LAU
Gilbert and Rose-Marie Chagoury
School of Medicine

# Graduate Medical Education
# Goals & Principles of Residency

## I. Goals

The main goals of residency are to provide the residents with enough training by the end of which resident will acquire:

(i) Knowledge and clinical skills, competence, in depth knowledge in the field of training, ability to perform various procedures and be able to safely practice medicine independently. Furthermore, the resident will have the necessary tools to pursue further growth in knowledge and skills via continued medical education; and

(ii) Well-rooted ethical behavior and professional conduct but most importantly with a clear sense of social responsibility and resource sustainability

LAU residency programs follow a competency based system of training in compliance with the ACGME guidelines which outlines the core competencies of post graduate training. As such, all resident's evaluations and assessment tools revolve around the attainment of these core competencies, which are stated below.

**Throughout the years of study and training, residents will be expected to reach the core competencies that serve as basis for promotion.**

## II. Definitions

For the purpose of this policy, the following definition shall have the meaning assigned to them:

**"ACGME"** means the Accreditation Council of Graduate Medical Education.

**"CCC"** means the Clinical Competence Committee.

**"GME"** means the Graduate Medical Education Office.

**"LAUMC-RH"** means the Lebanese American University Medical Center – Hospital Rizk S.A.L.

**"Program Director"** means the director/responsible of the specific residency program.

**"Core Competencies"** means the six core competencies as outlined by the ACGME guidelines, i.e.: Medical Knowledge, Patient Care, Interpersonal and Communication Skills, Practice-Based Learning and Improvement, System-Based Practice and Professionalism.

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# Graduate Medical Education
# Goals & Principles of Residency

**"Resident"** means a graduated medical doctor.

**"SOM"** means Gilbert and Rose-Marie Chagoury School of Medicine at the Lebanese American University.

## III. Core Competencies

### A. Medical Knowledge:

1. Learn in-depth the fundamentals of basic science as they apply to the clinical practice of medicine.

    a. The resident must prepare for and attend the daily didactics structures.

    b. The resident should prepare for and participate in monthly selected readings in medicine conferences by reading assigned material and answering questions during discussion. The resident will participate in yearly assessment of medical knowledge.

    c. The resident should participate in scheduled delivery and presentation of lectures from the curriculum as assigned by chief residents.

2. Develop technical skills appropriate to level of training. The resident will attend simulation skills training sessions on scheduled times and periodically. The resident will demonstrate proficiency in basic skills. Under supervision and with appropriate guidance, the resident will be performing procedures on patients after obtaining the appropriate informed consent. The performance will be evaluated for the level of competence and feedback provided to the patient by the senior supervising the act. Eventually, the resident should be able to perform the procedure competently, safely and independently. Residents should document in the medical record, the time, date, indication, details of the procedure and the number of attempts. Any immediate complications-or lack of-should be documented along with the type of follow-up needed. The names of the supervising or senior faculty need to be included.

### B. Patient Care:

1. The resident should assume care of all patients on the hospital ward and be responsible for admission/discharge of all patients on the hospital wards and day care units. The resident should assume care of all patients on the hospital wards and intensive care units.

2. The resident should perform a complete and accurate history and physical examination on every new admission to the service as soon as possible after admission and on a daily basis. This should be clearly documented by a daily progress note.

# Graduate Medical Education
# Goals & Principles of Residency

3. The resident should perform all invasive procedures on ward and ICU patients, with appropriate supervision from faculty or a senior resident.

4. The resident should arrange for appropriate diagnostic and imaging tests on ward patients.

5. The resident should insure proper disposition and follow-up of all patients discharged from the hospital.

6. Residents caring for a patient should:

   - Read about the patient case and understand the differential diagnoses, therapeutic indications and prognosis
   - Have a basic knowledge of possible complications for all therapeutic approaches.
   - Discuss with the attending faculty any questions they may have.
   - Read about the co-morbid conditions of those on their inpatient service.

7. Residents should meet the same standards of patient care for urgent and emergency cases for the good of their patients as well as their own education.

**C. Interpersonal and Communication Skills:**

1. The resident should be able to clearly, accurately, and succinctly present patient information to faculty and senior residents regarding newly admitted patients.

2. The resident should keep the senior resident and faculty aware of all progress of all patients and will alert the senior resident and faculty of new problems on the service.

3. The resident should clearly, accurately, and respectfully communicate with nurses and other hospital employees.

4. The resident should clearly, accurately, and respectfully communicate with referring and consulting physicians, including residents.

5. The resident should clearly, accurately, and respectfully communicate with patients and appropriate members of their families about identified disease processes (including complications), the expected courses, operative findings and operative procedures.

6. The resident should maintain clear, concise, accurate and timely medical records including (but not limited to) admission history and physical examination notes, consultation notes, progress notes, written and verbal orders, operative notes, and

discharge summaries.

7. Resident should dictate or write discharge summaries, at the time of or prior to patient discharge from the hospital. Discharge summaries should be concise and accurate, and should include all relevant information.

8. The resident should be able to clearly and accurately teach medical students about the procedures performed on this rotation when qualified and credentialed to do so by hospital and program policy.

9. The resident will ensure that all students' note are accurate, reflect a proper plan, and are countersigned by a physician each day.

**D. Practice-Based Learning and Improvement:**

1. The resident will write an accurate, detailed and legible admission and preoperative assessment note on all patients. Notes should be timed and dated.

2. The resident must enter all procedures and operative cases in which he /she is the physician of record.

3. The resident must document or dictate an accurate and descriptive narration of any operative procedure (medical or surgical) in which he/she is the primary operator immediately after the procedure is completed and within 24 hours of the procedure, at the latest.

4. The resident must be prepared to participate in discussions at morbidity and mortality conferences for cases in which they were involved with critical portions of the care.

5. The resident must take responsibility for, and be actively involved in his/her own education: every day, it's the resident responsibility to ensure that he/she is prepared to optimize his/her learning for that day.

**E. System-Based Practice:**

1. The resident should be able to appropriately utilize, in a timely and cost efficient manner, ancillary services including social services, discharge planning, physical therapy, nutrition services and pharmacy.

2. The resident should be able to justify all diagnostic tests (including laboratory studies) ordered and document when needed.

# Graduate Medical Education
# Goals & Principles of Residency

**F. Professionalism:**

1. The resident must be honest with all individuals at all times in conveying patient care issues.

2. The resident should place the needs of the patient above all the needs or desires of him/herself.

3. The resident should maintain high ethical behavior in all professional activities.

4. The resident should remain compliant with all required training.

5. The resident must demonstrate a commitment to the continuity of patient care through carrying out professional responsibilities Or through assuring that those responsibilities are fully and accurately conveyed to others acting in his/her stead (e.g. checkout procedures).

6. The resident must understand the institutional policy on duty hours and remain compliant with all duty hour regulations.

7. The resident should attend and reply to all requests by the GME via email in less than 48 hours from the receipt of the email.

8. The resident should be professionally attired and groomed at all times while engaged in patient care.

9. The resident should demonstrate sensitivity to issues of age, race, gender and religion with patients, families, and members of the health care team.

10. The resident should at all-time treat patients, families, and all members of the health care team with respect.

11. The resident should reliably be present in pre-arranged places at prearranged times except when actively engaged in the treatment of a medical or surgical emergency. The resident must notify the appropriate supervisor if he or she will be unable to be present.

12. The resident must attend the following mandatory conferences:
- Departmental grand rounds (staff meetings)
- Multidisciplinary grand rounds
- Selected subspecialty conferences according to the rotations
- Morbidity and mortality conference
- Morning report
- Journal club

13. Any of the following, inter alia, will be considered a breach to the resident's professionalism core competency and might be a cause for dismissal and/or disciplinary action in addition to any other breaches to LAU's policies and regulations, and the applicable laws:

- Failure to be present during duty hours or when on call.
- Intoxication or being under the influence of alcohol or substances of abuse while on duty or on call.
- Conviction of a felony or violation of the law.
- Falsification of medical records.
- Repeated violation of department rules after counseling.
- Repeated patient neglect resulting in injury or harm to the patient.
- Performance of invasive procedures without appropriate authorization, except indefinite life-threatening situations.
- Failure to maintain academic standards and educational requirements of the department.
- Falsification of data on the application.
- Performing operating room procedures without proper attending supervision.
- Failure to give emergency help to all patients at all times throughout the hospital, regardless of whether or not that patient is on the service.
- Writing prescriptions for controlled illegal substances without the proper supervision of a medical attending and for the purpose of allowing purchase of substances for abuse.
- Recommendation by faculty evaluation process.
- Repeated failure to answer pagers during assigned duty hours.
- Repeated delinquent administrative responsibilities.(Medical records, duty hours, answering emails, completing evaluations and logbooks, etc.)
- Failure to attend more than 20% of the conferences, including without being limited to didactic lectures, rounds, hospital conferences, morning reports, etc..

**Such misconduct shall be dealt with in accordance with the student code of conduct, and LAU's policies and regulations.**

## IV. EVALUATIONS, ASSESSMENT AND MENTORING OF RESIDENTS

### A. BASIS OF THE RESIDENT EVALUATIONS

**Parameters of the evaluations**

All evaluations are designed around the six PGYI-core competencies and are specific to each residency program.

Residents will be evaluated on individual specialty requirements, program

requirements, and compliance with policies at LAUMC, its affiliated facilities, and other sites where residents may rotate.

Residents will also be evaluated throughout the year based on the following:

- Record review
- Chart stimulated recall
- Global ratings
- 360˚ Evaluations
- Exams (MCQs)
- Case logs (logbooks)
- Research/Conferences
- Mini-CEX (to be used for formative assessment of the Residents mainly during PGYI & PGYII).

The departmental CCC has the responsibility of oversight to ensure that the evaluations are made in accordance with the abovementioned basis.

**Evaluations to be kept in file**
Evaluations shall be kept in the resident's personal file and will be accessible to the resident through the GME.

**Confidentiality Process**
All evaluations, counseling and probationary actions involving residents will be kept in a confidential manner and be accessible to the program director and the GME office. Under no circumstances will such actions be discussed in a public forum.
Additionally, all evaluations of faculty by residents will be treated as confidential by the program director.

## B. TYPES OF EVALUATION OF RESIDENTS

**Faculty Evaluations of Residents**
Residents will be evaluated by the teaching faculty at the end of each rotation, addressing each of the six PGYI-core competencies. Faculty evaluations and results from written examinations will be utilized in determining the progress of the resident.

**Resident Self Evaluation**
Residents will complete annually a self-evaluation which will be discussed with their advisor.
At the meeting to discuss the self-evaluation a performance plan will be implemented. Resident's advisor will discuss his/her improvements, strengths and weaknesses.

# Graduate Medical Education
# Goals & Principles of Residency

**360° Evaluation**

Residents will be evaluated at the end of each rotation by means of a 360˚ approach by peers (senior residents), nurses, and periodically by patients. The results of these evaluations will also be discussed with the resident during meetings with the advisor and the program director.

By virtue of the 360 ˚ evaluation, all residents will be asked to:

- Anonymously evaluate the program annually.
- Anonymously evaluate the services/rotations they rotated in for a cumulative service/rotation evaluation, to evaluate the educational value of each service/rotation.
- Anonymously evaluate each attending, senior resident (if applicable) and the service in general at the end of each rotation.

**Advisor\mentor Evaluation**

Advisors/mentors shall complete an evaluation of the residents after review of their files and discussion with the residents, as set forth in section F here below.

## C. RESIDENCY ASSESSMENT

The program director is responsible for monitoring the clinical and technical competence and professionalism of residents in the program. The program director will work in conjunction with the CCC, the educational committee and the GME to provide educational oversight for residents and medical students.
The program director will meet with the residents at least biannually to review performance.
The program director has the responsibility for recommending promotion and certification based on the attainment of the requisite PGYI-core competencies.
The program director is responsible for initial counseling of residents regarding any remedial or adverse action which may be needed, and when indicated, individuals may be placed on probation or suspended.

## D. OUTCOME OF THE EVALUATIONS

Evaluations will be reviewed periodically by the CCC and the program director.

If an evaluation of a resident indicates a suboptimal rating, the resident's performance will be discussed by the CCC and a copy of that evaluation is forwarded to the program director and the GME office.
Upon review of the evaluation, the program director may request additional documentation or provide this documentation at the next CCC meeting and the resident's performance will be discussed.

The CCC may recommend the following:

# Graduate Medical Education
# Goals & Principles of Residency

1. The resident will be carefully monitored in the upcoming months due to recent evaluations. This discussion will be documented in the minutes of the meeting.
2. Review of the resident by the GME.

It is the responsibility of the CCC to review, with the program director, any resident's clinical, technical or professional performance which has been rated unsatisfactory. Should the committee feel that action is warranted, they may refer the matter to the GME for their review. It is the primary responsibility of the GME to review the performance of any resident who has been referred by the departmental CCC and to make recommendations to the program director regarding what specific action/s they deem appropriate. Where circumstances necessitate, the membership of the departmental CCC and/or the GME may be altered to avoid a potential conflict of interest, or to protect the privacy of the resident.

**E.RESIDENT ADVISING AND MENTORING**

Each resident will have a mentor/advisor for the duration of their training. Program directors should notify the GME office by October 1st of the advisors and their advisees. Residents are required to meet with their advisor at least once every quarter or as often as needed to review their progress and discuss strengths and weaknesses.
The advisor will complete an evaluation after review of the file and discussions with the resident. These evaluations will suffice as a semiannual review to assess the resident's progress in the program. Should remediation be necessary the mentor/advisor plays a key role in developing a plan for the Resident whereby improvement can be assessed and measured.
Advisors also help residents prepare for presentations for local, national, regional and/or international meetings.

It is the residents' responsibility to set up meetings with their advisors throughout the year. It is anticipated that residents will demonstrate professionalism by assuming responsibility in coordinating these meetings with the assistance of the program director.

The mentor/advisor shall:

- Meet on a regularly scheduled basis with each resident, at least once every quarter to offer professional mentorship.
- Advise and assist the resident in the definition and resolution of interpersonal and system problems that may arise.
- Assist the resident in identifying and evaluating strengths and weaknesses in his/her clinical abilities and training on an ongoing basis.
- Oversee and guide the resident's overall educational and professional progress.

- Follow up with the resident on suggestions and recommendations and document any actions taken.

## V. EVALUATIONS BY RESIDENTS OF FACULTY TEACHING AND PROGRAM

**Resident Evaluation of Faculty Teaching**
Residents will turn in written anonymous evaluations of the program, rotations, and faculty on an on-going basis. The results of these evaluations will be reviewed by the program director and appropriate feedback will be given to individual faculty members. The information will also be used by the core curriculum committee to revise and alter the educational content of the program and its rotations. All evaluations should be entered on the My-Evaluation platform.

**Annual Program Evaluation by Resident**
Each year all residents will complete an anonymous evaluation of the program identifying strengths and weaknesses. This evaluation will be used to improve the educational components of the residency program.

## VI. STANDARDS OF PROFESSIONAL BEHAVIOR

The following standards describe behaviors expected from all members of the SOM community, in educational, clinical, research and administrative settings. Professionalism is expected during all interactions, whether face-to-face or via telephone, video, email, or social networking technologies.

Members of the SOM community will:

- Recognize their positions as role models for others in all settings.
- Carry out academic, clinical and research responsibilities in a conscientious manner, make every effort to exceed expectations and make a commitment to life-long learning.
- Treat everyone in the SOM community with sensitivity to diversity in culture, age, gender, disability, social and economic status, sexual orientation, and other personal characteristics without discrimination, bias or harassment.
- Maintain patient, research subject, and student confidentiality.
- Be respectful of the privacy of all members of the SOM community and avoid promoting gossip and rumor.
- Interact with all other members of the SOM community in a helpful and supportive fashion without arrogance and with respect and recognition of the roles played by each individual.
- Provide help or seek assistance for any member of the SOM community who is recognized as impaired in his/her ability to perform his/her

professional obligations.

- Be mindful of the limits of one's knowledge and abilities and seek help from others whenever appropriate.
- Abide by accepted ethical standards in scholarship, research and standards of patient care.

Residents are requested to abide by all applicable policies, rules and regulations of LAU and the ones applicable on LAUMC-RH, its affiliated facilities and other sites where residents may rotate. This includes, without being limited to, the code of conduct, code of ethics and policy on sexual harassment.

## VII. ON-CALL ACTIVITIES

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period.

In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

- In-house call must occur no more frequently than every third night, averaged over a four-week period.
- Continuous on-site duty, including in-house call, must not exceed 36 consecutive hours.
- Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.
- No new patients, as defined in specialty and subspecialty program requirements, may be accepted after 36 hours of continuous duty.
- All call schedules are generated by the chief resident/senior resident in charge
- All changes in the call schedule at any hospital must be authorized by the chief resident/senior resident, the service attending and the program director.
- Senior residents must be readily available at all times for consultation and patient care at night and throughout the year.

## VIII. MOONLIGHTING

Moonlighting is defined as duty hours performed outside the regular assigned duty hours organized and approved by the individual department.
The program realizes that such activities occur but are not encouraged. Residents should inform the chairperson of the department of their wish to perform such activities in order to obtain the chairperson's prior acceptance. The latter shall ensure that the moonlighting activities do not interfere with the objectives of the educational program and the physical endurance of the resident, and shall, at its entire discretion accept or reject such request.

# Graduate Medical Education
# Goals & Principles of Residency

## IX. SIGN-OUTS/HAND-OFF

Sign out/Hand-off round consists of transmitting information about patients to the residents on call. They are to be conducted:

- At the time of transferring a patient from one ward/department/service to another.
- At the end of a regular working day.

Effective communication is central to patient safety. There is abundant evidence of negative consequences of poor communication and inadequate hand-offs. Five attributes of certain sign-outs contributed to problems, and present opportunities for practical interventions to improve teaching and practice:

1. Sign-outs truncated or omitted due to work demands or time constraints resulting from duty hour limits, with documentation, replacing all or some of the interactive exchange.
2. Diagnostic and care activities unfinished at the end of the outgoing's shift and carried through a shift-change, which put them at a higher risk of being "dropped."
3. Sign-outs participants perceived as challenging because residents may not know or trust each other, with lack of confidence in the outgoing physician's judgment a critical factor.
4. Sign-outs under cross-coverage, due to larger patient loads, lower familiarity with patients and an expectation of less information needing to be shared.
5. Coordination problems and lack of a sense of who was responsible for patients, both among the residents and on the part of other professionals.

**Structure of sign-outs**
Sign-outs/hands-off should be structured as follow:
***S***ick or DNR
***I***dentifying data
***G***eneral hospital course
***N***ew events (of the day/12-24 hours) update the clinical data
***O***verall health status/clinical conditions/co-morbidities
***U***pcoming possibilities/possible problems/contingency plans/rationale
***T***asks – pending tests, anticipate results, plan/rationale

**Elements of an effective face-to-face sign-out/Hand-off**
Checklist for elements of a safe and effective written sign-out—anticipate

**A**dministrative data
Patient name, age, sex

Medical record number
Room number
Admission date
Primary inpatient medical team, primary care physician
Family contact information

**N**ew Information (clinical update)
Chief complaint, brief HPI, and diagnosis (or differential diagnosis)
Updated list of medications with doses, updated allergies
Updated brief assessment by system/problem, with dates
Current "baseline" status (e.g., mental status, cardiopulmonary, vital signs, especially if abnormal but stable)
Recent procedures and significant events

**T**asks (what needs to be done)
Specific, using if-then statements
Prepare cross-coverage (e.g., patient consent for blood transfusion)
Alert to incoming information (e.g., study results, consultant recommendations), and what action, if any, needs to be taken during the cross-coverage

**I**llness
Is the patient sick?

**C**ontingency planning/Code status
What may go wrong and what to do about it.
What has or has not worked before (e.g., responds to 40 mg IV furosemide)
Difficult family or psychosocial situations
Code status, especially recent changes or family discussions

**Web-based handoff:**
LAU is currently implementing a new web-based handoff system that generates a clearer and Targeted sign-out and which helps ensure a systematic sign-out of patients. This is a HIPPA-compliant system and it is a free application: listrunnerapp.com. The system is accessible through an app on iPhone and iPad and is user friendly. Residents should use this application for patient handoff.

## X. PHARMACEUTICAL AND INDUSTRY RELATION POLICY

The GME acknowledges that a responsible and productive alliance between residency training programs and the pharmaceutical industry can be beneficial to the goals of graduate medical education. However, there is increasing awareness of the potential for ethically unsound relationships leading to conflict of interest and negative perceptions by the public. Therefore, the GME established the following policy to guide relations between the residency programs at LAU and the pharmaceutical industry:

# Graduate Medical Education
# Goals & Principles of Residency

• All marketing activities by pharmaceutical companies and their representatives must be approved by the residency program director and the GME office.
• Marketing activities are prohibited in all clinical areas.
• A faculty member will review and/or be present during all presentations given to residents by pharmaceutical companies and their representatives.
• Residents may not receive for personal benefit "incentives" to enroll patients in pharmaceutical company sponsored trials. All relationships concerning the acquisition of patients for drug trials shall occur as contractual agreements between institutions.