admission is to notify the attending physician of his/her findings and go over the appropriate orders.

PLEASE NOTE: It is our desire to make sure the attending physician knows which trainee is in charge of the admission at the time they call the admission in. This is to encourage the attending physician to notify the trainee in charge of their admission of any...
information that may be helpful to him/her in facilitating the admission, i.e. needs to be seen right away, etc.

The Admitting Department needs only to notify the respective house officer that they are in charge of the admission, and that name should be on the face sheet.

5.7 Admission Orders

If you have written any STAT or “now” orders, notify the unit secretary or appropriate nurse so that undue delays do not occur. Always date, time and sign your orders. Include your printed name and pager number to facilitate nursing follow up of orders.

The attending physician may request consultations for his/her patient. This order must be written as the following:

  a) **Consultation only** which leaves management to the attending physician and prohibits consultants from writing orders on the chart.

  b) **Consultation and management of a specific entity or procedure** in which the consultant may write orders to manage the special entity or procedure but overall responsibility remains with the attending physician.

  c) **Consultation and co-management** which permits the attending physician and the named physician to write orders, however, overall chart responsibility remains with the attending physician.

  d) **Consultation and full management** where the consultant assumes full responsibility for writing orders and management of the patient and prohibits the attending physician from writing orders.

  e) **Transfer of management** to another named physician in which case the patient care responsibilities in the hospital are transferred to the named physician and the admitting physician may no longer write orders.
6 ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Harnett Health’s Family Medicine Residency Policy & Procedure Manual, and I do commit to read and follow these policies.

I am aware that, at any time, I have questions regarding Harnett Health’s Family Medicine Residency policies I should direct them to my Program Director, Director of Medical Education or the Administrative Director of Medical Education.

I know that Harnett Health’s Family Medicine Residency policies and other related documents do not form a contract of employment and are not a guarantee by Harnett Health of the conditions and benefits that are described within them. Nevertheless, the provisions of such Harnett Health policies are incorporated into the acknowledgment, and I agree that I shall abide by its provisions.

I also am aware that Harnett Health, at any time, may on reasonable notice, change, add to, or delete from the provisions of the company policies.

______________________________  ______________________
Trainee’s Printed Name                  PGY Level

______________________________  ______________________
Trainee’s Signature                   Date
7 APPENDICES

7.1 Common Trainee Policy and Procedure Manual
7.2 ACGME Milestones
7.3 ACGME Family Medicine Standards
7.4 Structural Exam Forms

Return to the beginning of the Manual