### MHMH Graduate Medical Education
#### House Staff Residency & Fellowship Accredited Programs Directory

- **GME Office**
  - H. Worth Parker, MD, *Director*
  - Carolyn Dole, *Assistant Director*
  - Tina C. Foster, MD, *Associate Director*
  - Walter F. Wallace, *ACGME Regulations Manager*
  - Denise Shibles, *Academic Assistant*
  - Christina Trottier, *Academic Assistant*

- **Residency Programs**
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    - Dermatology: Kathryn Schwarzenberger, MD
    - Internal Medicine: Harley Friedman, MD
    - Internal Medicine/Primary Care Track: Kelly Kieffer, MD
    - Internal Medicine/Psychiatry: B. Vincent Watts, MD
    - Neurology: Morris Levin, MD
    - Neurosurgery: David W. Roberts, MD
    - Obstetrics & Gynecology: Karen George, MD
    - Orthopaedic Surgery: Charles Carr, MD
    - Otolaryngology: J. Oliver Donegan, MD
    - Pathology: James P. AuBuchon, MD
    - Pediatrics: Carole Stashwick, MD, PhD
    - Preventive Medicine: Paul B. Batalden, MD
    - Psychiatry: Ronald Green, MD
    - Psychiatry (Child & Adolescent): Robert Racusin, MD
    - Radiology/Diagnostic: Jocelyn Chertoff, MD
    - Surgery, General: Daniel Walsh, MD
    - Surgery, Plastic: Carolyn Kerrigan, MD
    - Urology: E. Ann Gormley, MD

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  - Cardiology, Interventional: John F. Robb, MD
  - Cardiology, Electrophysiology: Mark Greenberg, MD
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  - Critical Care, Internal Medicine: Athos Rassias, MD
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  - Hematology/Oncology: Thomas H. Davis, MD
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  - Psychiatry, Forensic: James Knoll, MD
  - Psychiatry, Geriatric: Thomas Oxman, MD
  - Pulmonary/Critical Care: Thomas Prendergast, MD
  - Rheumatology: Lin Brown, MD
  - Vascular Interventional Radiology: Andrew R. Forauer, MD
  - Vascular Surgery: Jack Cronenwett, MD

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  - Sleep Disorders: Glen Greenough, MD
  - Rheumatology: Lin Brown, MD
  - & Christopher M. Burns, MD
  - Vascular Interventional Radiology: Andrew R. Forauer, MD
  - Vascular Surgery: Jack Cronenwett, MD

- **Section Chief or Dep’t Chair**
  - Cardiology: Michael Simons, MD
  - Cardiology, Interventional: Michael Simons, MD
  - Cardiology, Electrophysiology: Michael Simons, MD
  - Clinical Neurophysiology: Gregory Holmes, MD
  - Critical Care, Anesthesiology: Howard Corwin, MD
  - Critical Care, Internal Medicine: Howard Corwin, MD
  - Gastroenterology: Richard Rothstein, MD
  - Hematology/Oncology: Christopher Lowrey, MD, Acting Section Chief
  - Infectious Disease: Ford von Reyn, MD
  - Neonatology: John Modlin, MD
  - Neuroradiology: Peter Spiegel, MD
  - Pain Management: David Glass, MD
  - Psychiatry, Addiction: Alan Green, MD
  - Psychiatry, Forensic: Alan Green, MD
  - Psychiatry, Geriatric: Alan Green, MD
  - Pulmonary/Critical Care: Harold Manning, MD, Acting Section Chief
  - Rheumatology: Lin Brown, MD
  - Vascular Interventional Radiology: Peter Spiegel, MD
  - Vascular Surgery: Richard Dow, MD
Graduate Medical Education

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For House Staff

2005-2006
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I • About Graduate Medical Education at DHMC

Overview

Graduate Medical Education is the phase of formal medical education beginning at graduation from medical school and ending after the educational requirements for one of the medical specialty certifying boards have been completed. The objective is to prepare physicians for the independent practice of medicine.

State licensing boards have varying requirements for post-MD clinical training, and almost every medical school graduate now spends from three-to-seven years in postgraduate training. The term “residency” is commonly used to describe this training period. At the conclusion of the residency period, some individuals enter an additional year of training as chief resident. Others, particularly in internal medicine, enter a fellowship in one of the discipline’s subspecialties. A fellowship usually encompasses a two-or-three-year period, and often includes time for research.

The resident physician is both a learner and a provider of medical care. The resident is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, residents gain competence and require less supervision, progressing from on-site and contemporaneous supervision to more indirect and periodic supervision. Throughout their training, residents also serve as teachers and join with faculty members to educate medical students in hospital settings.

Programs are accredited by the Accreditation Council for Graduate Medical Education (ACGME), which, in turn, acts on the recommendations of 26 Residency Review Committees (RRC), each of which serves a medical and surgical specialty. Specialty certifying boards establish the educational criteria that residents must achieve to be eligible for board certification. These criteria include the length of time for education and training and, to a significant degree, the content of the training program. These are detailed in the Special Requirements for each specialty’s residency programs and complement the General Requirements of the Essentials of Accredited Residencies in Graduate Medical Education promulgated by the ACGME.

Mary Hitchcock Memorial Hospital (MHMH) assumes accountability for the quality of the GME training programs it sponsors. While each program assumes responsibility to ensure integrity under the purview of each RRC, institutional oversight is maintained by the MHMH Graduate Medical Education Advisory Committee (GMEAC). The GMEAC is comprised of all program directors and has representation from the Department of Nursing, Administration, program coordinators, and house staff. The Committee meets monthly except in July and August. The GME Office (hereafter in this manual referred to as GME) implements institutional policies and procedures approved by the GMEAC. GME maintains house-staff and accreditation records, facilitates internal reviews of educational programs, serves as liaison with the ACGME, coordinates benefit programs for house staff, and supports the administration of individual programs.

ACGME General Competencies

MHMH is committed to providing house staff with an educational environment that allows a resident or fellow to demonstrate to the satisfaction and understanding of the faculty, the following attributes and objectives as proposed by the ACGME.

Each residency program enables its residents to develop competencies in six areas. Toward this end, programs define the specific knowledge, skills, and attitudes required, and provide educational experiences as needed, in order for their residents to demonstrate the competencies.

- PATIENT CARE

Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

  1. Communicate effectively and demonstrate caring and respectful behavior when interacting with patients and their families.
2. Gather essential and accurate information about their patients.
3. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment.
4. Develop and carry out patient management plans.
5. Counsel and educate patients and their families.
6. Use information technology to support patient care decisions and patient education.
7. Perform competently all medical and invasive procedures considered essential for the area of practice.
8. Provide health care services aimed at preventing health problems and maintaining health.
9. Work with health care professionals, including those from other disciplines, to provide patient-focused care.

● MEDICAL KNOWLEDGE

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

1. Demonstrate an investigatory and analytic thinking approach to clinical situations.
2. Know and apply the basic and clinically supportive sciences which are appropriate to their discipline.

● PRACTICE-BASED LEARNING AND IMPROVEMENT

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

1. Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
2. Locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems.
3. Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
4. Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
5. Use information technology to manage information, access online medical information, and support their own education.
6. Facilitate the learning of students and other health care professionals.

● INTERPERSONAL AND COMMUNICATION SKILLS

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients’ families, and professional associates. Residents are expected to:

1. Create and sustain a therapeutic and ethically sound relationship with patients.
2. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills.
3. Work effectively with others as a member or leader of a health care team or other professional group.

● PROFESSIONALISM

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

1. Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development.
2. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices.
3. Demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.

**SYSTEMS-BASED PRACTICE**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

1. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice.
2. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health-care costs and allocating resources.
3. Practice cost-effective health care and resource allocation that does not compromise quality of care.
4. Advocate for quality patient care and assist patients in dealing with system complexities.
5. Know how to partner with health-care managers and health-care providers to assess, coordinate, and improve health care and know how these activities can affect system performance.

Source: ACGME Outcome Project

**Physician Attributes and Educational Objectives**

MHMH affirms the Association of American Medical Colleges (AAMC) Medical School Objectives Project (MSOP). Although initially designed with a focus on undergraduate medical education, the project has expanded to encompass GME. MSOP outlines objectives to address the central question: What knowledge, skills, attitudes, and values should medical students and residents be expected to demonstrate? The objectives are summarized as follows, and serve as a core for GME programming at MHMH:

**PHYSICIANS MUST BE ALTRUISTIC**

- Knowledge of the theories and principles that govern ethical decision-making and of the major ethical dilemmas in medicine, particularly those that arise at the beginning and end of life and those that arise from the rapid expansion of knowledge of genetics.
- Compassionate treatment of patients, with respect for their privacy and dignity.
- Honesty and integrity in all interactions with patients’ families, colleagues, and others with whom physicians must interact in their professional lives.
- An understanding of, and respect for, the roles of other health care professionals and the need to collaborate with others in caring for individual patients, while promoting the health of defined populations.
- A commitment to advocate at all times the interests of one’s patients over one’s own interests.
- An understanding of the threats to medical professionalism posed by the conflicts of interest inherent in various financial and organizational arrangements for the practice of medicine.
- The capacity to recognize and accept limitations in one’s knowledge and clinical skills, and a commitment to continuously improve one’s knowledge and ability.

**PHYSICIANS MUST BE KNOWLEDGABLE**

- Knowledge of the normal structure and function of the body (as an intact organism) and of each of its major organ systems.
- Knowledge of the molecular, biochemical, and cellular mechanisms that are important in maintaining the body’s homeostasis.
• Knowledge of the various causes (genetic, developmental, metabolic, toxic, microbiologic, autoimmune, neoplastic, degenerative, and traumatic) of maladies and the ways in which they operate on the body (pathogenesis).
• Knowledge of the altered structure and function (pathology and pathophysiology) of the body and its major organ systems that are seen in various diseases and conditions.
• An understanding of the power of the scientific method in establishing the causation of disease and efficacy of traditional and nontraditional therapies.
• An understanding of the need to engage in lifelong learning to stay abreast of relevant scientific advances, especially in the disciplines of genetics and molecular biology.

PHYSICIANS MUST BE SKILLFUL

• The ability to obtain an accurate medical history that covers all essential aspects of the history, including issues related to age, gender, and socioeconomic status.
• The ability to perform both a complete and an organ-system-specific examination, including a mental status examination.
• The ability to perform routine technical procedures including, at a minimum, venipuncture, inserting an intravenous catheter, arterial puncture, thoracentesis, lumbar puncture, inserting a nasogastric tube, inserting a Foley catheter, and suturing lacerations.
• The ability to interpret the results of commonly used diagnostic procedures.
• Knowledge of the most frequent clinical, laboratory, roentgenologic, and pathologic manifestations of common maladies.
• The ability to reason deductively in solving clinical problems.
• The ability to construct appropriate management strategies (both diagnostic and therapeutic) for patients with common conditions, both acute and chronic, including medical, psychiatric, and surgical conditions, and those requiring short- and long-term rehabilitation.
• The ability to recognize patients with immediately life-threatening cardiac, pulmonary, or neurological conditions regardless of etiology, and to institute appropriate initial therapy.
• The ability to recognize and outline an initial course of management for patients with serious conditions that require critical care.
• Knowledge about relieving pain and ameliorating the suffering of patients.
• The ability to communicate effectively, both orally and in writing, with patients, patients’ families, colleagues, and others with whom physicians must exchange information in fulfilling their responsibilities.

PHYSICIANS MUST BE DUTIFUL

• Knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies.
• Knowledge of the epidemiology of common maladies within a defined population, and the systematic approaches useful in reducing the incidence and prevalence of those maladies.
• The ability to identify factors that place individuals at risk for disease or injury, to select appropriate tests for detecting patients at risk for specific diseases or in the early stage of disease, and to determine strategies for responding appropriately.
• The ability to retrieve (from electronic databases and other resources), manage, and use biomedical information for solving problems and making decisions that are relevant to the care of individuals and populations.
• Knowledge of various approaches to the organization, financing, and delivery of health care.
• A commitment to provide care to patients who are unable to pay and to advocate for access to health care for members of traditionally underserved populations.

(Source: AAMC Medical School Objectives Project)
GME General Competencies

In support of learning consistent with the ACGME General Competencies and the AAMC Medical Schools Objectives Project, cross-program elective educational opportunities sponsored by the GME Office supplement events organized by individual training programs. During the 2004-2005 training year opportunities will include:

- GME Grand Rounds
- Biomedical Libraries Workshops and Grand Rounds
- Online Courses
- Videoconferences
- Independent Study Electives

In addition, the GME Office in partnership with the Biomedical Libraries maintains a video collection of conferences, workshops, and grand rounds appropriate to support learning consistent with the General Competencies. Video kits are on seven-day circulation reserve at the Matthews-Fuller Library Circulation Desk, DHMC 5th Level.

Evaluation and Supervision of Residents

Each MHMH residency program utilizes measures to assess residents’ competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Mechanisms are developed and updated to provide regular and timely performance feedback to residents. This process involves the use of assessment results to achieve progressive improvements in residents’ competence and performance consistent with graduated roles and responsibilities as assigned.

The objective for supervised graduate medical education is to prepare the resident physician for the independent practice of medicine and includes:

a. Participation in safe, effective and compassionate patient care;
b. Developing an understanding of ethical, socioeconomic and medical-legal issues that affect graduate medical education, and how to apply cost containment measures in the provision of patient care;
c. Participation in the educational activities of the training program, and as appropriate, assumption of responsibility for teaching and supervising other residents and students, and participation in institutional orientation and education programs and other activities involving the clinical staff;
d. Participation in institutional committees and councils to which the house staff physician is appointed or invited; and
e. Performance of these duties in accordance with the established practices, procedures and policies of the institution, and those of its programs, clinical departments and other institutions to which the house staff physician is assigned; including, among others, state licensure requirements for physicians in training.

The resident physician is both a learner and a provider of medical care. The resident physician is involved in caring for patients under the supervision of more experienced physicians. As their training progresses, resident physicians are expected to gain competence and require less supervision, progressing from on-site and contemporaneous supervision to more indirect and periodic supervision.

Resident physicians are given progressive responsibility for the care of the patient. The determination of a resident physician’s ability to provide care to patients without a supervisor present or act in a teaching capacity includes formative and summative evaluations of the resident physician’s clinical experience, judgment, knowledge, and technical skill. These evaluations follow institutional guidelines and align resident physician learning in relation to the general competencies of medical knowledge, patient care, practice-based learning, interpersonal and effective communication, professionalism, and systems-based practice.
Ultimately, it is the decision of the Program Director and attending physician with direct responsibility of the resident as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

Both formal examinations and performance evaluations by the faculty are utilized, and the resident physician is personally apprised of his or her strengths and weaknesses at appropriate intervals at least twice annually. Completion by the program director of resident yearly report forms is an important part of this evaluation process.

The Residency Program Director has the responsibility to determine that the resident physician possesses the skills necessary to practice at the level commensurate with their training. Annually, at the time of promotion, or more frequently, appropriate documentation will be provided to the Department Chair, the GME Director (Designated Institutional Official), Residency Program Coordinator or Administrator, and into the residency program's records.

Licensed independent practitioners who are faculty members practicing at DHMC or affiliated institution are among those who supervise all resident physicians.

The resident physician shall participate in patient care under the direction of physicians whose clinical privileges are appropriate to the activities in which the resident physician is engaged. Neither the resident physician’s clinical privileges nor his/her clinical responsibilities shall exceed in scope those of his/her supervising physician. The supervising physician shall make clinical assignments to each assigned resident physician consistent with the resident physician’s experience and demonstrated clinical competence, and strive to ensure that each resident physician performs assigned duties in an appropriate manner. Resident physicians shall be responsible in their clinical activities to the Chief of the designated Section and through the Chief to the Clinical Department Chair. Except for admitting privileges, the responsibilities of each resident physician are determined by the appropriate Section members and Department Chair in context of the respective professional graduate training program requirements.

General Supervision is provided by appropriately privileged teaching staff. This supervision is proximal, continual, and based on normative and summative evaluations following ACGME and institutional guidelines. All resident care is supervised and the attending physician is ultimately responsible for care of the patient. The proximity and timing of supervision, as well as the specific tasks delegated to the resident physician depend on a number of factors, including:

a. the level of training (i.e., year in residency) of the resident
b. the skill and experience of the resident with the particular care situation
c. the familiarity of the supervising physician with the resident’s abilities
d. the acuity of the situation and the degree of risk to the patient

Outpatient Clinics: Resident physicians in all outpatient clinics are supervised by attending faculty members on-site. Resident physician clinics are held in designated areas (or the same practice area as the faculty practice) and are supported in the areas of nursing, laboratory and other services in the same manner as the faculty practice settings.

Impatient Settings at Night and on Weekends: Faculty members are available at DHMC 24 hours per day (or generally present in-house but available by telephone at all times). A faculty member will customarily see any complex or seriously ill patient promptly after admission. Immediate specialty consultations by attending faculty are available on-call at all times to resident physician staff in the same manner that is available to any active member of the medical staff. Faculty review all patients admitted by resident physicians. In the case of critically ill patients, an attending staff member usually initiates a treatment plan and/or consultants in the Emergency Room prior to transfer to the critical care units.
Emergency Room: Full-time emergency room faculty supervise resident physicians 24 hours per day. The faculty members are responsible for demonstrating and instructing resident physicians in proper emergency patient management. They supervise the clinical activity of the resident physician and assume the responsibility for evaluating the resident physician’s clinical competence and delegating increasing patient care responsibilities as appropriate.

Evaluations

Assessment of Learning
DHMC recognizes learning on a continuum from novice to advanced beginner to competent at a level expected of a new practitioner. Each MHMH training program provides assessment of trainee learning in consideration of this continuum, aligned with basic RRC requirements as to the scope and number of both formative and summative evaluations.

Evaluation of Residents/Fellows
Written assessments of learning focus on a trainee’s ability to perform up to defined expectations. These expectations are outlined in a program curriculum. At scheduled intervals during the training year, written formative evaluations are provided to the trainee. At the conclusion of a training year, and at the end of the training program, written summative evaluations are provided to the trainee.

Quality Assurance for Residents/Fellows
All residency programs participate in the medical center-wide quality assurance system. Performance evaluations of residents are coordinated and administered by Residency Program Directors (staff physicians within a particular specialty). Performance evaluations are reflective of both academic knowledge and patient care/clinical skills. These evaluations are considered to be confidential and privileged (by New Hampshire laws RSA 151:13a, RSA 329:29a).

Quality Assurance Algorithm
A. Observation
   1. Recognize problem
   2. Develop plan
   3. Method of assessment
   4. Verbal notice to resident
   5. Written notice in program file, noting verbal interaction only
B. Concern
   1. Culpable or recurring adverse behavior or failure to respond to observed concerns
   2. Written notification
   3. Fair hearing policy
   4. Remedial plan including problems, remediation, time frame, method to assess, and warning about possible need to report to the NH Board of Medicine.
   5. Notice to GME and resident’s file
C. Probation
   1. Failure to meet remedial plan
   2. Analysis of need for suspension
   3. Written evaluation considering dismissal, non-renewal
   4. Formal notice to GME and resident’s file
   5. GME report as needed to NH Board of Medicine

Evaluation of Faculty
Each MHMH residency program monitors educational effectiveness of faculty and attending physicians. At prescribed intervals, programs circulate amongst residents formal written evaluation forms to solicit feedback about individual faculty. These evaluations are confidential.

Program Evaluation
Each MHMH residency program uses resident performance and outcome assessment results in their evaluation of the educational effectiveness of the residency program.
The residency programs have in place a process for using resident and performance assessment results together with other program evaluation results to improve the residency program. This includes ongoing internal review processes to ensure continuous quality improvement.

(Source: ACGME Outcome Project)
Graduate Medical Education
Quality Assurance Committee

A. Description

The Graduate Medical Education Advisory Committee is responsible for monitoring and advising on all aspects of residency education and is an integral component of the quality assurance structure of DHMC. The GMEAC is designated by the Quality Management Plan as the Committee responsible for overseeing the clinical and academic performance of house staff and for ensuring the quality of patient care rendered by residents and fellows. The Quality Assurance Committee is a subcommittee of the GMEAC.

B. Composition

The GME Quality Assurance (QA) Sub-Committee consists of the Director of Graduate Medical Education (the ACGME-Designated Institutional Official) who is the chairperson, the Assistant Director of GME, and the Vice President for Human Resources of DHMC, and such ad hoc members the subcommittee, from time to time, deems necessary, which could include representatives from the Department of Risk Management and the House Staff Association.

C. Purpose

The purpose of the GME QA Committee is to ensure there are systems for the evaluation of residents and fellows and the quality of their patient care. Also, it ensures compliance with the quality-assurance aspects of the ACGME Institutional and Program Requirements.

D. Meetings

The GME QA Committee meets at least quarterly. Minutes are kept and made available for reporting to the GME Advisory Committee.

E. Reports

The GME QA Committee chairperson submits a written report, which summarizes the quality-assurance activities taken, to the GMEAC at least quarterly and to the Executive Medical Director, in the Office of Clinical Affairs, at least annually. At the discretion of the Executive Medical Director, a verbal report may be requested for presentation to the Board of Governors. All quality assurance records and reports of this Committee are confidential and protected under New Hampshire RSA 151:13-a and New Hampshire RSA 329:29a.

F. Functions

The GME QA Committee will:

a) Monitor and evaluate the clinical competence of residents and fellows and the quality of patient care they render, by review of evaluation systems, reporting systems and internal program review and other actions brought to the attention of the Committee.

b) Identify and analyze and manage the institutional and training program impact of certain events, including reduction or addition of house staff to training programs, patient care issues, and other house staff issues.

c) Review, apply and update, as necessary, the Policies and Procedures for House Staff as outlined in the GME “Red Book.”

d) Serve as a resource for the programs and institution, and to other institutions and organizations, for matters relating to quality assurance.
Duty Hours

Duty Hours Statement of Support

DHMC is committed to the provision of a high-quality resident-training environment, balancing time for educational experiences with patient care responsibilities. We supervise and promote resident physicians’ health and well-being while they learn to deliver safe, effective patient care. We have instituted and we support limits on resident work hours, while assuming responsibility for evaluating (and addressing) the impact of compliance with the ACGME Duty Hours requirements on our system of delivery of care and our resident physicians’ educational experience.

GMEAC 3/24/03

Resident Supervision and Duty Hours

DHMC strictly monitors program adherence to the ACGME duty hour supervision regulations. All DHMC house staff are required to log their duty hours with their program. This data is monitored on an ongoing basis by the GME Office, with reports made regularly to the GMEAC at its monthly meetings. Measures associated with the ACGME general competency of professionalism are used in assessing individual as well as program compliance with the regulations. Egregious or consistent non-compliance by an individual resident will result in severe consequences, up to and including disciplinary action.

Resident Duty Hours and the Working Environment

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education have priority in the allotment of residents’ time and energies. Duty hour assignments shall recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents
   
   a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents training at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
   
   b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
   
   c. Faculty and residents must be educated to recognize the signs of fatigue and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours
   
   a. Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
   
   b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
   
   c. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
d. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour-time period provided between all daily duty periods and after in-house call.

3. 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.

a. In-house call must occur no more frequently than every third night, averaged over a four-week period.

b. Continuous on-site duty, including in-house call, must not exceed 24 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 as defined in Specialty and Subspecialty Program Requirements.

c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.

d. At-home call (pager call) is defined as call taken from outside the assigned institution.

1.) The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.

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

3.) The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. Moonlighting

a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

b. The program director must comply with the sponsoring institution’s written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.

c. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor’s primary clinical site(s), i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

5. Oversight

a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.

b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

6. Duty Hours Exception

An RRC may grant exceptions for up to 10% of the 80-hour limit to individual programs based on a sound educational rationale. However, prior permission of the institution’s GMEC is required.

Source: ACGME.
II • PROGRAM ELIGIBILITY REQUIREMENTS
Graduate Medical Education Residency Program Eligibility Requirements

Applicants with a combination of the following qualifications are eligible for appointment to ACGME-accredited residency programs at DHMC:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   
   a. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or
   b. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are in training.

4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.
   [*A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions:

   a. Have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school;
   b. Have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools;
   c. Have completed all of the formal requirements of the foreign medical school except internship and/or social service;
   d. Have attained a score satisfactory to the sponsoring medical school on a screening examination; and
   e. Have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).]

5. Has successfully passed (www.usmle.org) sets of examinations:
   Step 1, Step 2 CK and CS as applicable for training license and, additionally, Step 3 if required for visa purposes.
   
   a. You must meet the appropriate examination requirements set by the medical licensing authority to which you are applying. You must pass Step 1, Step 2 CK, and, if required Step 2 CS and Step 3 if required for visa purposes.
   b. Obtain the MD degree (or its equivalent) or the DO degree,
   c. Obtain certification by the ECFMG or successfully complete a "Fifth Pathway" program if you are a graduate of a medical school outside the United States and Canada.

   *(The NBME certifying examinations, Part I, Part II, and Part III, and the Federation Licensing Examination (FLEX) Components 1 and 2 are no longer administered. Use of the former NBME Parts or FLEX Components to fulfill eligibility requirements for Step 3 is no longer accepted.)
It is a requirement of the New Hampshire Board of Medicine to have successfully passed USMLE Steps 1 and 2 CK, CS within two attempts, or NBME Parts 1 and 2, or have obtained ECFMG Certification before in-coming house staff can apply for a training license. Typically this requires that you have passed these examinations or obtained ECFMG Certification no later than January 1st of the year in which there is an anticipated June or July residency start date. It is imperative that applicants meet these requirements in order to be appointed to his or her program and begin training on time. Noncompliance will jeopardize acceptance of the application. NH Training licenses shall be confined to activities performed in the course of the qualifying residency or graduate fellowship training program, shall expire automatically upon the licensee's separation from the residency or graduate fellowship training program for any reason, and may be issued on a restricted or conditional basis.

1. In addition to successful completion of USMLE Step 1 and Step 2 CK, CS and/or an acceptable combination of the former NBME Parts 1 and 2, applicants must meet the following qualifications to be eligible for appointment to an accredited DHMC Residency program:
   a. Has the ability to obtain the appropriate visa (non-USA citizens only); and is
   b. Fully competent in written and oral English; and is
   c. Willing and able to appear for an interview, if invited.

2. Foreign national physicians seeking ECFMG sponsorship as J-1 exchange visitors for enrollment in accredited programs of graduate medical education or training at DHMC, must, among other requirements, meet the following general requirements:
   a. Have passed USMLE Step 1 and Step 2 CK, CS (and/or an acceptable combination of the former FMGEMS or NBME examinations);
   b. Hold a valid Standard ECFMG Certificate at the time of commencement of training;
   c. Be offered a GME contract or an official letter of offer for a position in a DHMC accredited program of graduate medical education or training that is affiliated with Dartmouth Medical School;
   d. Provide a Statement of Need from the Ministry of Health of the country of last legal permanent residence (LPR), regardless of country of citizenship. This statement provides written assurance that the country needs physicians trained in the proposed specialty and/or subspecialty. It also serves to confirm the applicant physician's commitment to return to that country upon completion of training in the United States, as required by §212(e) of the Immigration and Nationality Act, as amended, unless given a waiver to remain in the USA in return for providing primary health care services in federally designated health professional shortage areas.

   The objectives of the Exchange Visitor Program are to enhance international exchange and to promote mutual understanding between the people of the United States and other nations through the interchange of persons, knowledge, and skills.

3. Candidates who have graduated, or are expected to graduate, in good standing from a U.S. Medical or Osteopathic school, and are presently holding an F-1 visa, may also be considered for continuing training under the F-1 visa status at DHMC.

   The “Citizenship and Immigration Services” (CIS) may authorize students in F-1 status to engage in "optional practical training" (OPT) for up to 12 months after completion of studies, provided the appointment can be completed in 12 months. This OPT authorization is appropriate for the first or matched year, which is a 1-year contract. International Medical Graduates who receive US medical degrees while in F-1 status may apply to the CIS for OPT work authorization. If the CIS grants employment authorization, the individual may use that
authorization for residency education for a period of 12 months. The F-1 "designated school official" (DSO) at the US medical school can usually provide information necessary to make employment eligibility determinations for these graduates. Pending meeting program requirements, students engaged in OPT for 12 months could be sponsored for further training under the H-1B visa status.

9. Training programs will apply program specific criteria for screening of H-1B applicants who are presently holding H-1B clinical visas and transferring from other clinical training programs.

There are several basic requirements physicians must meet to enter in an H-1B status to perform clinical medicine, including the following,

   a. The physician has a license or other authorization required by the state where the physician will practice;
   b. They physician has an unrestricted license to practice medicine in a foreign country or has graduated from a foreign or U.S. medical school; and
   c. The physician has passed the appropriate examinations that include:

      1) Federation Licensing Examination (FLEX) parts I and II, or an ‘equivalent examination as determined by the Secretary of Health and Human Services’;
      2) National Board of Medical Examiners (NBME), Parts I, II and III; or
      3) The United States Medical Licensing Examination (USMLE), Steps 1,2 and 3.  

The USMLE has become the exclusive examination for over 12 years. Passage of earlier examinations is still recognized, but “mixing and matching” parts of different examinations is not permitted for H-1B purposes.

Programs must present all candidates for training to the GME Office for final approval. 
Voted as Accepted by GMEAC 9/20/04
Selection Process for MHMH GME Accredited Residency Programs (9-20-04)

1. Applicants obtain program information on the World Wide Web at http://www.hitchcock.org and click under Residency/Fellowship Programs to access the DHMC Residency Directory. Programs specify if they are utilizing ERAS Electronic Residency Application Service or if applications are accepted by mail. Some programs allow applicants to use the Universal Application Form, but they must complete the GME application form as well. As of July 2004, the following DHMC programs accept ERAS applications: Anesthesiology, Dermatology, Diagnostic Radiology, General Surgery, Internal Medicine, Internal Medicine-Primary Care Track, Internal Medicine/Psychiatry Combined Program, Obstetrics/Gynecology, Orthopaedic Surgery, Pathology, Pediatrics, Psychiatry, Rheumatology, Urology, and Vascular Surgery.

2. Applicants send to the program, through ERAS, or directly as instructed, their completed application form and make arrangements to have mailed directly to program: medical school dean’s letter, medical school transcript, and three letters of recommendation. Any document not printed in English must be accompanied by an acceptable original English translation performed by a qualified translator. Each translation must be accompanied by an affidavit of accuracy acceptable to the Hospital.

3. Applicant must document with the program and the successful completion of USMLE Steps 1 and 2 CK and CS, or NBME Parts 1 and 2, or have obtained ECFMG Certification recommended to be no later than January 1st of the year in which he or she anticipates a June or July Residency start date.

4. Applicants make arrangements for interview with Program, based upon guidelines in the web site.

5. Interview day generally includes orientation, tours, attendance at conferences, and interviews with faculty and house staff.

6. Faculty and house staff evaluation of applicants takes place. Generally, all GME training positions are offered by programs participating in a matching program, such as the NRMP. Programs that start their training at the second post-graduate year also offer positions in organized matching programs, such as the NRMP, and applicants may be able to link their first with subsequent years of training.

7. The new house staff list is distributed to participating programs by GME.

8. Written letter of agreement outlining the terms and conditions of house staff appointment to residency program is mailed to new house staff with new employment forms by GME.

9. Participation in mandatory GME and program orientation for all new house staff.

10. New training year usually begins June 26 or July 1.

11. Ability to be accepted and appointed for training is contingent upon:
(a) Meeting all ACGME Eligibility Requirements; and
(b) Being medically able to begin; and
(c) Being physically present on the date in the mutually signed GME Resident-Fellow Agreement of Appointment; and
(d) Functioning at the agreed upon level of training; and
(e) Obtaining the appropriate visa, if applicable.

Mary Hitchcock Memorial Hospital presently has no pre-employment drug testing policy and has no requirement that residents must sign a non-competition clause in the Resident Agreement.
I certify that I am aware of the above listed requirements and that I understand and meet these requirements.

_____________________________________/______________________________________________/
Name (signature) (print name) Date
Graduate Medical Education Fellowship Program Eligibility Requirements

Applicants with combinations of the following qualifications are eligible for appointment to ACGME-accredited residency programs at DHMC:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME) and successful completion of any pre-requisite accredited training. Some programs require successful passage of board exams (or good faith effort to pass) for promotion through subsequent years of fellowship.

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA) and successful completion of any pre-requisite accredited training.

3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   a. Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment or
   b. Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are in training AND
   c. Successful completion of any pre-requisite accredited training.

4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school and successful completion of any pre-requisite accredited training.
   [*A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who meet the following conditions:
   a. Have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school;
   b. Have studied at a medical school outside the United States and Canada but listed in the World Health Organization Directory of Medical Schools;
   c. Have completed all of the formal requirements of the foreign medical school except internship and/or social service;
   d. Have attained a score satisfactory to the sponsoring medical school on a screening examination; and
   e. Have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).]

5. Has successfully passed (www.usmle.org) sets of examinations:
   Step 1, Step 2 CK and CS as applicable for training license and, additionally, Step 3 if required for visa purposes.
   a. You must meet the appropriate examination requirements set by the medical licensing authority to which you are applying. You must pass Step 1, Step 2 CK, and, if required Step 2 CS and Step 3 if required for visa purposes.
   b. Obtain the MD degree (or its equivalent) or the DO degree,
   c. Obtain certification by the ECFMG or successfully complete a "Fifth Pathway" program if you are a graduate of a medical school outside the United States and Canada.
*(The NBME certifying examinations, Part I, Part II, and Part III, and the Federation Licensing Examination (FLEX) Components 1 and 2 are no longer administered. Use of the former NBME Parts or FLEX Components to fulfill eligibility requirements for Step 3 is no longer accepted.)*

It is a requirement of the New Hampshire Board of Medicine to have successfully passed USMLE Steps 1 and 2 CK, CS within two attempts, or NBME Parts 1 and 2, or have obtained ECFMG Certification before in-coming house staff can apply for a training license. Typically this requires that you have passed these examinations or obtained ECFMG Certification no later than January 1st of the year in which there is an anticipated June or July residency start date. It is imperative that applicants meet these requirements in order to be appointed to his or her program and begin training on time. Noncompliance will jeopardize acceptance of the application. NH Training licenses shall be confined to activities performed in the course of the qualifying residency or graduate fellowship training program, shall expire automatically upon the licensee's separation from the residency or graduate fellowship training program for any reason, and may be issued on a restricted or conditional basis.

6. In addition to successful completion of USMLE Step 1 and Step 2 CK, CS and/or an acceptable combination of the former NBME Parts 1 and 2, applicants must meet the following qualifications to be eligible for appointment to an accredited DHMC Fellowship program:

   a. Has the ability to obtain the appropriate visa (non-USA citizens only); and is
   b. Fully competent in written and oral English; and is
   c. Willing and able to appear for an interview, if invited.

7. Foreign national physicians seeking ECFMG sponsorship as J-1 exchange visitors for enrollment in accredited programs of graduate medical education or training at DHMC, must, among other requirements, meet the following general requirements:

   a. Have passed USMLE Step 1 and Step 2 CK, CS (and/or an acceptable combination of the former FMGEMS or NBME examinations);
   b. Hold a valid Standard ECFMG Certificate at the time of commencement of training;
   c. Be offered a GME contract or an official letter of offer for a position in a DHMC accredited program of graduate medical education or training that is affiliated with Dartmouth Medical School;
   d. Provide a Statement of Need from the Ministry of Health of the country of last legal permanent residence (LPR), regardless of country of citizenship. This statement provides written assurance that the country needs physicians trained in the proposed specialty and/or subspecialty. It also serves to confirm the applicant physician's commitment to return to that country upon completion of training in the United States, as required by §212(e) of the Immigration and Nationality Act, as amended.

The objectives of the Exchange Visitor Program are to enhance international exchange and to promote mutual understanding between the people of the United States and other nations through the interchange of persons, knowledge, and skills.

8. Candidates who have graduated, or are expected to graduate, in good standing from a U.S. Medical or Osteopathic school, and are presently holding an F-1 visa, may also be considered for continuing training under the F-1 visa status at DHMC.
The Citizenship and Immigration Services (CIS) may authorize students in F-1 status to engage in "optional practical training" (OPT) for up to 12 months after completion of studies, provided the appointment can be completed in 12 months. This OPT authorization is appropriate for the first or matched year, which is a 1-year contract. International Medical Graduates who receive US medical degrees while in F-1 status may apply to the CIS for OPT work authorization. If the CIS grants employment authorization, the individual may use that authorization for residency education for a period of 12 months. The F-1 "designated school official" (DSO) at the US medical school can usually provide information necessary to make employment eligibility determinations for these graduates. Pending meeting program requirements, students engaged in OPT for 12 months could be sponsored for further training under the H-1B visa status.

9. Training programs will apply program specific criteria for screening of H-1B applicants who are presently holding H-1B clinical visas and transferring from other clinical training programs.

There are several basic requirements physicians must meet to enter in an H-1B status to perform clinical medicine, including the following,

a. The physician has a license or other authorization required by the state where the physician will practice;
b. The physician has an unrestricted license to practice medicine in a foreign country or has graduated from a foreign or U.S. medical school; and
c. The physician has passed the appropriate examinations that include:

1) Federation Licensing Examination (FLEX) parts I and II, or an ‘equivalent examination as determined by the Secretary of Health and Human Services’;
2) National Board of Medical Examiners (NBME), Parts I, II and III; or
3) The United States Medical Licensing Examination (USMLE), Steps 1, 2 and 3.

The USMLE has become the exclusive examination for over 12 years. Passage of earlier examinations is still recognized, but “mixing and matching” parts of different examinations is not permitted for H-1B purposes.

Programs must present all candidates for training to the GME Office for final approval.
*Voted as Accepted by GMEAC 9/20/04*
Selection Process for MHMH GME-Accredited Fellowship Programs

1. Applicants obtain program information on the World Wide Web at http://www.hitchcock.org and click under Residency/Fellowship Programs to access the DHMC Residency Directory. Programs specify if they are utilizing ERAS Electronic Residency Application Service or if applications are accepted by mail. Some programs allow applicants to use the Universal Application Form, but they must complete the GME application form as well. As of July 2004, the following DHMC programs accept ERAS applications: Anesthesiology, Dermatology, Diagnostic Radiology, General Surgery, Internal Medicine, Internal Medicine-Primary Care Track, Internal Medicine/Psychiatry Combined Program, Obstetrics/Gynecology, Orthopaedic Surgery, Pathology, Pediatrics, Psychiatry, Rheumatology, Urology, and Vascular Surgery.

2. Applicants send to the program, through ERAS, or directly as instructed, their completed application form and make arrangements to have mailed directly to program: medical school dean’s letter, medical school transcript, and three letters of recommendation. Any document not printed in English must be accompanied by an acceptable original English translation performed by a qualified translator. Each translation must be accompanied by an affidavit of accuracy acceptable to the Hospital.

3. Applicant must document with the program and the successful completion of USMLE Steps 1 and 2 CK and CS, or NBME Parts 1 and 2, or have obtained ECFMG Certification recommended to be no later than January 1st of the year in which he or she anticipates a June or July Residency start date.

4. Applicants make arrangements for interview with Program, based upon guidelines in the web site.

5. Interview day generally includes orientation, tours, attendance at conferences, and interviews with faculty and house staff.

6. Faculty and house staff evaluation of applicants takes place. Generally, all GME training positions are offered by programs participating in a matching program, such as the NRMP. Programs that start their training at the second post-graduate year also offer positions in organized matching programs, such as the NRMP, and applicants may be able to link their first with subsequent years of training.

7. The new house staff list is distributed to participating programs by GME.

8. Written letter of agreement outlining the terms and conditions of house staff appointment to residency program is mailed to new house staff with new employment forms by GME.

9. Participation in mandatory GME and program orientation for all new house staff.

10. New training year usually begins June 26 or July 1.

11. Ability to be accepted and appointed for training is contingent upon:
   (f) Meeting all ACGME Eligibility Requirements; and
   (g) Being medically able to begin; and
   (h) Being physically present on the date in the mutually signed GME Resident-Fellow Agreement of Appointment; and
   (i) Functioning at the agreed upon level of training; and
   (j) Obtaining the appropriate visa, if applicable.

Mary Hitchcock Memorial Hospital presently has no pre-employment drug testing policy and has no requirement that residents must sign a non-competition clause in the Resident Agreement.

I certify that I am aware of the above listed requirements and that I understand and meet these requirements.

_________________________/______________________________________________/
Name (signature) (print name) Date
This Agreement of Appointment is entered into between Resident Name, MD/DO, and Mary Hitchcock Memorial Hospital for graduate training as a Program Resident at the GL-# Level to engage in graduate medical education or training, pending successful appropriate certification from the USMLE, NBME and/or ECFMG by the agreement start date. Both parties agree to their respective ethical and legal obligations and have entered into this Agreement in good faith. This Agreement shall be in effect from Month 1, 200- through Month 30, 200- at the stipend level of $--,----, so long as resident performance is satisfactory within the terms of this Agreement. Ability to be accepted and appointed for training is contingent upon meeting all DHMC and ACGME Eligibility Requirements, ability to function at the agreed upon training level, and being physically present and medically able to begin training on the agreed upon date in this mutually signed GME Resident-Fellow Agreement of Appointment, and pending obtaining the appropriate training visa if applicable.

Mary Hitchcock Memorial Hospital agrees to provide a resident training program that meets the requirements of the Accreditation Council on Graduate Medical Education. The resident/fellow agrees to perform his/her duties to the best of his/her ability, and to abide by applicable hospital and medical staff rules and regulations and provide safe, effective and compassionate patient care.

Information regarding resident/fellow compensation, including stipend and benefits, vacation policies, sick leave, professional liability that includes coverage for claims arising out of medical incidents occurring during the period of participation in the program, disability insurance and health insurance for residents and their families, leave of absence benefits that include parental and professional leave, conditions for call room, living quarters, meals and laundry, counseling, medical, psychological and other support services, and related program policies, including moonlighting, successful completion of the program, Fair Hearing and Concern Policies, sexual or other harassment, House Staff Association, and residency closure or reduction of program, are enclosed in the GME Red Book and are considered to be part of this Agreement.

As terms of this Agreement, the resident/fellow agrees that:

A. He/she will perform all duties and accept all reasonable assignments designated by the Program Director and/or his/her designee. Performance will be evaluated periodically by program director and/or departmental chair. Reappointment will be dependent upon satisfactory evaluations and fulfillment of program and institutional requirements and availability of positions.

B. He/she will fulfill the obligations set forth in this Agreement and comply with, and be subject to, all other applicable hospital policies and medical staff by-laws; rules and regulations; state, federal and local laws; and standards required to maintain accreditation by relevant accrediting, certifying, or licensing organizations, including maintaining a valid training or permanent New Hampshire license throughout duration of this Agreement.

C. He/she will return all hospital properties such as books and equipment; complete all records; and settle his/her professional and financial obligations prior to departure from the residency program.

The Resident/Fellow training at Mary Hitchcock Memorial Hospital is also expected to:

A. Develop a personal program of study to foster continual professional growth with guidance from the teaching staff.
B. Participate in safe, effective, and compassionate patient care under supervision commensurate with his/her level of advancement and responsibility.

C. Participate fully in the educational and scholarly activities of the program, as required, and assume responsibility for teaching and supervising other residents and students.

D. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.

E. Become involved with institutional committees and councils whose actions affect their education and/or patient care;

F. Apply cost containment measures to the provision of patient care; and

G. Submit to program director and/or GME at least annually, confidential written evaluations of the faculty and of their educational experiences.

Mary Hitchcock Memorial Hospital and through its participating hospital(s) and institution(s) will provide:

A. An accredited educational program that provides for the educational needs of the resident/fellow including the opportunity to acquire the skills, attitudes, and knowledge consistent with proper patient care and meets the ACGME Requirements for the above named training Program.

B. Patient support ancillary services; laboratory, medical records, and radiologic structures appropriate and consistent with quality and timely patient care;

C. Appropriate, readily available supervision;

D. Appropriate stipends and benefits, including malpractice insurance;

E. Counseling services;

F. Duty hour schedule consistent with the Institutional and Program Requirements that apply to the Program; and

G. Work environment that includes the following conditions:
   1) Provision of adequate and appropriate food services and sleeping quarters;
   2) Patient support services consistent with educational objectives and patient care;
   3) Appropriate security measures.

Mary Hitchcock Memorial Hospital presently has no pre-employment drug testing requirement. House Staff are not required to sign a non-competition clause as part of this Agreement.

Nonrenewal of Agreement of Appointment

A. In the event that it is determined by Responsible Person(s) that renewal of this Agreement for a subsequent year of residency/fellowship will not be made, Mary Hitchcock Memorial Hospital shall use its best efforts to provide resident/fellow written notice of such determination within no less than one hundred twenty (120) days prior to the expiration of this Agreement. If primary reason(s) for non-renewal occur(s) within four months prior to end of Agreement of Appointment, written notice will be provided as circumstances reasonably allow.
B. In the event the resident/fellow intends not to seek renewal of this Agreement for a subsequent year of training, resident/fellow shall use best efforts to furnish the Responsible Person(s) written notice of such intent within no less than one hundred twenty (120) days prior to the expiration of this Agreement. If Primary reason(s) for non-renewal occur(s) within four months prior to end of agreement of appointment, written notice will be provided as circumstances reasonably allow.

WITH INTENTION to be legally bound hereby, the Parties have duly executed this Agreement on the date(s) indicated below.

<table>
<thead>
<tr>
<th>Resident/Fellow</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolyn Dole</td>
<td>Date</td>
</tr>
<tr>
<td>Assistant Director, Graduate Medical Education</td>
<td></td>
</tr>
</tbody>
</table>

1/05 GME
GME Visa Policy

DHMC Graduate Medical Education Training Program Visa Policy

I. Applicants who are non-USA citizens must meet the following qualifications to be eligible for appointment to an accredited DHMC Graduate Medical Education Training Program:
   A. Have the ability to obtain the appropriate visa as applicable; and are
   B. Fully competent in written and oral English; and are
   C. Willing and able to appear for an interview, if invited.

II. Visa Categories

A. The J Exchange Visitor category was developed to implement the Mutual Educational and Cultural Exchange Act (Fulbright-Hayes Act) of 1961. The overall purpose of that Act, and the objective of the Exchange Visitor category, is “to increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchanges.” Applicants who are foreign national physicians seeking ECFMG sponsorship as J-1 exchange visitors for enrollment in accredited programs of graduate medical education or training at DHMC, must, among other requirements, meet the following:
   1. Have passed USMLE Step 1 and Step 2 CK, CS(and/or an acceptable combination of the former FMGEMS, or NBME examinations);
   2. Hold a valid Standard ECFMG Certificate at the time of commencement of training;
   3. Be offered a GME contract or an official letter with an offer for a position in a DHMC accredited program of graduate medical education or training that is affiliated with Dartmouth Medical School;
   4. Provide a Statement of Need from the Ministry of Health of the country of last legal permanent residence (LPR), regardless of country of citizenship. This statement provides written assurance that the country needs physicians trained in the proposed specialty and/or subspecialty. It also serves to confirm the applicant physician’s commitment to return to that country upon completion of training in the United States, as required by §212(e) of the Immigration and Nationality Act, as amended and is subject to a two-year home residence requirement after completion of the training program.

B. Candidates who have graduated, or are expected to graduate, in good standing from a U.S. Medical or Osteopathic school, and are presently holding an F-1 visa, may also be considered for continuing training under the F-1 visa status at DHMC.

An F-1 student is a nonimmigrant who is pursuing a full course of study towards a specific educational or professional objective, at an academic institution in the United States that has been designated by the Immigration and Naturalization Service (INS) to offer courses of study to such students. The “Citizenship and Immigration Services” (CIS) may authorize students in F-1 status to engage in "optional practical training" (OPT) for up to 12 months after completion of studies, provided the appointment can be completed in 12 months. This OPT authorization is appropriate for the first or matched year, which is a 1-year contract. International Medical Graduates who receive US medical degrees while in F-1 status may apply to the CIS for OPT work authorization. If the CIS grants employment authorization, the individual may use that authorization for residency education for a period of 12 months. The F-1 "designated school
official” (DSO) at the US medical school can usually provide information necessary to make employment eligibility determinations for these graduates. Pending meeting program requirements, students engaged in OPT for 12 months could be sponsored for further training under the H-1B visa status.

C. The H visa category is for the temporary employment or training of foreign nationals by a specific employer. The H-1B visa allows professional foreign physicians to work in the US in specialty occupations for up to six years. Training programs will apply program specific criteria for screening of H-1B applicants who are presently holding H-1B clinical visas and transferring from other clinical training programs.

There are several basic requirements physicians must meet to enter into an H-1B status to perform clinical medicine, including the following.

A. Have a license or other authorization required by the state where they will practice;
B. Have an unrestricted license to practice medicine in a foreign country or have graduated from a foreign or U.S. medical school; and
C. Have passed the appropriate examinations that include:

1) Federation Licensing Examination (FLEX) parts I and II, or an ‘equivalent examination as determined by the Secretary of Health and Human Services’;
2) National Board of Medical Examiners (NBME), Parts I, II and III; or
3) The United States Medical Licensing Examination (USMLE), Steps 1, 2 and 3;

The USMLE has become the exclusive examination for over 12 years. Passage of earlier examinations is still recognized, but “mixing and matching” parts of different examinations is not permitted for H-1B purposes.

III. Programs will select applicants on the basis of preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs will not discriminate with regard to sex, sexual orientation, race, age, religion, color, national origin, disability, or veteran status.

IV. All fees related to obtaining appropriate visa status including USMLE or other examinations, credentialing, licensure and or legal fees are the full responsibility of the applicant or resident or fellow.

Programs must present all candidates for training to the GME Office for final approval.

CD/GME/10-12-2004

Status of the USMLE Clinical Skills Examination

In October 2004, the NH Board of Medicine adopted the USMLE’s new mandatory Clinical Skills Assessment component to Step 2 testing for US Medical School graduates and Canadian Medical School grads who take the USMLE’s. This is an additional exam on top of the existing Clinical Knowledge component of Step 2.

US and Canadian Med School students must take and pass the clinical skills component of Step 2 if they: a) have graduation dates in 2005 or later, or b) have graduation dates prior to 2005 and have not passed the clinical knowledge component of Step 2 taken on or before June 30, 2005.
Graduates previous to this date who have already taken and passed Step 2 are exempt from taking the extra component.

International Medical Grads have always been required to take the CSA as well as the Clinical Knowledge portion of Step 2.

The Clinical Skills Assessment exam is a complicated and time consuming process. There is no guarantee that Step 2 scores will be available to applicants or residency programs until after the NRMP Match in March of 2005. There are only five testing sites for CSA in the US and all Step 2 candidates must participate.

The testing centers are located in: Atlanta, Chicago, Houston, Los Angeles and Philadelphia.

Also, the scores for these exams will only be reported in 'batches’. So an examinee might test on Dec. 5, but still have to wait for another six dozen people to participate before their scores are reported.

The scores are reported only as ‘Pass/Fail’. No numeric scores will be assigned.

**Educational Commission for Foreign Medical Graduates Certification**

The purpose of ECFMG Certification is to assess the readiness of IMGs to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME). If you wish to enter such a program, you must be certified by ECFMG before you can start the program. ECFMG Certification is also required before applying to take Step 3 of the United States Medical Licensing Examination (USMLE). In the United States, to obtain a license to practice medicine, physicians must apply directly to the jurisdiction where they plan to practice medicine. Licensing jurisdictions in the United States require that IMGs applying for unrestricted licensure be certified by ECFMG.

To be certified by ECFMG, you must satisfy ECFMG's medical education credential requirements. You must also pass a series of exams. Applicants who satisfy all requirements are issued ECFMG's Standard ECFMG Certificate.

**Eligibility & Requirements**

To apply for ECFMG Certification, you must be an international medical student or graduate. This means that your medical school is located outside the United States and Canada. U.S. citizens who graduate from such schools are considered IMGs and are eligible to apply for ECFMG Certification. Non-U.S. citizens who graduate from schools in the United States and Canada are not considered IMGs and are not eligible for ECFMG Certification.

Additionally, your medical school must be listed in the International Medical Education Directory (IMED) of the Foundation for Advancement of International Medical Education and Research (FAIMER®). If you are a medical school graduate, your graduation year must be included in your school's IMED listing. If you are a student, the "Graduation Years" in IMED for your medical school must be listed as "Current." You can access IMED on the ECFMG website.

To be eligible for certification, you must graduate from a medical school that meets the requirements described above, and fulfill the following additional medical education credential requirements:

- You must have had at least four credit years (academic years for which credit has been given toward completion of the medical curriculum) at a medical school listed in IMED.
- You must supply ECFMG with copies of your medical education credentials. These medical education credentials are listed in ECFMG's Reference Guide for Medical Education Credentials, available in the ECFMG Information Booklet on the ECFMG website. ECFMG sends medical education
credentials to the medical school that issued them and must receive verification of these documents directly from the medical school.

Applicants for ECFMG Certification must also satisfy the following examination requirements:

- **Medical Science Examination.** USMLE Step 1 and Step 2 Clinical Knowledge (Step 2 CK) are the exams currently administered that satisfy this requirement. Applicants register for these exams with ECFMG and take these exams worldwide at test centers of Prometric, a division of Thomson Learning, Inc. ECFMG also accepts certain former medical science exams to fulfill this requirement. Refer to the ECFMG Information Booklet for more information.

- **Clinical Skills Requirement.** USMLE Step 2 Clinical Skills (Step 2 CS) is the exam currently administered that satisfies this requirement. Applicants register for Step 2 CS with ECFMG and take the exam at one of several regional Clinical Skills Evaluation Centers in the United States. Applicants who have both passed the former ECFMG Clinical Skills Assessment (CSA®) and achieved a score acceptable to ECFMG on an English language proficiency test (such as the Test of English as a Foreign Language™ [TOEFL®] or the former ECFMG English test) can use these passing performances to fulfill this requirement. Refer to the ECFMG Information Booklet for more information.

Step 1, Step 2 CK, and Step 2 CS are the same exams taken by graduates of U.S. and Canadian medical schools. Detailed information on the USMLE is available on the USMLE website.

Refer to the ECFMG website for information on exam eligibility, fees, application, scheduling, test centers, preparation, and sample test materials.

### Applying for ECFMG Certification

The certification process begins when you send your first exam application to ECFMG. Before applying for examination, you must read the appropriate editions of the ECFMG Information Booklet and the USMLE Bulletin of Information. Both publications are available on this website. You can apply for the exams online, or you can download paper application materials. Detailed instructions accompany each application.

Both medical school students and graduates can begin the certification process. You can apply for the required exams as soon as you meet the exam eligibility requirements. All of the required exams are offered continuously throughout the year. However, since one of the requirements for ECFMG Certification is verification of your medical education credentials with your medical school, you cannot complete the process until you graduate and obtain these documents.

There is no time limit for completing the certification process. However, there are specific time requirements for completing the exams for ECFMG Certification and medical licensure. These requirements are described in the ECFMG Information Booklet and USMLE Bulletin of Information, respectively.

The academic year for U.S. graduate medical education programs typically begins in July. You must be certified by ECFMG before your program's start date, although you can apply to programs before becoming certified. In planning the timing of your exam application and scheduling, you should also consider deadlines imposed by the programs to which you plan to apply and the National Resident Matching Program. See Applying to Graduate Medical Education Programs.

### Applying to Graduate Medical Education Programs

The Graduate Medical Education Directory, published by the American Medical Association (AMA), is recognized as the official list of ACGME-accredited graduate medical education programs. For each medical specialty, the Directory provides general and special requirements and specific information on each program in that specialty. You can order the Directory on the AMA website. Application deadlines vary among programs. You should contact programs directly for information on their deadlines.
Most programs require applicants to submit their applications using the Electronic Residency Application Service (ERAS®). ERAS was developed by the Association of American Medical Colleges (AAMC) to transmit residency applications via the Internet. ECFMG coordinates the ERAS application process for IMGs. ERAS information for IMGs is available on this website. Programs that do not participate in ERAS require applicants to use paper application materials. You should contact programs directly for their requirements.

The National Resident Matching Program (NRMP), also known as "the Match," matches applicants with available residency positions in the programs to which they have applied. If you wish to participate, you must register with the NRMP. Refer to the NRMP website for requirements and deadlines, as well as information on the numbers of IMGs who have obtained residency positions through the Match in recent years.

Obtaining a Visa

IMGs who are neither citizens nor lawful permanent residents of the United States must obtain an appropriate visa to participate in U.S. graduate medical education programs. The most common visa employed for this purpose is the J-1 visa. ECFMG is authorized by the U.S. Department of State to sponsor foreign national physicians for the J-1 visa. Information on eligibility and deadlines is available from ECFMG's Exchange Visitor Sponsorship Program. Additional information is available from the U.S. Department of State Exchange Visitor Program. General information on the entry of foreign nationals to the United States is available from the Bureau of Citizenship and Immigration Services and the U.S. Department of Homeland Security.

Resources

ECFMG Certification
The ECFMG website provides access to important updates, application materials, and publications, including:

- ECFMG Information Booklet, including the Reference Guide for Medical Education Credentials
- USMLE Bulletin of Information
- International Medical Education Directory
- The ECFMG Reporter - ECFMG's free e-mail newsletter for IMGs interested in ECFMG Certification. Subscribe

Applying to Graduate Medical Education Programs

- Graduate Medical Education Directory
- AAMC ERAS website
- ERAS for IMGs
- ECFMG-ERAS News - ECFMG's free e-mail newsletter for IMGs participating in ERAS. Subscribe at www.ecfmg.org/eras

National Resident Matching Program www.nrmp.org

Visas

- ECFMG Exchange Visitor Sponsorship Program
- ECFMG® J-1 Visa Sponsorship Fact Sheet
- U.S. Department of State Exchange Visitor Program
- Bureau of Citizenship and Immigration Services
- U.S. Department of Homeland Security
Additional Information
ECFMG representatives are available to answer your questions by

- e-mail at info@ecfmg.org, or
- phone at (215) 386-5900 from 9:00 am to 5:00 pm, Eastern time in the United States, Monday through Friday.

ECFMG

ECFMG is a private, non-profit organization committed to promoting excellence in international medical education. ECFMG's aims and missions include providing information to IMGs regarding entry into graduate medical education and health care systems in the United States, evaluating the qualifications of IMGs, and providing international access to testing and evaluation programs.

ECFMG's organizational members are:

American Board of Medical Specialties
American Medical Association
Association of American Medical Colleges
Association for Hospital Medical Education
Federation of State Medical Boards of the United States, Inc.
National Medical Association

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III • HOUSE STAFF ORIENTATION

Mandatory Orientations

Each training program has its own mandatory orientation program. In addition, there are two-day mandatory GME Orientations.

The annual June 24 and June 25 GME Orientations are generally for First Year Residents (those who have completed four years in medical school and received their MD in May, prior to joining GME).

The annual July 1 and 2 GME Orientations are generally for GL-2’s (those who have had one year of training after completion of medical school) and Fellows (those who have completed their MDs, a specialty training program, and are entering a subspecialty program).

Attendance is mandatory for all new house staff before beginning their training year. House Staff will not be allowed to train until they have completed all Orientation requirements.

Please make arrangements to attend GME Orientation in addition to your program orientation. Be sure to sign in with GME when you arrive. Please make child-care arrangements as children are not allowed at orientation.

If you begin your training on June 26, you will attend the June 24 AND June 25 orientation. You must arrive by 7:00 a.m. in Auditorium F. You will finish each day at approximately 5:30 p.m.

If you begin your training on July 1, you will attend the July 1 AND July 2 orientation. You must arrive by 7:00 a.m. in Auditorium F. You will finish each day at approximately 5:30 p.m.

GME Orientation Information and Topics Include:

- Antimicrobial Program
- Beepers and beeper codes
- Biomedical Libraries Information
- Charting Guidelines
- Communications
- Computer Information Systems
- Curriculum
- Deceased Patient Coordination
- DHMC Intranet
- Discharge Summaries
- Duty Hours
- Health Improvement Program
- HIPAA
- Laboratory Policies
- Laboratory Testing for: a positive titer for measles, German measles and varicella (chicken pox), if resident is not immune, he/she will receive vaccination; and Hepatitis B Surface Antibody. House staff must be able to document they have tested negative, otherwise will receive a booster. House staff must have had a negative Mantoux Skin test for Tuberculosis within the last twelve months of testing. If tested positive or are known to have tested positive, house staff must provide documentation of bump size in millimeters, the duration of the welt and a copy of their chest x-ray and documentation of treatment where applicable. Note: People arriving from countries other than the USA regularly test positive on the Mantoux skin test because of vaccinations they received as children.
- Medical Records and Services
House staff beginning their training year off-cycle must complete a specific GME orientation before they are allowed on the floor to train and provide patient care. Visiting house staff from other institutions must also complete a specific GME orientation prior to being allowed to train and provide patient care.
IV • HOUSE STAFF ASSOCIATION

The House Staff Association comprises all house staff in GME-accredited training programs at Dartmouth-Hitchcock Medical Center. The purpose of the Association is to provide house staff representation as it pertains to the Institution. The House Staff Association is provided equal representation at the GME Advisory Committee meetings. It organizes extracurricular activities, provides advocacy for residents in matters of grievances and due process, shares and exchanges information, and responds to administration about proposals that might affect house staff.

The House Staff Association elects Officers on an annual basis. The President, Vice President, Secretary and Treasurer act as the Executive Committee for the HSA. They are representative on committees including the GME Advisory Committee, the GME Curriculum Committee and the Social Committee.

V • CALL

On-Call Quarters

The call rooms are located on the fifth level and are accessible 24 hours a day, seven days a week. Cross either the first or second bridge across the Mall on the north end nearest the patient towers. The doors have coded locks. The code is entered in a specific order on a keypad, allowing you to turn the knob. The code is changed intermittently.

The rooms are labeled for specific in-house rotations. Be sure you use your program’s assigned room.

Help yourself to bread, peanut butter and jelly, coffee, tea, hot chocolate, and a variety of food provided in your call-room kitchen.

Exercise equipment is provided by donations from an MHMH physician, Dartmouth Medical School, and GME for use by house staff in the call-room area.

There are computers available for your use in the call-room kitchen.

On-Call Meals

Call night allowances will be distributed in July and finalized in October to those house staff required to be in the hospital overnight. You will be asked by the cashier to give your GME identification card as you go through the cashier’s line. Please help their workload by stating you are house staff courteously. Your allowance can be used as you wish, but it is designated as call-night allowance and once it is gone, there will be no more until the next training year begins. GME receives a listing of your charges each month.

At all other times you will receive the discount on food offered to all Hospital house staff in the cafeteria. The food stores on the Mall are private enterprises and do not offer discounts.

If you have any problems with the cafeteria concerning your ID card, do not discuss them with the cashiers; call Graduate Medical Education, 5-5748.

VI • STIPENDS AND BENEFITS

Stipend Level Policy
Stipend levels are paid commensurate with the responsibility of training position. All house staff in the same Program Level are paid the same Stipend Level. Only Board eligibility and ACGME prerequisite years of training for the current training program are applicable towards the Stipend Level. Incentive pay for house staff joining any training program is not allowed. (This policy approved by GMEAC September 18, 1997.)

GME Stipend Levels

<table>
<thead>
<tr>
<th>GL LEVEL</th>
<th>STIPEND</th>
</tr>
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<tr>
<td>GL-1</td>
<td>$41,750.00</td>
</tr>
<tr>
<td>GL-2</td>
<td>$44,030.00</td>
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<td>GL-3</td>
<td>$46,500.00</td>
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<td>$51,240.00</td>
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<td>GL-7</td>
<td>$56,100.00</td>
</tr>
<tr>
<td>GL-8</td>
<td>$58,350.00</td>
</tr>
</tbody>
</table>

Medical Insurance
Anthem replaced Comprehensive Benefits Administrator (CBA) as the hospital’s health plan administrator. effective January 1, 2005.

Spouses, domestic partners and their minor children are covered for most services at reduced cost to the house officer. ‘Domestic Partner’ is defined as an individual living with the house officer in the same capacity as that of a legal spouse, without regard to gender or sexual orientation.

If you marry, have or adopt a child, or if you have a change in domestic partner status: Add your spouse, domestic partner or child to your coverage by coming to GME and filling out a form with this information within thirty days of the event. Your newborn or adopted child will be covered for the first thirty days, even if you have single coverage. If you already have family coverage, Anthem requires notification of any additional dependents. It is your responsibility to inform GME of this change.

Coverage starts on the first day of the month after the month in which you are hired unless you begin work on the first day of that first month. Coverage continues to the end of the month you finish your training, plus one month, after which you can elect to pay for COBRA coverage or wait until your new medical coverage begins.

Your coverage includes an enhanced managed care program which requires you to call MHMH Care Management (866-212-1838) three days prior to all non-emergency and non-maternity hospital admissions not in the Anthem network.

Pertinent Points
Anthem/Blue Cross’ network includes:
- 100% of hospitals in NH and VT are on the Anthem network.
- Over 90% of other healthcare providers in NH and VT are also on the network.
- The search engine for Anthem providers is found at: www.anthem.com

- There is no preexisting conditions clause attached to this policy.

- Anthem issues a card for each family member covered by the plan. All the cards are identical and bear the subscriber’s name.

- Anthem issues a subscriber number instead of using the subscriber’s social security number.

- Subscribers are also issued a Blue Card. This is a card with a number to call when the subscriber is out of the NH/VT area. It gives the location of the nearest participating provider or facility. Anthem is also recognized throughout the world because of the Blue Cross/Blue Shield affiliation.

- Anthem’s health benefits card is the same as the Anthem pharmacy plan card. One card serves both purposes.

The House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff employees of Mary Hitchcock Memorial Hospital (SPD) describes the benefits available to house staff members of GME training program sponsored by the hospital. Please refer to it for full details of the medical insurance benefits. If you have questions after reviewing your SPD, call GME, ext. 5-5748.

**Dental Insurance**

Dental insurance coverage is optional for House Staff. All house staff choosing dental coverage pay 50% of the premium costs, and MHMH pays the other 50%. House staff portion of the premium is deducted in 26 parts from your biweekly paychecks. There are three categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Annual Cost To You</th>
<th>Pay Period Cost To You</th>
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</thead>
<tbody>
<tr>
<td>Single</td>
<td>$130.00</td>
<td>$ 5.00</td>
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<tr>
<td>Double*</td>
<td>$240.00</td>
<td>$ 9.23</td>
</tr>
<tr>
<td>Family</td>
<td>$390.00</td>
<td>$15.00</td>
</tr>
</tbody>
</table>

*Double means: either for the employee and spouse/domestic partner or employee and one child

Coverage is provided by Northeast Delta Dental. Claims should be mailed to: Northeast Delta Dental, One Dental Drive, P.O. Box 2002, Concord, New Hampshire 03302-2002. Telephone: 1-800-537-1715 (direct line for eligibility department).

Please stop by GME and pick up forms before you go to the dentist. Any dentist who accepts Northeast Delta Dental insurance, anywhere in the country, will cover you for treatment. However, if the dentist is not a preferred provider with Northeast Delta Dental in Vermont, New Hampshire or Maine, the dollar percentage of the coverage may decrease. All covered persons are issued a Delta Dental card. Each card bears the name of the insurance subscriber only, no matter the number of cards issued.

It is important to ask if there is a need for predetermination of benefits before the treatment is provided if the charges will exceed the dollar minimum set by your plan.

For full details of the dental insurance benefit see House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff Employees of Mary Hitchcock Memorial Hospital.
Life Insurance

All MHMH House Staff are insured for one times their stipend, rounded to the next higher $1,000, subject to a maximum of $50,000 through term insurance from GE Group Life Assurance Company. You may purchase additional term insurance coverage, if you wish. For more information, call our agent George R. Ramel, at 1-802-649-2869.

You will be asked to fill out a form designating your beneficiary at Orientation, or when you begin your training. You may change your beneficiary at any time by filling out a change of beneficiary form at the GME office.

For full details of the life insurance benefit see House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff Employees of Mary Hitchcock Memorial Hospital.

Long-Term Disability Insurance/Sick Leave

You are covered for 90 days of sick leave per training year, through the Health Care Plan, administered by Comprehensive Benefits Administrators.

Long-term disability benefits may begin on your 91st day of disability. Application for long-term coverage through Northwestern Mutual Life Insurance Company is recommended by the 60th day of illness.

Your maximum benefit payment period is up to age 65. You receive up to 80% of your earnings, to $3,150 per month; the minimum benefit payment amount is $1,200 per month. You can convert your coverage. Your survivors’ benefits payment is up to three times the amount of your long-term disability benefit.

If you have any questions about this coverage, call our agent, George R. Ramel, at 1-802-649-2869.

For full details of the long-term disability insurance and sick-leave benefit see House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff Employees of Mary Hitchcock Memorial Hospital.

House Staff Pay, Deductions, Direct Deposit and W-4 Forms

Checks are issued biweekly, on alternate Thursdays, and paid for time worked through the previous Saturday. You receive an annual stipend, but your checks will indicate you worked 80 hours for each two-week pay period. We know you work many, many, more hours. The 80 hours logged onto your payroll file enables the Hospital Payroll Department software to produce your paycheck.

Deductions Deductions are Federal Income Tax, Social Security (divided into two parts), Vermont State Income Tax if you live in Vermont – you must request that this be done – and dental insurance if you choose that option. If you buy prescriptions at the in-house pharmacy, that amount can be paid through payroll deduction. If you come here to train from a country other than the USA, please discuss your tax deductions with Payroll, since some countries have tax variations. As MHMH is the common law employer of a resident, FICA (Social Security) deductions will be made from the resident’s stipend paycheck.

Direct Deposit Your stipend can be directly deposited into any bank that has the appropriate electronic hookup, anywhere in the country. You can also split your direct deposit in the same bank or into two different banks. If you choose direct deposit you will receive an informational stub each payday. You can start or stop this service at any time during the year. Sign-up forms will be available at orientation or at any other time in the GME Office. We cannot stop direct deposit without your signature; a phone call will not be sufficient. Direct deposit begins with your second paycheck after you complete the request form and the payroll department receives it. You need to stop direct deposit at least four weeks before you leave your training program.

W4 Forms You must fill out a W4 Form stating the number of deductions you wish to take. You can change this at any time during the year if you decide that too much or too little is being withheld. The number of deductions you choose will be the only determining factor in the amount withheld from your
stipend; we simply take your number and read off the corresponding deduction from a government table. It is your responsibility to see that enough has been paid in to avoid a penalty at tax time.

Payroll has a schedule of Federal Income Tax deductions in their office. If you tell them the number of deductions you want to take they can tell you how much will be withheld from your paycheck (Extension 3-1172).

**Health Care Reimbursement Program**

The Health Care Reimbursement Program (HCRP) is offered under the Flex Plan to provide you with a tax-effective way to pay for medical and dental services outside of the Medical and Dental Plans. Since some health care services are not covered due to deductibles, or other benefit limitations, or only partially covered, employees and dependents usually pay for them out of their own pocket. HCRP establishes a reimbursement account that can be an important part of your annual budget planning as it allows you to set aside funds, before paying taxes, that may be used to pay for some or all of these expenses.

For full details of the HCRP benefit see *House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff Employees of Mary Hitchcock Memorial Hospital*.

**Dependent Care Assistance Program**

The Dependent Care Assistance Program (DCAP) is offered under the Flex Plan to provide a tax-effective way to pay for dependent care expenses resulting from the employment of an employee and spouse. DCAP allows you to set aside funds, before paying taxes, to cover certain dependent care expenses.

For full details of the DCAP benefit see *House Staff Summary Plan Description of the Welfare Benefit Plans for House Staff Employees of Mary Hitchcock Memorial Hospital*.

**Vacation**

House staff at all levels are allowed three weeks time off per training year, 15 business days and six weekend days.

**Parking**

Free parking space is available throughout the Hospital premises and off-site locations are provided. Security and Parking maintains shuttle bus services to lots 9, 20, and between DHMC campus sites. Read messages and bulletins about parking to be updated through the construction process.

**Child Care Center**

DHMC has an on-site Child Care Center designed to care for the children of employees and house staff. It includes eight classrooms, two large indoor play areas and two separate outdoor playgrounds. Adjacent to the Medical Center, it can accommodate children from six weeks through five years of age. A highly qualified staff provides professional care from 6:30 AM to 6:00 PM, Monday through Friday. There is a sliding fee scale based upon your income. Those interested in this care should apply as early as possible by calling 603-643-6504.

**Child Care Project**

The Child Care Project in the Upper Valley will advise you on the sources of child care services in the area and will assist you with any problems you may have as a child care consumer, and generally help you make informed child care decisions. Mary Hitchcock Memorial Hospital will not be responsible for the nature or quality of services provided by child care service providers listed by the Hospital. The Child Care Project may be reached at 603-646-3233.
Coats

Two lab coats are provided to all house staff at the beginning of training, and two additional coats are available upon request each following year. We offer both polyester/cotton blend and 100% cotton, unisex-sized coats in coat sizes ranging from 32 to 56. Coats are embroidered with the DHMC logo in dark green thread.

Laundry services are provided for coats and scrubs. Place soiled articles in the appropriate bags provided. Laundered coats for house staff are found in the call room kitchen area. Standard coats, which come through the GME Office, are marked to return to the call-room area. House staff who buy their own coats must put “GME” and their last name in permanent laundry marker on the inside collar of their coats, just above the label. Coats not properly marked will not be returned to the call room, may be lost and will not be replaced by GME.
VII • MALPRACTICE INSURANCE

History of The MHMH Insurance Program

In 1977 Mary Hitchcock Memorial Hospital, the Hitchcock Clinic, and the Trustees of Dartmouth College for Dartmouth Medical School created a unique insurance arrangement. By pooling their financial resources they purchased a single professional and comprehensive general liability insurance policy to cover all medical center staff and employees, including physicians, nurses, employees, and volunteers.

This program was effective from both a risk-funding and a claims-management perspective. The joint program secured cooperation among the insureds by requiring the joint defense of claims. When a claim was asserted against more than one of the institutions, potentially divisive forces were avoided by coordinating a defense of all co-defendants rather than each institution attempting to minimize its separate liability. The plan was arranged through DHMC’s insurance brokers, Johnson & Higgins of Boston.

Under the retrospectively rated primary program, the annual premium was adjusted, subject to certain minimum and maximum limitations, to reflect the DHMC institutions’ actual loss experience. The DHMC institutions received the benefit of a portion of the investment earnings generated by excess funds resulting from favorable loss experience, but were required to share a portion of these earnings with the commercial insurance carrier.

In an effort to assume the full benefit of our investment earnings as well as exercise more control over investment policies and administrative costs associated with the program, the Professional Liability Committee began considering a variety of alternatives to the primary program. Under the guidance of Johnson & Higgins, the DHMC institutions decided to form an offshore captive subsidiary insurance company domiciled in Bermuda. The captive was formed on July 1, 1990. Under this plan, the DHMC institutions obtained primary coverage from a commercial insurance company and the captive reinsured the risk of that commercial carrier. This approach is called a “fronted” insurance arrangement. The excess insurance for catastrophic losses continued to be purchased from commercial carriers but went into effect only when the primary limits were exhausted or when a single large claim exceeded the primary per claim limit.

Questions and Answers About The Insurance Program

This is not an insurance policy. To review the complete terms and conditions of this program please contact the Regional Risk Management office at 650-7770.

● What are the advantages of an “off shore” captive program?

A captive allows the participating institution(s) to: 1) exert more control over risk management and underwriting strategies; 2) realize financial benefits from favorable loss experience and superior claims management; 3) obtain more flexible coverage; 4) maintain direct control of investment income; 5) exercise control over expenses including claims adjustment and the services of independent contractors; 6) obtain more favorable excess insurance costs; 7) benefit from a favorable legal environment including lower taxes and minimal capitalization requirements.

● Who fronts our captive?

The Lexington Insurance Company. Lexington is part of the American International Group (AIG) which is one of the largest and strongest insurance groups in the world.
● What form of coverage is provided?

The policy is written on a “claims-made” basis which means it covers claims or adverse incidents actually reported to Lexington during the policy year, resulting from services rendered after inception of an employee’s coverage under this program. The primary limits are $1 million per claim and $3 million aggregate.

● Will the Lexington policy cover me for claims incurred before I began my Residency at MHMH?

No. Claims related to a service rendered prior to the Resident’s employment by MHMH should be covered by the insurance carried by such employee at the time the service was rendered. Employees who previously had a claims made policy from another insurance company should procure appropriate “tail coverage” from that carrier before entering this insurance program.

Physicians who previously had an occurrence policy do not need to purchase tail coverage.

● What happens when a Resident leaves the program?

Residents who leave MHMH employ will continue to be covered for claims made subsequent to their departure, but only for covered claims arising out of medical incidents occurring during the period of their participation in the program.

● Are Residents covered while moonlighting at institutions that are not insured under the program?

No. Residents are not covered while they are moonlighting outside the Hitchcock Clinic or The Hitchcock Alliance-insured institutions. It is important that anyone contemplating moonlighting makes sure the other institution provides adequate professional liability coverage.

● Are Residents covered while moonlighting at institutions that are insured under the program?

A Resident will be covered under the policy while moonlighting within the Hitchcock Clinic or The Hitchcock Alliance-insured institutions so long as he/she has written permission from the Director of Graduate Medical Education and notifies the Regional Risk Management Office.

● Do I only report adverse events to Risk Management? What about near-misses?

One of the most useful risk management tools, and one that is often neglected, is the thorough investigation of “near-misses.” As any claims manager can attest, before a catastrophic event occurs, the same set of circumstances may have been in place multiple times without triggering such an event. Your risk management program encourages the investigation and discussion of “near-misses.” This is the best way to address problems related to the idiosyncrasies of a particular institution before a catastrophic event occurs.

● Do I need to report a bad outcome if it was a known risk/complication which was fully discussed and documented in the informed consent process?

Yes. Any loss of function at the time of discharge and any iatrogenic injury that extends the hospital stay, requires additional treatment or readmission, even if the loss is a known risk/complication of the treatment provided should be reported.

● Does my insurance policy cover me for any eventuality in my practice?

Your policy covers you for allegations brought against you while you are practicing within the scope of your employment. Allegations of sexual misconduct, if found to be true, cannot be covered.
Malpractice Assurance Request for GME House Staff Off-Site Rotation

To: Carolyn Dole, Graduate Medical Education

From: _________________________________________________________
      Coordinator Name Program
      ____________________________

Date: __________________________________________

Name of Resident/Fellow: __________________________________________
Date(s) of off-site rotation(s): _______________________________________

PLEASE COMPLETE AND RETURN THIS FORM TO GME at least sixty (60) days in advance of off-site rotation.

ROTATION: This rotation is within the auspices of the training program. It is the responsibility of the program coordinator and/or resident/fellow to obtain the appropriate license in the state where this rotation takes place. Licensure, if necessary, should be obtained before sending this request to GME.

Description of responsibilities (include amount of patient contact and reasons why this experience is not available at DHMC):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Advisor name and title: _____________________________________________

Administrator’s name (if different than advisor): ______________________

Name of specific facility where rotation takes place: _____________________

Address: ___________________________________________________________

Telephone: ___________________________ Fax: __________________________

E-mail: ________________________________

Do you want copy of insurance letter sent to you? YES NO (Circle one)

THIS SECTION MUST BE COMPLETED—OTHERWISE, FORM WILL BE RETURNED:

License obtained _____________, 200___. If not obtained, please explain: _____________

______________________________________________________________

PLEASE ATTACH COPY OF LICENSE WITH THIS FORM

Program Coordinator’s signature and date: ________________________________

Resident/Fellow’s signature and date: _________________________________

GME Approval: ____________________________ Date: _____________________

To Risk Management: ____________________________________________

GME/Dole/02
VIII • General Policies

Legal Counsel

If you are approached for any reason by a representative from a law firm, your representation is by the Mary Hitchcock Memorial Hospital Risk Management office, and you should refer all calls to them at ext. 5-7864.

Jury Duty

The Hospital believes it is the civic responsibility of an employee or house staff member to fulfill his/her jury duty obligation, and will ensure that he/she does not lose normal pay during that duty. The Hospital will not attempt to have a release from such service. It is expected that, with due consideration to time and travel factors, the employee or house staff member will return to work when a court recess temporarily releases him/her from jury duty.

Reimbursement: The house staff member will be fully compensated by the Hospital for time spent on jury duty. The employee or house staff member may accept any additional pay received from the state for jury duty.

Dress Code

Neatness of appearance, personal cleanliness, and wearing appropriate clothing in your professional environment is essential when in contact with patients, visitors, and other employees.

Inspections

Inspections of Hospital Property

To control shortages, theft and to locate missing items, inspections of work and personal areas may be conducted at any time. Similarly, the hospital may conduct unannounced random inspections for drugs and alcohol on hospital facilities and property such as, but not limited to, hospital vehicles, equipment, desks, file cabinets, or hospital-issued lockers. Individuals who work at the hospital are expected to cooperate in the conduct of such inspections. Inspections of hospital facilities and property may be conducted at any time and do not have to be based on reasonable suspicion.

Inspections of House Staff Property

In addition to routine inspections conducted in accordance with loss prevention policies and practices, inspections of house staff and their personal property such as, but not limited to, vehicles, clothing, packages, purses, brief cases, lunch boxes, or other containers brought into the hospital premises may be conducted when there is reasonable suspicion to believe that the individual may have or has violated the drug or alcohol prohibitions contained in this policy manual.

Notary Public

There are two notaries public and a Justice of the Peace in the Graduate Medical Education Office. Please remember: You must sign documents to be notarized in the presence of the notary. There is no charge for this service.

Security

Security measures are provided within the institution, including foot and vehicle patrol of the facilities and general response to problems that arise. Security also provides a lost-and-found department, assistance with
ambulance security, transportation of patients to and from aircraft into the hospital, unlocking doors, escorts to vehicles, and assistance with cars that will not start in the middle of the night.

**Smoking**

Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic are committed to providing a healthy, productive and safe environment for their patients, employees and visitors. Medical evidence clearly shows that smoking is harmful to the health of smokers. Smoke from cigarettes, cigars and pipes is also an irritant to many non-smokers and can worsen allergic conditions. Research indicates that long-term exposure to second-hand smoke will seriously threaten the health of the non-smoker.

As health-care institutions, Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic believe smoking is a serious health hazard and therefore are smoke-free. This policy extends to our satellite locations.

Smoking will not be allowed outside public entrances of the Hospital and/or Clinic by patients, visitors, employees, or house staff, or on Medical Center property except in designated areas.

**Designated Smoking Areas**

**Patient/Visitor**  In back of Patient Tower East, Level 1

**Employee**  Outside entrance to the corridor connecting Building 2 to the Power Plant

**Employee**  North side of Building 8

The success of this policy will depend upon the thoughtfulness, consideration and cooperation of smokers and non-smokers. All persons share in the responsibility for adhering to and enforcing the policy.

The management of Mary Hitchcock Memorial Hospital and the Dartmouth-Hitchcock Clinic realize that it will be difficult for some employees to refrain from smoking in the workplace. To this end, we periodically offer smoking cessation and educational programs.
The Dartmouth-Hitchcock Medical Center (DHMC) and its component institutions are committed to excellence in patient care, education and training, research; public service, and organizational/business conduct. To further the goal of excellence, all professionals at DHMC are expected to adhere to the Code of Professional Conduct in their interactions with patients, colleagues, health professionals, students, trainees, and the public. All DHMC employees, including nonprofessionals and volunteers, adhere to the Core Code of Ethical Conduct.

Professionals at DHMC are essential to our mission. All professionals at DHMC have self-imposed obligations that exceed legal and regulatory requirements. Professionals have responsibilities to the public, their colleagues, and those whom they serve. Our professions bring distinguished traditions of honorable and trustworthy conduct which help create our distinctive professional reputation.

The Code of Professional Conduct is a series of principles and their subsidiary rules that govern professional interactions. The Code consists of two complementary sections: professional obligations and professional ideals. "Obligations" refer to necessary professional behaviors that are required by the ethical foundation of medical practice, teaching, learning, research, and business conduct. "Ideals" refer to desirable professional behaviors to which professionals at all levels should aspire.

The Code applies to all professionals at DHMC but certain portions of the Code are more directly applicable to some disciplines than to others. Some have direct application in clinical settings, while others are applicable to teaching, research, or business activities. The general portions of the Code which discuss confidentiality, conflicts of interest, interpersonal relations, and professional ideals apply to all DHMC professionals because they are based on common principles of professionalism.

Failure to meet the professional obligations described below represents a violation of the DHMC Code of Professional Conduct. Items marked with an asterisk indicate behaviors that may additionally violate federal or state laws. Alleged infractions of the professional obligations of the Code will be dealt with by the appropriate DHMC disciplinary committees and processes. Alleged failure to meet the professional ideals, although less serious, also may be grounds for disciplinary review.

A. Professional Obligations

1. Respect for Persons
   - Treat those whom you serve, with whom you work, and the public with the same degree of respect you would wish them to show you.
   - Treat patients and colleagues with kindness, gentleness, and dignity.
   - Respect the privacy and modesty of patients.
   - Do not use offensive language, verbally or in writing.
   - Do not harass others physically, verbally, psychologically, or sexually. *
   - Do not discriminate on the basis of sex, religion, race, disability, age, or sexual orientation. *

2. Patient Confidentiality
• Do not share the medical or personal details of a patient with anyone except those health care professionals integral to the well being of the patient or within the context of an educational endeavor. *
• Do not seek confidential data on patients without a professional "need to know." *
• Do not discuss patients or their illnesses in public places where the conversation may be overheard.
• Do not publicly identify patients, in spoken words or in writing, without adequate justification.
• Do not invite or permit unauthorized persons into patient care areas of the institution.
• Do not share your confidential Clinic Information System or Veterans Affairs computer system passwords with unauthorized persons.

3. Confidential and Proprietary Information
• Do not share details of employee or staff grievances.
• Do not share the personal compensation data of others beyond those with a need to know.
• Do not discuss personal information about colleagues or coworkers.
• Do not discuss business negotiations outside of the context of the negotiation itself.
• Do not misuse electronic mail for patient or business purposes.

4. Honesty, Integrity
• Be truthful in verbal and in written communications.
• Acknowledge your errors of omission and commission to colleagues and patients.
• Protect the integrity of clinical decision making, regardless of how the medical center shares financial risk with or compensates its leaders, managers, and clinical staff.
• Do not knowingly mislead others.
• Do not cheat, plagiarize, or otherwise act dishonestly.
• Do not abuse special privileges, e.g., by making unauthorized long-distance telephone calls.
• Be truthful in all negotiations and business transactions.

5. Responsibility for Patient Care
• Obtain the patient's informed consent for diagnostic tests or therapies.
• Assume 24-hour responsibility for the patients under your care; when off duty, or on vacation, assure that your patients are adequately cared for by another practitioner.
• Follow up on ordered laboratory tests and complete patient record documentation conscientiously.
• Coordinate with your team the timing of information sharing with patients and their families to present a coherent and consistent treatment plan.
• Charge patients or their insurers only for clinical services provided or supervised. *
• Do not abuse alcohol or drugs that could diminish the quality of patient care or academic performance.
• Do not have romantic or sexual relationships with patients; if such a relationship seems to be developing, seek guidance and terminate the professional relationship.*
• Do not abandon a patient. If you are unable/unwilling to continue care, you have an obligation to assist in making a referral to another competent practitioner willing to care for the patient.
• Cooperate with other members of the health care team in clinical activities.

6. Awareness of Limitations, Professional Growth
• Be aware of your personal limitations and deficiencies in knowledge and abilities and know when and whom to ask for supervision, assistance, or consultation.
• Know when and for whom to provide appropriate supervision.
• Assure that students and other trainees have all patient workups and orders countersigned by the appropriate supervisor.
• Avoid patient involvement when you are ill, distraught, or overcome with personal problems.
• Do not engage in unsupervised involvement in areas or situations where you are not adequately trained.
• Act in accordance with your authorized role and level of responsibility.
• Keep abreast of professional, technological, and regulatory developments.

7. Deportment
• Clearly identify yourself and your professional level to patients and staff; wear your name tag when in patient areas.
• Dress in a neat, clean, professionally appropriate manner.
• Maintain a professional composure despite the stresses of fatigue, professional pressures, or personal problems.
• Do not introduce medical students as "doctor" or allow yourself as a medical student to be introduced as "doctor."
• Do not write offensive or judgmental comments in patients' charts.
• Do not criticize the medical decisions of colleagues in the presence of patients.
• Avoid the use of first names without permission in addressing adult patients.
• Conduct yourself in a professional manner as a representative of the organization.

8. Avoiding Conflicts of Interest
• Resolve all clinical conflicts of interest in favor of the patient.
• Avoid conflicts of interest whenever possible. Disclose all real or perceived conflicts of interest.
• Maintain your objectivity in all decision making and avoid creating any perceptions of impaired objectivity.
• Do not accept non-educational gifts of value from any existing or potential vendor, supplier, or consultant.
• Do not participate in incentive programs, especially when this involves prescribing drugs made by the company.
• Do not refer patients to laboratories or other agencies in which you have a direct financial stake.*
• Do not accept a "kickback" for any patient referral.*
• Do not recommend or participate in the negotiation of any contract from which you or your family would receive any direct or indirect financial benefit.
• Do not participate in personnel recruitment or performance management which would benefit you or members of your family.

9. Responsibility for Self and Peer Behavior
• Take the initiative to identify and help rehabilitate impaired students, physicians, nurses, and other employees with the assistance of the DMS Student Needs and Assistance Program, the DHMC Physicians Health Committee, the MHMH and HC Employee Assistance Program, or the employee's supervisor.
• Report serious breaches of the Code of Professional Conduct to the appropriate person.
• Indicate disapproval or seek appropriate intervention if you observe less serious breaches.
• Seek input and feedback from patients and colleagues on your own professional behavior.

10. Respect for Personal Ethics
• You are not required to perform procedures (e.g., elective abortions, termination of medical treatment) that you, personally, believe are unethical, illegal, or may be detrimental to patients.
• You have an obligation, however, to inform patients and their families of available treatment options that are consistent with acceptable standards of medical and nursing care.

11. Respect for Property and Laws
• Adhere to the regulations and policies of Dartmouth College, DHMC, and its component institutions, e.g., policies governing fire safety, hazardous waste disposal, and universal precautions.
• Adhere to local, state, and federal laws and regulations.
• Do not misappropriate, destroy, damage, or misuse property of DHMC or its component institutions. *
• Conduct business in accordance with all pertinent laws and regulations.

12. Integrity in Research
• Report research results honestly in scientific and scholarly presentations and publications.
• When publishing and presenting reports, give proper credit and responsibility to colleagues and others who participated in the research.
• Report research findings to the public and press honestly and without exaggeration.
• Avoid potential conflicts of interest in research; disclose funding sources, company ownership, and other potential conflicts of interest in written and spoken research presentations.
• Adhere to the institutional regulations that govern research using human subjects and animals.
• Cooperate with other members of the research team in research activities.

B. Professional Ideals

1. Clinical Virtues
• Strive to cultivate and practice clinical virtues, such as caring, empathy, and compassion.

2. Conscientiousness
• Fulfill your professional responsibilities conscientiously.
• Notify the responsible supervisor if something interferes with your ability to perform clinical tasks effectively.
• Learn from experience and knowledge gained from errors in order to avoid repeating them.
• Dedicate yourself to lifelong learning and self-improvement by implementing a personal program of continuing education and continuous quality improvement.
• Students and trainees should complete all assignments accurately, thoroughly, legibly, and in a timely manner.
• Students and trainees should attend scheduled classes, laboratories, seminars, and conferences except for justified absences.

3. Collegiality
• Teach others at all levels of education and training.
• Be generous with your time to answer questions from trainees, patients, and patients' family members.
• Shoulder a fair share of the institutional administrative burden.
• Adopt a spirit of volunteerism and altruism in teaching and patient care tasks.
• Use communal resources (equipment, supplies, and funds) responsibly and equitably.

4. Personal Health
• Develop a life style of dietary habits, recreation, disease prevention, exercise, and outside interests to optimize physical and emotional health and enhance professional performance.

5. Objectivity
• Avoid providing professional care to members of your family or to persons with whom you have a romantic relationship.
6. Responsibility to Society
   • Avoid unnecessary patient or societal health care monetary expenditures.
   • Provide services to all patients regardless of their ability to pay.

7. Advancement of Professionalism
   • Actively discuss and develop improved professionalism in society, professional organizations, and regulatory bodies.

* Behaviors that also may violate federal or state laws.
I. Purpose

The purpose of this policy is to delineate Fair Hearing procedures which assure due process to Residents who are recommended for non-renewal or dismissal from a program due to academic deficiency, non-academic deficiency or behavior incompatible with the role of the physician, or for other reasons that could significantly threaten a Resident’s intended career development.

II. Procedures

A. Academic Deficiency

Definition: Academic deficiency shall include, but not be limited to: (a) insufficient fund of medical knowledge, (b) inability to use knowledge effectively, and/or (c) behavior detrimental to the educational process or the care of patients.

Length and Goals of Remediation: A Resident whose academic performance does not meet departmental standards may be entitled to a defined period of remedial training in order to allow the Resident to improve academically and remain in the program.

B. Non-academic Deficiency

Definition: Medical and surgical disciplines require unique abilities and talents which are unrelated to intellect, motivation or other academic qualities common to the physician. When a Resident’s non-academic abilities and talents are judged insufficient by the Program Director, notification should be offered at an early stage, when a change in career direction will be least disruptive to the Resident.

Length and Goal of Remediation: A Resident whose non-academic performance does not meet departmental standards may be offered a defined period of remedial training in order to allow the Resident to improve and remain in the program. If correction is not deemed feasible by the Program Director, the Resident’s exploration of career alternatives and Program Director’s assistance in finding a position more in keeping with the Resident’s abilities and talents will take place.

C. Behavior Incompatible with the Role of the Physician

Definition: Some behavior may be judged by the Program Director to be illegal, immoral, unethical or so objectionable as to be incompatible with the role of the physician. When such behavior on the part of a Resident has been alleged and not refuted to the Program Director’s satisfaction, the Program Director, after discussion with the Director of GME, may recommend the Resident’s dismissal without an intervening probationary period.

Length and Goal of Remediation: There is no right to remediation under these circumstances.

D. Procedure for Notification of Non-renewal, Dismissal or Other Concerns

1. The Resident shall be informed in writing of the documented deficiencies or allegations and of the recommendation for non-renewal, dismissal or remedial training in a private meeting with the Program Director or a duly appointed representative. At this meeting or as soon thereafter as possible, the Resident shall be provided with a copy of this policy.

2. The Program Director shall submit written notification of the deficiencies, allegations and recommendation for non-renewal or dismissal to the Resident, the Director of Graduate Medical Education, the Chief of Staff of the Veterans Affairs Medical Center (White River Junction, Vermont) and the GMEAC where appropriate.
3. The Resident shall have five days, or within a mutually agreed upon time, from the date of this written notification to either (a) agree to the remedial plan (b) submit a resignation effective at a mutually acceptable date within the context of these guidelines, or (c) request a review of the case from the Director of Graduate Medical Education.

4. If the Resident does not reach resolution after meeting with the Director of GME and attempted mediation, the Resident may request a review in a written request for the Fair Hearing Process, as described below, to be followed.

III. Fair Hearing Process

At any time during this process, the Resident may resign. Once a written resignation has been delivered to the Program Director, however, the Resident shall be deemed to have waived all rights to a hearing or to a continuance of his/her appointment.

A. Hearing Procedure

1. Upon notification by the Resident that a review is requested, the Director of Graduate Medical Education or his designee shall form a committee consisting of the Director of Graduate Medical Education or his designee, a Hospital administrator, a house officer and two program directors or one program director and one physician faculty member selected by the Director of Graduate Medical Education or his designee (hereafter called the Committee.) The Director shall not select any person having a direct working relationship with the Resident. The Director of Graduate Medical Education or his designee shall chair the Committee.

2. The Committee shall schedule a hearing to occur within 14 days, or within a reasonable period of time based upon availability of the Resident, Program Director and Committee, but not less than seven days from the date of the Resident’s request for review. In the interim, the GME Office shall obtain all relevant evaluation and academic records.

3. All evidence available to the Committee shall be provided to the Resident and Program Director at least three working days prior to the hearing. The specification of reasons for non-renewal or dismissal or other factors in the original written notice shall not prevent the Committee from relying on other reasons which are presented at the hearing; provided that the Committee may, at the request of the Resident and without special notice, recess the hearing and reconvene later in order to allow the Resident adequate opportunity to address reasons not included in the notice. The Committee may also, at its sole discretion and without special notice, recess the hearing and reconvene later in order to study new evidence presented by the Resident at the hearing.

4. The Resident shall be present and prepared to proceed at the scheduled hearing or shall be deemed to have waived all rights to a hearing and to have accepted any adverse recommendation or decision made by the Committee. Another hearing may be scheduled at the Committee’s sole discretion if the Resident presents good cause for failing to appear or proceed. Hearings scheduled under these Guidelines shall be postponed only for good cause and at the sole discretion of the Committee.

5. The Resident and the Program Director may invite up to five witnesses each to present before the Committee. The Resident and Program Director may also ask others not invited to speak to submit written statements which will be collected for the GME Office at least five days prior to the hearing date.

6. The GME Director may appoint a separate hearing officer or designate a member of the Committee to preside over the hearing, to determine the order of procedure, to assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence, to maintain decorum and to make any necessary procedural rulings.

7. The hearing need not be conducted strictly according to the rules of law relating to the examination of witnesses or the presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered.

8. The Resident shall be entitled to submit, either prior to or during the hearing, memoranda concerning any issue of procedure or fact and such memoranda shall become part of the hearing record.
9. The order of presentation shall be determined by the Chair of the Committee. The Program Director shall be responsible for presenting appropriate evidence in support of the decision being questioned by the Resident. The Resident shall be responsible for presenting evidence which contradicts the Program Director's evidence or indicates that the Program Director's decision was arbitrary, unreasonable or capricious.

10. The Resident, the Program Director and the Committee may be entitled to consult with legal counsel in preparation for the hearing or with regard to other related matters.

11. Neither the Resident nor the Program Director shall be represented at the hearing by an attorney.

12. The Resident or Program Director may utilize a DHMC physician or staff member as an advisor during the Fair Hearing Process. This advisor may be present throughout the hearing.

13. The Committee may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

14. The hearing may not be tape-recorded.

B. Post-Hearing Procedure

1. The Committee shall conduct its deliberations in closed sessions. Only Committee members will be permitted to observe or participate in the deliberations.

2. Within 14 days, or a reasonable period of time after the conclusion of the hearing, the Committee shall make its final decision and shall deliver written notice thereof to the Program Director and the Resident. The notice shall indicate the reasons relied upon by the Committee in reaching its decision.

3. In the event the Committee should not concur with the Program Director’s recommendation for non-renewal or dismissal or other issues regarding the Resident, the Program Director may be asked to accept the Resident in the departmental program for an additional period of specified duration during which remedial efforts may be continued on the Resident’s behalf. The Resident’s appointment shall be continued under such conditions as shall be defined in writing by the Program Director to the Resident and to the Director of Graduate Medical Education.

4. There shall be no appeal from the decision of the Committee.

**GME Concern Policy**

*As revised and adopted by the GMEAC, December, 2000*

A concern is defined as an issue perceived by a resident or program director as needing resolution. Generally, such a matter will not significantly threaten a resident’s intended career development nor have the potential of leading to a recommendation of dismissal or non-renewal.

**Process for Addressing House Staff Concerns**

House staff concerns may be brought to the Chief Resident, Program Director, Department Chair, the House Staff Association, or to the Office of Graduate Medical Education. The process of mediation is available for house staff to address concerns or differences and eliminate or resolve a concern in a confidential and protected manner without fear of reprisal.

**Discussion**

Step I: Any concern may be discussed first with the Chief Resident, Residency Program Director, and/or the Department Chair. Discussions may include a member of the House Staff Association.

Step II: If not resolved, the concern may be brought to the attention of the Director or Assistant Director of Graduate Medical Education. The house staff member may also come directly to the Office of Graduate Education.
Medical Education and discuss the concern confidentially. The Office of Graduate Medical Education may act as mediator and intercede for the house staff member, so as to try to reconcile differences and resolve the concern in a confidential manner. The resolution of the Office of Graduate Medical Education using appropriate interaction with the resident, Program Director, and any others deemed integral to the decision, will be final.

Reduction in Program, Loss of Accreditation, or Closing Program Policy

Approved by the GMEAC, September 18, 1997

Commitment will be made by GME to ensure the DHMC Residency Training Program has continued support through the academic year and/or through completion of training by the current number of house staff before it is closed. The GME Resident Agreement will indicate clearly the agreement is for one training year at a time only, and renewal is dependent upon many factors including requirements set by the Accreditation Council for Graduate Medical Education.

GME will assist with new program information and transfers as appropriate.

Time Lost From Residency Training Years

Time lost from residency training must be made up according to the specifications of the Accreditation Council for Graduate Medical Education, Residency Review Committee for that particular specialty, and at the discretion of the Program Director.

Remuneration for time off, other than the specified three weeks paid vacation per year, and the particular benefits of health coverage, will be at the discretion of the Program Director and Director of Graduate Medical Education. House staff personal time and conference time is allowed at discretion of Program Director.

Sexual Harassment Policy

Sexual harassment is deemed to be a form of sex discrimination, and therefore any sexual harassment of house staff at the institution will not be tolerated. Sexual harassment is understood to mean:

Unwelcome sexual advances, or requests for sexual favors, when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual’s employment or status as a House Officer;
2. Submission to or rejection of such conduct by an individual is used as the basis for employment or academic decisions affecting him or her, or for the awarding or withholding of favorable employment or academic opportunities, evaluations or assistance, or
3. Other verbal or physical conduct related to sex when such conduct has the purpose or effect of substantially interfering with an individual’s performance at work or in study by creating an intimidating, hostile or offensive environment in which to work or learn.

Professional Deportment and Consideration of Others

House staff and other health team members should not expect to be mistreated or abused, nor be participants in the behaviors listed below. Any concern about the following may be discussed first with the residency program director, chief resident, and/or the department chairman. If not resolved, the concern may be brought to the attention of the Director or Assistant Director of Graduate Medical Education. The house staff member may also come directly to the Office of Graduate Medical Education and discuss the concern confidentially.

1. Verbal abuse
   Being yelled at
   Experiencing inappropriately nasty, rude or hostile comments
   Being belittled or humiliated
2. **Psychological-Institutional-Academic-Educational Abuse**
   Being assigned tasks as punishment rather than for educational purposes, such as running personal errands or arranging meals for others
   Academic neglect or lack of communication
   Inappropriate scut work (no learning value)
   Threatening an unjustifiably bad evaluation
   Having someone else take credit for your work
   Unwarranted removal of normal privileges
   Unfair or malicious competition
   Having others put you at an unfair disadvantage by cheating
   Hostility from others after an academic or research achievement
   Having others try to turn a supervisor against you
   Making negative remarks to you about training as a physician
   Excessive workload
   Excessive sleep deprivation

3. **Physical abuse**
   Threatening you with physical harm
   Subjecting you to physical harm or unwanted touching
   Placing you at unnecessary medical risk, such as having you do procedures for which you have not been trained or feel ready to perform, on patients whose illnesses could pose a risk to you

4. **Sexual Harassment**
   Sexual advances or requests for dates or sex
   Unwanted physical contact
   Speculation about one’s sexual behavior or orientation
   Sexual slurs or names
   Discomfiting humor
   Malicious rumors
   Implication that opportunities are being offered or withheld based upon physical attributes, behavior or participation

5. **Discrimination based upon gender, culture or race**
   Stereotyping based upon gender, culture, race or arbitrary personal characteristics
   Slurs or demeaning terminology
   Discomfiting humor or humor based upon stereotypes
   The implication of superiority or inferiority based upon gender, culture or race
   Stated or implied slurs about a group, or an individual as a member of a group, based upon gender, culture, race or other arbitrary characteristics
   Implication that opportunities are being offered or withheld based upon gender, culture, race or other arbitrary characteristics

6. **Ethical or professional misconduct**
   Cover-up of mistreatment of patients or others
   Alcohol or drug abuse
   Falsifying information
   Cheating in research
   Cover-up of unethical behavior

11-5-02gme-dole
Non-Discrimination, Equal Employment Opportunity, and Affirmative Action

It is the policy of Mary Hitchcock Memorial Hospital to provide equal employment opportunities for all house staff, employees and applicants, in compliance with our Affirmative Action Plan, as follows:

- To recruit, train, hire, transfer, and promote in all job classifications without regard to race, color, religion, age, sex, national origin, physical or mental disability, veteran status, sexual orientation or marital status.
- To base decisions on employment in accordance with the principles of equal employment opportunity.
- To make promotion decisions in accordance with the principles of equal employment opportunity.
- To provide that all other personnel actions and terms and conditions of employment will be administered without regard to race, color, religion, age, sex, physical or mental disability, national origin, sexual orientation, or marital status.

The Equal Employment Opportunity Officer for Mary Hitchcock Memorial Hospital is William V. Geraghty, Vice President of Human Resources.
The Dartmouth-Hitchcock Privacy Group
Policy Statement on the Privacy & Confidentiality of Patient Information

The Dartmouth-Hitchcock Privacy Group is a single affiliated covered entity formed for the purposes of complying with the requirements of the Health Insurance Portability and Accountability Act (HIPAA), the federal privacy rule.

Dartmouth-Hitchcock Privacy Group
Mary Hitchcock Memorial Hospital
Dartmouth-Hitchcock Clinic
Dartmouth-Hitchcock Psychiatric Associates
West Central Behavioral Health
Dartmouth Medical School
Cheshire Medical Center
Upper Connecticut Valley Hospital
Weeks Medical Center
Mount Ascutney Hospital & Health Center

STATEMENT OF PURPOSE
It is our intent to establish policies and procedures governing the privacy of our patients’ personal health information and to provide guidelines for the security and appropriately controlled release of such information, consistent with applicable federal and state laws, including the federal privacy rule.

We support the patient’s right to privacy (that is, the right to control access to his or her personal health information) and accept responsibility to keep secure and confidential the information collected about our patients during their encounters with us. We also understand that releasing parts or all of that information is appropriate under certain circumstances, such as providing for continuity of care, participating in approved research and educational activities, complying with laws, and assuring reimbursement for services provided, and that such releases provide benefit to the patient and/or to society.

SCOPE AND DEFINITION OF TERMS
This Policy Statement applies to all personnel of the Dartmouth-Hitchcock Clinic, the Mary Hitchcock Memorial Hospital, the Dartmouth Medical School, and other members of the Dartmouth-Hitchcock Privacy Group (together, “Dartmouth-Hitchcock”), as well as business associates, volunteers, and students participating in medical educational programs within these organizations.

This Policy Statement applies to all types of personal health information, regardless of form. Health information is information we receive or create relating to someone’s past, present, or future physical or mental health or condition, or the provision of or payment for health care provided to someone. Personal health information (defined in the federal rule as “individually identifiable health information” or “protected health information”) is any item containing health information about a patient that reasonably could directly or indirectly identify the patient, whether in electronic, hard copy, oral, or any other format, original or copied, or any electronic data base, whether free-standing or networked, or any medical records, whether maintained by the medical records department or any other department, section, or provider. This Policy Statement covers personal health information regardless of storage medium or location. In addition to medical records, it covers operating schedules, registration forms, billing and claims information, financial documents, patient conference notes, provider’s personal notes, photographs or videos, information in registries, room assignments, radiology films, cine film, computer-generated microfilm, electronic mail correspondence, etc. We expect technology to continue to change the media upon which patient information is stored, and we intend to extend our privacy policies and procedures to these as they come into use.

Types of release covered by this Policy Statement (“uses” and “disclosures” as defined by the federal privacy rule) include, but are not limited to, written, verbal, telephonic, or electronic, transmitted intentionally or unintentionally, in public or in private, inside or outside the walls of our organizations. Also included is information released to regional health data networks, insurance companies, managed care providers, medical data banks and other data repositories, affiliated institutions, researchers, business associates, government agencies, news organizations, pharmaceutical and medical equipment suppliers, clergy, and family and friends of patients – in short, all releases of personal health information.
This document provides philosophy and direction for decision-making and procedure development throughout the Dartmouth-Hitchcock Privacy Group. Medical record departments will develop implementation policies to provide mechanisms for appropriate protection and releases of information. These implementation policies will define the circumstances under which an unauthorized access to or release of a patient’s personal health information will constitute a breach of confidentiality. At a minimum, any disclosure of personal computer password(s) which risks unauthorized access to confidential patient information will be construed as a breach of confidentiality. If you have any questions about this Policy Statement or release of any patient-related information, contact the medical records department in your institution.

GENERAL PRINCIPLES

1. Patients own their personal health information, and with limited exceptions set forth in the federal rule or state law (e.g. psychotherapy notes), they have a reasonable right to access their own health information and to control access to it by others, to correct or comment on information contained in their medical record, and to know if and how their personal health information is being used for purposes other than treatment, payment, or health care operations. Patients have a right to receive notice of their rights and our obligations and policies regarding their personal health information.

2. Although individual Dartmouth-Hitchcock institutions own the media on which the information is kept (paper records, videos, photographs, electronic storage media, etc), we hold the personal health information stored on those media in trust for the benefit of our patients. We will not use, disclose, or release such information to persons other than the patient or his/her authorized representative except:
   A. For purposes of treatment, payment and health care operations, as authorized by the federal privacy rule;
   B. As required by law (e.g. to comply with statutory reporting requirements) or as permitted by law and by our written privacy policies (e.g. in medical emergencies, or for medical research purposes, or for public health oversight functions); and
   C. Otherwise, only with the patient’s specific written authorization.

3. Individual employees and other members of the workforce of each Dartmouth-Hitchcock institution are held accountable to read, know, and understand this Policy Statement, to adhere to approved specific policies and procedures for protecting the privacy of patients’ personal health information, and to exercise care and good judgment in accessing, using, or disclosing such information.

4. We assume that an individual provider responsible for the care of a patient should be able to access all or any part of the patient’s record deemed relevant to treatment. In all other circumstances, only the minimum amount of personal health information necessary for the relevant purpose will be released to those individuals or entities with a need or right to access such information.

5. We believe that the patient should be informed as much as possible about the release and use of his/her information. We will provide patients with a written notice of our privacy policies and practices, explaining how we use and disclose their personal health information to provide them with care, and we will ask them to acknowledge receipt of that notice.

6. A person other than the patient may authorize access to or release of the patient’s information only when granted by a competent patient or his/her attorney, the parent or guardian of a minor child, the guardian or conservator of an incompetent adult patient, or by a court order.

7. We support access to patient information to evaluate exposure to risk or to evaluate patient complaints, but it is our intent to limit access to the minimum information required by the minimum number of persons necessary to handle directly the evaluation or complaint.

STATEMENTS ON SPECIFIC SITUATIONS

Treatment The sharing of medical information required for the patient’s ongoing care is assumed to be in the patient’s best interest. To facilitate a patient’s treatment, disclosure of personal health information regularly occurs among Dartmouth-Hitchcock providers. Patient information will also be released to non-Dartmouth-Hitchcock providers when appropriate to do so, such as in a medical emergency, when providing test results and/or reports to referring physicians, or to facilitate follow-up care by other providers. The patient should also be informed that attending, consulting, and referring physicians may have access to their medical record for treatment purposes.

Payment All patients should be informed about the following:
- that data from their medical records, required to support claims for payment for covered services, may be
released to primary and secondary payers;
• that payers maintain claims databases on their clients;
• that payers may contribute patient data to the Medical Information Bureau;
• that third-party reviewers may request and receive patient information over the telephone or by electronic transmission for utilization review, pre-authorization of services, or case management purposes, or may review the medical record on the premises.

Health Care Operations  Patient-specific information is essential to many corporate administrative functions required to support modern health care delivery systems. The federal privacy rule refers to these as “health care operations” functions. They include activities such as:
• Surveys by accrediting bodies and evaluations of clinical outcomes (non-patient specific and non-diagnostic information should be used for these purposes whenever possible, and in all cases, only the minimal amount of information should be accessed and only by those with a need to know the information);
• Quality assurance functions used to evaluate the adequacy and appropriateness of care rendered. (Documentation generated during this process is confidential and is protected by state statutes from disclosure. When disseminating information from these reviews at section or department meetings, patient-specific information is to be deleted whenever possible);
• Credentialing and re-credentialling of individual providers;
• Clinical education programs for medical students and other trainees;
• Legal, auditing, and compliance functions;
• Business planning, management, and general administrative functions; and
• Fundraising consistent with the federal privacy rule.

Medical Research The release and use of patient-specific information for medical research must be approved by the appropriate Institutional Review Board. Articles, papers, copies of records, x-rays, photographs, and/or other artifacts of research must not divulge patient identity without authorization of the patient or his/her legal representative.

Medical Education  We recognize the necessity of sharing patient-related information to fulfill our educational mission. This includes, for example, reviewing a patient’s medical records with residents, medical students, and other trainees engaged in clinical education under the supervision of an attending physician.

Release of Information to News Media Requests from the news media for patient information should be referred to the public affairs department within each institution.

Reporting Required By Law  In accordance with state law, certain diagnoses (e.g. communicable diseases) and circumstances (e.g. evidence of child abuse) require reporting to state agencies without patient consent. Each institution’s medical records department policy will explicitly describe these situations with references to the applicable statutes and regulations.

OTHER RELEASES PERMITTED BY LAW
The Dartmouth-Hitchcock institutions have specific policies governing requested releases of patients’ personal health information that are permitted but not required by law, e.g. in connection with public health oversight, research, workers compensation, or law enforcement activities. Reference should be made to these specific policies in the event of questions about the appropriateness of a requested release.

Release of Sensitive Information  State and federal laws contain special confidentiality provisions regarding sensitive diagnoses. These include, but are not limited to, HIV test results, mental health records, and records of patients who have been diagnosed or treated for drug or alcohol abuse. These laws require special authorizations or court orders for release of information. Each institution’s medical record department policy will describe how to handle these situations.

State and federal laws contain special confidentiality provisions regarding sensitive diagnoses. These include, but are not limited to, HIV test results, mental health records, and records of patients who have been diagnosed or treated for drug or alcohol abuse. These laws require special authorizations or court orders for release of information. Each institution’s medical record department policy will describe how to handle these
situations.

Releases to Business Associates  The Dartmouth-Hitchcock institutions have many relationships with independent contractors (“business associates,” as defined in the federal privacy rule) who assist us in performing essential health care operations, payment, and other functions using patient-specific health information provided by us. These business associates include consultants, attorneys, auditors, utilization reviewers, debt collection agencies, software vendors, data analysts and aggregators, research sponsors, accreditation agencies, and others. In each case our contract with a business associate must include specific provisions governing the use and disclosure of personal health information by the business associate, as required by the federal privacy rule.

COMPUTERIZED PATIENT RECORDS
We support the concept of the computerized patient record and believe that it enhances the effectiveness and efficiency of medical care.

A computerized patient record should be structured so that patient records created and stored on the system can also be admitted as evidence in court. This means, in general, that the computerized patient record must:

• be kept during the ordinary course of business
• be created contemporaneously with the event being documented
• include documentation dates, times, and the identity of every individual making or modifying any entry (maintaining the original plus the modified entry)
• be protected by publicized and enforced rules against unauthorized access to and disclosure of personal health information.

By definition the Dartmouth-Hitchcock Clinic/Mary Hitchcock Memorial Hospital medical record contains information in both paper and electronic formats, so medical record information on the computer (Clinical Information System) or in hard copy will be considered part of the medical record. All confidentiality rules and security precautions set up for the paper record also apply to the computerized patient record.

IMPLEMENTATION POLICIES AND PROCEDURES
This Policy Statement is intended as the basic policy foundation for the Dartmouth-Hitchcock institutions with respect to the privacy of our patients’ personal health information. Clinical departments, sections, and program offices will adopt and implement more specific policies and procedures, consistent with the federal privacy rule, other applicable law, and this Policy Statement. These more specific implementation policies and procedures will include, without limitation:

• A notice to patients of our privacy policies and procedures (in paper, electronic, and any other media used for communication with patients)
• An acknowledgement of receipt of that notice, to be signed by patients (when possible)
• Authorizations for other specific disclosures of personal health information
• Minimum necessary use and disclosure protocols and criteria
• Medical Records Department release of information policies
• Procedures for statutory reporting requirements by jurisdiction
• Information Systems policies and procedures
• Security policies appropriate to the range of technologies used within information systems
• Business Associate contracts
• Affiliate Information Systems Agreements
• Billing and claims policies and procedures
• Employment policies and procedures relating to role-based access to personal health information in any form
• Complaints, investigations, and sanctions policies and procedures
• Workforce training standards, on a role-based need-to-know basis

REVIEW/AMENDMENT OF THIS DOCUMENT AND THE IMPLEMENTATION POLICIES
Because of the rapidly changing healthcare environment and technologies, we anticipate that this Policy Statement as well as the implementation policies and procedures can represent only the current thinking and law at any point in time and, therefore, will need periodic reviewing and updating. This review will be
coordinated by the appropriate governing bodies or their designees.

XI • DHMC HOUSE STAFF LEAVE POLICY
December 6, 2004 – Approved and accepted by the GME Advisory Committee

It is the policy of DHMC to make leaves of absence (LOA) available to its House Staff employees (interns, resident or fellows) to meet individual needs in accordance with the intent of the following policy. Specific information on appropriate process and benefit continuation is available at the Graduate Medical Education (GME) office.

Satisfactory resolution of issues affecting the on-call schedule is the responsibility of the resident requesting LOA and the Program Director. Consideration should be given to the needs of that House Staff member, the welfare of others training in the program, and the needs of the program as a whole.

Each specialty board residency review committee (RRC) and/or intramural residency program has its own unique requirements related to board eligibility or program completion. House Staff members may be required to make up absent time should there be a limit on missed time from training as specified by any of these bodies. In general, if the House Staff member received appropriate pay, i.e., unused vacation time, during this leave, the make up time will be served with pay. If the leave was not paid during this leave, the pay scale will be identical to the pay scale in force during the leave when the House Staff member returns to duties.

DISABILITY LEAVE Medical Leave of Absence
A leave of absence (LOA) for a resident’s own medically verified disability will be granted for the length of the disability to a maximum period of 90 days.

For the purpose of this policy, disability includes any injury or illness including those arising from pregnancy, childbirth, and related medical conditions that temporarily impede a resident from being able to perform the essential functions of their position.
A female House Staff member affected by pregnancy, childbirth or related medical conditions will be treated in the same manner as any resident affected by any other temporary disability. Any House Staff member absent from work, or expected to be absent from work for more than two consecutive calendar weeks due to disability should be placed on disability leave. The leave date begins on the initial date of the inability to work because of the disability.

All House Staff members, regardless of benefit status or hire date, are eligible for a disability leave of absence.

House Staff members on disability leave will be reinstated to a position in accordance with the Family and Medical Leave Act of 1993, if applicable. For situations that extend beyond FMLA protection, the reinstatement policy will be as stated in the GME Red Book except in workers’ compensation situations when an employee has a potential right to job reinstatement for eighteen (18) months from date of injury. Also, see Specialty Board Requirements in Leave Policy. Depending on the nature of the medical leave, a Program Director may request a Fitness for Duty evaluation through Occupational Medicine prior to the resident’s return to work.

Disability leave may be granted with full pay and continued benefits for 90 days. Disabilities extending beyond 90 days will be covered according to Long Term Disability (LTD) policy. This would include disabilities involving pregnancy, pre and post partum.

PERSONAL LEAVE
A leave of absence (LOA) for personal reasons may be granted to House Staff with at least one year of continuous service at DHMC for a period up to, but not exceeding, 90 days. This leave will be unpaid. A personal leave may be used by male house staff in the event of a birth of child, or for the adoption of a child. The leave will commence at the birth or placement of the child.
Mothers of newborn babies may request up to an additional six weeks of personal leave beyond their disability leave for delivery. **Unless this further six weeks is based on necessity or requested as vacation time, it will be unpaid.** The combination of the disability and personal leave should not exceed 12 weeks (90 days).

Personal leave must be approved by the Program Director, Department Chairperson and the Director of GME. It is suggested that personal leaves not qualifying under the Family and Medical Leave Act (FMLA) be submitted at least 60 days in advance. Application for personal leave is accomplished by completing and submitting the GME LOA Request Form. See Specialty Board Requirements in previous section.

**FAMILY AND MEDICAL LEAVE ACT (FMLA)**

In January 1993 the Family and Medical Leave Act (FMLA) was passed by Congress and became law in August 1993. This Act entitles employees who have worked for at least one year and completed a minimum of 1250 hours in that year up to 12 work weeks away from their employment due to serious health conditions of their own, or of certain family members. The Act states this is an unpaid leave that guarantees job reinstatement and continuation of benefits up to 12 weeks in a rolling year (a rolling year begins when the event occurs and rolls to one year to the day later). DHMC House Staff are paid for the disability leave portion of their FMLA by DHMC policy.

Qualifying events covered by FMLA are:

1. The birth of a child of the House Staff member, and to care for such child
2. The placement of a child with the House Staff member for adoption or foster care
3. To care for a spouse, child or parent of the House Staff member if such spouse, child or parent has a serious health condition (see definition)
4. A serious health condition that makes the House Staff member unable to perform the functions of their job

A serious health condition is defined as an illness, injury, impairment or physical or mental condition that involves inpatient care in a hospital, hospice or residential medical care facility, or continuing treatment by a health care provider for more than three days.

As stated, FMLA is an unpaid leave except in disability situations of the House Staff member. Benefits will be continued during the FMLA. Should the House Staff member fail to return from leave, the employer may recover the premium for the dental coverage incurred during the leave time.

Program Directors may request that a House Staff member use paid vacation, personal or sick pay so long as they request the same for non-FMLA situations. Family leave may be taken on an intermittent or reduced hourly schedule. This arrangement requires approval from the Program Director and the Director of GME.

Two House Staff members who wish to take leave to care for their newborn, or newly placed child, are limited to a 12 week aggregate. However, a leave requested for a serious medical condition of a qualifying member (child or spouse) entitles both members to 12 weeks each.
Death in the Family

In the event of a death in the immediate family, the Department Director or Practice Manager may approve up to five (5) days bereavement leave with pay (equals 40 hours for employees in the F40 employment benefit classification, and is pro-rated for others). Mary Hitchcock Memorial Hospital and Dartmouth-Hitchcock Clinic North acknowledge that some relationships are generally closer than others. For those relationships, the Department Director or Practice Manager may give the maximum of five (5) days of bereavement leave with pay. For these purposes, immediate family includes: spouse, partner, parents, grandparents, grandchildren, mother/father-in-law, brother, sister, step-parents, step-brother, step-sister, child, step-child, brother-in-law and sister-in-law. The leave may be used over an extended period of time to accommodate the reasonable needs of the employee.

The intent of the policy is to provide time to recognize the emotional impact of the death of a member of the immediate family. The Hospital and Clinic accepts that there may be other relationships which have equal meaning to an employee but cannot provide bereavement paid time off for all such extended relationships. If it does not impact departmental functions, Department Directors/Practice Managers will try to approve unpaid time off, or Earned Time requests for such non-covered situations.

July 1, 1993
GRADUATE MEDICAL EDUCATION
HOUSE STAFF REQUEST FOR LEAVE OF ABSENCE
Approved by GMEAC October 25, 2004

This is to be completed by House Staff member and submitted to Program Director 60 days, when possible, prior to beginning of leave. Please refer to House Staff Leave Policy in the GME Red Book.

Name: ___________________ GL-Level: _________ Program: ___________________

Purpose for leave request (circle):
A. **Medical Leave**
   1. A health condition that makes you unable to perform functions of the training program including pregnancy, pre and postpartum complications
B. **Personal Leave**
   1. To care for a spouse, child or parent due to a serious medical condition
   2. The placement of a child with you for adoption or foster care
   3. Military obligation
C. **Vacation Request**

Leave will begin on:____________________  Anticipated return date:____________________

Leave WITH pay from:___________________ through finish date:____________________

Leave WITHOUT pay from:_______________ through finish date:____________________

# of days with pay:_____________________

RETURN DATE:_____________________

SEVEN or more consecutive days off must be reported to GME. Before return of House Staff member from disability leave to program, Program Director must receive physician provider letter confirming house staff member is “physically and mentally able to resume requirements of the training program”. This will be placed in house staff file with copy sent to GME indicating actual end date of leave and return to training. A “Fit for Duty” evaluation may be requested through the Department of Occupational Medicine. Illnesses anticipated to extend beyond 90 days should have LTD application submitted by House Staff member as soon as need for extension is identified, or by end of 60 days of disability.

I understand that any leave of absence granted me is in accordance with the terms and conditions stated in the GME House staff Policies and Procedures Red Book as well as Federal and State regulations. I am aware of my program training requirements and obligations.

_____________________________________________________________________________________

House staff member signature (print name beside signature)  Date

Program Director must fill out following:
Will house staff member need to make up time caused by leave? YES □ NO □

If yes, how many days: ______ How many months to complete: ____________

Names of rotations and how much time (in days) needed to complete each rotation: ____________
I have reviewed this request with the above named. I approve the request. YES □ NO □ If no, please explain, with comments or special instructions:

Program Director signature (print name beside signature) Date
REQUEST FOR PART-TIME TRAINING IN RESIDENCY OR FELLOWSHIP PROGRAM

Program Director must fill out the following:
Please state the number of hours per week/percentage of time the house staff member will train:

________________________________________________________

Please detail the house staff member's exact duties (include dates) for the duration of the part-time training:

________________________________________________________

I understand that any variation from full-time training granted me is in accordance with the terms and conditions stated in the GME House Staff Policies and Procedures Red Book as well as Federal and State regulations. I am aware of my program training requirements and obligations.

House staff member signature Date
If request is due to a health condition that makes the house staff member unable to perform functions as required by the training program on a full-time basis: Please attach a note of verification from your physician.

Program Director Approval:

Will house staff member need to make up time caused by part-time training? YES □ NO □
If yes, how many rotations: ______________ How many months to complete: ___________

Names of rotations and how much time (in days) needed to complete each rotation:

________________________________________________________

The above named and I have reviewed this request together.
I approve the request. YES □ NO □
If no, please explain. Comments or special instructions:

Program Director signature Date:

Director of GME signature Date:
Response to request for leave of absence must be given to house staff member within two business days after receipt of request. Keep one copy of signed request in house staff file and send one copy to GME.

10-04 GME dole/martin
XII • MOONLIGHTING

Dartmouth-Hitchcock Medical Center
Mary Hitchcock Memorial Hospital

Moonlighting Policy
Approved by the GMEAC December 6, 2004

For purposes of this document the term resident will be used for residents and fellows. The term moonlighting means to work for pay outside the requirements and stipend of the Dartmouth-Hitchcock Medical Center training program and applies to DHMC residents and fellows only.

General

1. Dartmouth-Hitchcock Medical Center neither encourages nor discourages moonlighting.

2. The resident must have a permanent license to practice medicine in each state where he/she moonlights. A permanent license is different from a training license.

3. The resident must obtain permission to moonlight from Graduate Medical Education and his/her Program Director.

4. Graduate Medical Education and the resident’s Program Director must determine that a moonlighting or locum tenens position does not conflict with assigned duties and responsibilities within the training program.

5. The resident’s Program Director must sign the Moonlighting Request Form for each moonlighting assignment and may restrict moonlighting based upon training program considerations.
Dartmouth Hitchcock Medical Center
Mary Hitchcock Memorial Hospital
GME Resident/Fellow MOONLIGHTING REQUEST FORM

This form must be sent to GME for all moonlighting regardless of location

Request for permission to work for compensation outside responsibilities and stipend of training program.
Resident/Fellow’s name (print)_________________________Beeper #____________
Current training program_________________________Training year level____

Is training program accredited by ACGME? Yes/No
Is resident/fellow Board eligible or certified? Yes/No If yes, which Board?________________________

Plans to moonlight where: 1. ____________________________
2. ____________________________
3. ____________________________

Name of supervisor(s): 1. ____________________________
2. ____________________________
3. ____________________________

Facility  Department  Section

Describe work to be performed at each facility and check applicable box(es)               Inpt    Outpt
1. ____________________________  ____________________________
2. ____________________________  ____________________________
3. ____________________________  ____________________________

Moonlighting assignment start date: ____________________________ finish date: ____________________________

Will the services you provide as a moonlighter be billed in your name as an attending?
Yes/No (if you do not know, check with your Hiring Attending or Practice Manager)

RESIDENT – please read and sign below
I understand it is my responsibility to obtain the appropriate license, credentials, DEA certificate (if necessary) and malpractice insurance coverage before working. I am legally eligible to work and will not exceed the level of my training and scope of my employment. I am responsible for any billing done in my name.

Resident signature: ____________________________ Date: ____________

Program Director (check appropriate statement)

☐ I have reviewed this request and give the above resident/fellow permission to moonlight for this assignment. I cannot attest to this individual’s competency outside his/her training program responsibilities.

☐ I do not give this resident/fellow permission to moonlight for this assignment.

Program Director signature: ____________________________ Date: ____________

Graduate Medical Education

Received GME Moonlighting Request Form Date: ____________
Received Moonlighting checklist for Hiring Attending Date: ____________
Received Moonlighting Letter of Agreement Date: ____________
Copy of Request form sent to Risk Management Date: ____________
Copy of Request form to OCA/Med. Staff Office & Phys Recruitment/HR Date: ____________
Copy of Moonlighting checklist & original letter sent to Prov Enrollment Date: ____________

Final 10-04 C.Dole
XIII • HOUSE STAFF ASSISTANCE

GME House Staff Assistance

GME will act as advocate for house staff members and will act to promote and maintain house staff physician well-being and, when necessary, rehabilitation. Confidentiality of house staff will be paramount.

GME will provide procedures to assist house staff; a training and education program for house staff; and will provide them with an awareness of problems that may lead to impairment. GME will establish methods for assessment and treatment of house staff members who are impaired.

House staff may call the Employee Assistance Program (EAP) at 603-650-5819 and ask for consultation, counseling and referrals. House staff members may call GME and ask for Carolyn Dole, Assistant Director, or H. Worth Parker, MD, Director, and be given the names of providers with specific expertise. House staff may also consult the Provider Expertise List for assistance.

At GME Orientation, and in the Red Book provided annually, all house staff are given information about resources that include counseling, psychological support services and related assistance, as part of the GME House Staff Assistance and Education Program.

DHMC Employee Assistance Program
Telephone: 603-650-5819

The Employee Assistance Program (EAP) is a counseling resource for all employees, including house staff members, and their families. It is designed to help deal with a variety of life stressors that can affect family relationships, emotional or physical well-being, and job performance. Employees and family members are allowed up to six counseling sessions annually. These sessions last approximately one hour and generally can be scheduled at the employee’s or family member's convenience. Any size problem is appropriate for the EAP. Sometimes it is helpful just to have an objective person with whom to talk things over.

How do you seek assistance from the Employee Assistance Program?

Contact the Program yourself, if you wish. You or a family member can call the EAP for an appointment or for information.

A supervisor may suggest you make an appointment if job performance is affected. A friend, family members, co-worker, or healthcare provider may also refer you to the EAP.

Emergencies: When the counselor is not immediately available and emergency assistance is needed call 1-800-556-6249 to reach the Psychiatric Emergency Services.

Evenings and weekends call: 1-800-556-6249 and ask for the Doctor-on-Call in Psychiatry. Be sure you tell the person you see or talk with that you are an MHMH employee.

Confidentiality

Any conversation between the EAP counselor and an employee is strictly confidential. EAP records are never shared or in any way incorporated into an employee’s personnel file or medical record.
XIV • LOAN DEFERMENT/FORBEARANCE AND REVOLVING LOAN FUND

Loan Deferments and Loan Forbearance

GME helps fill out loan deferment and loan forbearance forms. You must get the appropriate form from your lender, fill out your section completely, sign it, and bring it to the GME Office. Be sure that the form has the return address on it or include the return envelope. It also helps us if you call for or bring any necessary instructions as well as appropriate signatures. We will complete our section of the form, send it to the state licensing board, if that is required, and send it to the lender. We pay the postage.

We mail these forms out approximately once a week. We keep a copy of every form we send in your file. You can come to look at them any time and make copies for yourself if you wish. Remember to plan ahead if you need our help sending in your deferment and forbearance requests.

You can no longer defer as a student. Most deferments are for internship or residency. In some cases we feel comfortable claiming Graduate Fellowship status as “Post-Graduate Medical Fellow.” Loan requirements vary, so bring instructions and your patience, and we’ll try and help you.

Regulations for the Residents’ Revolving Loan Fund

THE HITCHCOCK FOUNDATION

1. Loans are restricted to full-time Residents and Fellows in hospitals affiliated with the Dartmouth Hitchcock Medical Center.
2. Loans to an individual will not exceed $2,000 and will be made only for living expenses incidental to the period of training.
3. Applicants with combined credit card and charge card debt in excess of $5,000 must arrange for credit counseling prior to the approval of an application and a distribution of funds from the Resident’s Revolving Loan Fund. Please include a plan arranged by the credit counselor with your application.
4. The Loan Committee sets the terms for each loan and the repayment schedule. Loan repayment schedules may vary but the term of the loan will not exceed three years from completion of training at Dartmouth-Hitchcock Medical Center. A borrower may initiate partial or full repayment of a loan at any time. However, for short-term loans, i.e. those with a repayment schedule less than three years post graduation, the interest will be 12% per annum beginning the day after the loan is due. For loans written for the maximum allowable period, i.e. three years post graduation, interest will be 12% per annum beginning one year from completion of training at Dartmouth-Hitchcock Medical Center.
5. An applicant must secure the signature of his/her department chair prior to submitting a Loan Application for consideration by the Foundation.
6. When a Loan Application is approved by the Loan Review Committee, the borrower must sign a promissory note prior to the distribution of funds.
7. If a loan is in default or a borrower declares bankruptcy, the borrower will pay all costs of collection including attorney's fees. Note: Public Law 105-244 (10/98), an amendment to Section 523 of the Bankruptcy Reform Act of 1978, stipulates that this education loan is not dischargeable in a bankruptcy proceeding.
8. The Foundation must be notified in writing of changes in the borrower address during the period of the loan.

Source: The Hitchcock Foundation, 11/03
HITCHCOCK FOUNDATION
RESIDENTS' REVOLVING LOAN FUND APPLICATION

1. __________________________
   Name of applicant

2. __________________________
   Home address, City State Zip)

3. __________________________
   Other address, if any, for current correspondence, department extension/ beeper number

4. __________________________
   Social Security Number ________________ Citizen of ______ (Country)

5. __________________________
   Name and address of nearest relative not living with you

6. List dependents:
   Spouse __________________________ Children __________________________

7. __________________________
   Medical school
   Graduation date ________________

8. List below graduate training already obtained, including internship, other residencies, fellowships, etc.
   (name of institution and inclusive dates).

9. __________________________
   DHMC residency training in:
   (Department)

10. __________________________
    Inclusive dates of residency at DHMC (start and graduation dates):

11. __________________________
    Financial assistance you will receive from family or other sources during your residency?

12. References (Give the names, addresses and phone numbers of two physicians with whom you have been
    intimately connected in your training program, e.g. department chief or senior staff member)
    __________________________
    Name
    Phone number

    __________________________
    Name
    Phone number
13. General summary of the purpose and need for this loan:

__________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________

__________________________________________________________________________________________________________________________________

14. Amount of loan request: $_____________

15. Date needed _______________

I have read the terms and agree to abide by the regulations for the Residents' Revolving Loan Fund.

_____________________________________________________________________________ Date

Signature of applicant

_____________________________________________________________________________ Date

Approved, Department Chair

_____________________________________________________________________________ Date

Approved, Chair, Residents' Revolving Loan Fund

Submit your application to:

**The Hitchcock Foundation**
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756

11/03
Mary Hitchcock Memorial Hospital is responsible for providing a safe environment for patients, visitors, house staff and employees. It is the policy of Mary Hitchcock to establish the Hospital as a drug-free workplace and to provide a drug-free awareness program. It is also a condition of house staff employment under federal law to abide by the terms of this policy.

To meet the objective of assuring a drug-free workplace, the Hospital requires that:

- The manufacture, distribution, use, sale, purchase, transfer or possession of a controlled substance during working hours and/or on Hospital property is prohibited, unless performed by those legally authorized to do so as a part of necessary patient-related care.
- House staff are not permitted to work while under the influence of alcohol or controlled substances except as otherwise qualified herein.
- House staff who are using drugs as a medical therapy must use them only in accordance with a valid prescription by a licensed physician.
- Use of prescribed or over-the-counter drugs that may impair ability to function must be disclosed to the attending supervisor.
- House staff will be subject to disciplinary action, up to and including dismissal, for bringing unauthorized drugs or alcoholic beverages to work, being under the influence of such substances while working, using them while working, or dispensing, distributing, selling or manufacturing them in unauthorized or illegal manner on Hospital premises, work sites or property.
- House staff experiencing drug- or alcohol-related problems are strongly encouraged to seek help through the hospital's Employee Assistance Program (EAP), 603-650-5819. EAP counseling is confidential and is not part of the house staff’s personnel file or medical record and will not have an impact on an individual’s performance appraisal. Job performance alone, not the fact that an employee is receiving counseling, will be the basis for all performance appraisals.
- House staff diagnosed as chemically dependent may be granted a medical leave of absence to undertake rehabilitation treatment. House staff returning from leave will be requested to complete a follow-up treatment plan with the EAP counselor before returning to work.
- A hospital security representative may search house staff and their personal property, as well as Hospital facilities and property, if there is reasonable cause to believe that any part of this policy is being, or has been, violated.
- House staff may be requested to have a medical assessment, including blood and urine testing, to determine the presence or absence of drugs or alcohol in their systems where there is reasonable cause to believe that the house staff member is or has been working while under the influence of drugs or alcohol. Mary Hitchcock will take reasonable steps to confirm test results and maintain confidentiality. House staff who refuse to submit to such testing will be subject to discipline, up to and including immediate discharge.
- Federal law requires that house staff paid through a federal grant notify their program director of any criminal drug statute conviction occurring in the workplace no later than five days following the conviction. If an employee is paid through a federal grant and notifies his/her program director of a conviction, Mary Hitchcock is required to notify the federal agency within ten days after receiving notice from the employee of such a conviction. House staff must also indicate on their training license application for the Board of Registration in Medicine for the State of New Hampshire whether they were or are now dependent on alcohol or drugs. The Board reserves the right to perform further background checks after issuance of the house staff training license.
Required Tests

Reasonable Suspicion Drug or Alcohol Tests

An employee or house staff member must submit to a work impairment evaluation, including drug or alcohol testing, when a manager or supervisor believes that the employee or house staff member may have or has violated the drug or alcohol prohibitions contained in this policy. Reasonable suspicion determination must be based on specific, current observations that may be verbalized, including, but not limited to, the employee’s appearance, behavior, speech, or body odors. In addition, these observations may include indications of the chronic and withdrawal effects of drugs or alcohol. A reasonable suspicion determination may be based on a single instance of misconduct including the failure to perform or the improper performance of an employee’s job duties or any conduct which involved a potential risk of harm to our employees, patients, visitors, or other individuals working at the hospital or on its property.

Any supervisor or manager who has reasonable suspicion to believe that an employee or house staff member violated this policy, may immediately remove the employee from work and request such employee or house staff member be evaluated by the Occupational Medicine Department.

Self-Identification of Substance Abuse Problem

If an employee or house staff member voluntarily self-identifies as having a drug or alcohol problem and voluntarily requests assistance for such a problem prior to being selected for a drug or alcohol test required by this policy, the Hospital will refer such employee or house staff member to the Hospital’s Department of Occupational Medicine for an evaluation and the Employee Assistance Program for referral to an appropriate counseling, treatment or rehabilitation program, if recommended. Upon such employee’s or house staff member's return to duty, he or she may be required to submit to a drug or alcohol test and, if tested, must receive a negative result. Such employee or house staff member also may be required to submit to follow-up testing in accordance with the applicable Agreement of Rehabilitation and Conditions for Continued Employment.

Consequences for Refusal to Submit to Tests and Policy Violations

The Hospital has determined the following consequences for all employees or house staff members found to have violated this policy:

Refusal to Submit

Any employee or house staff member who engages in the following conduct, which constitutes a refusal to submit, will be subject to disciplinary action up to and including possible termination: (1) failure to complete the testing forms; (2) failure to provide a specimen, or an adequate amount of specimen; (3) engaging in conduct that clearly obstructs the testing process, including the adulteration of substitution of a urine specimen or attempting to substitute or adulterate a specimen; (4) failure to notify the Hospital that he or she was in an accident/incident as described by this policy or is not ready for testing after an accident/incident (except as necessary to obtain assistance or medical care); (5) failure to report directly to the collection site after notification; or (6) delaying the collection, testing or verification process.
XVI • EMERGENCY COURSE REQUIREMENTS AT DHMC

A. Basic Life Support (BLS) Healthcare Provider (CPR)

Course content: One and two person adult resuscitation
One person child & infant resuscitation
Obstructed airway management in the adult, child, & infant
Mouth/to/mask & bag-valve-mask ventilation
Automated external defibrillation using Philips AED

Requirement:

a. Required for every physician
b. BLS Healthcare Provider may be achieved at either Provider or Instructor level.

Length of recognition: Two years

Course schedule:

a. Provider training for house staff during orientation to DHMC; recertification available every May thereafter
b. Provider training held second Wednesday of every month from 9 to 3 p.m.

Cost of course: No charge for Provider Course ($10 for text)

B. Advanced Cardiac Life Support (ACLS)

Course content: Advanced airway management
Pharmacological intervention
Defibrillation/external pacing
Acute coronary syndrome
Acute ischemic stroke
Cardiac rhythm disturbances
Post resuscitation care

Requirement:

a. Required for Internal Medicine and Anesthesia house staff, GL 2 & 3
b. Desirable for Pediatric house staff, GL 2 & 3
c. ACLS may be achieved at either Provider or Instructor level

Length of recognition: Two years

Course schedule: Provider & Provider Recertification Courses are held during year; see Life Support Program poster and web page

Cost of course: No charge to CPR Team members
Others: $100 for Provider Course (texts included) & $50 for Provider Recertification Course ($35 additional for texts)

C. Pediatric Advanced Life Support (PALS)

Course content: Airway management
Pharmacological intervention
Cardiac rhythm disturbances
Defibrillation
Arrest prevention
Fluid resuscitation
Neonatal resuscitation

Requirement:

a. Required for all Pediatric house staff, GL 1, 2 & 3
b. PALS may be achieved at Provider or Instructor level

Length of recognition: Two years
Course schedule: Provider & Provider Recertification Courses are held during year; see Life Support Program poster and web page

Cost of course: No charge to CPR Team members
Others: $225 for Provider Course (texts included) & $75 for Provider Recertification Course ($40 additional for texts)

D. **Neonatal Resuscitation Program (NRP)**

Course content: Delivery room management
a. Initial steps of resuscitation
b. Use of bag/valve device
c. Chest compressions
d. Endotracheal intubation
e. Pharmacological intervention

Requirement: a. Required for all Pediatric house staff, GL 1, 2 & 3
b. NRP may be achieved at Provider or Instructor level

Length of recognition: Two years

Course schedule: Several courses are held during year; watch for poster

Cost of course: No charge

E. **Defibrillation Competency**

Course content: Manual defibrillator/external pacemaker operation using Zoll device

Requirement: Required for all Internal Medicine, Pediatric, and Anesthesia house officers; Psychiatric house officers GL 1 only; Family Practice GL 2 & 3 levels; Obstetrics/Gynecology GL level 1; Critical Care, Pediatric and Cardiology fellows.

Length of recognition: Two years

Course schedule: For designated house officers during orientation to DHMC; during ACLS course for Internal Medicine house officers at end of GL 1 year

Cost of course: No charge

For more information and sign-up, call Life Support Program, ext. 5-7089.

*(JB  Emergency Course Requirements for HOs.doc 11/09/04)*
Basic Life Support (BLS) Training

The following excerpt from the 2004 “Policies for Cardiopulmonary Resuscitation” developed by the CPR Committee and approved by the Staff Board of Governors relates to the institutional policy for BLS.

It is well documented that training and competency in Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation Program (NRP) substantially improve performance of life support skills involved in a resuscitation. In order to insure that BLS is administered as quickly as possible to a victim of cardiopulmonary arrest, it is required that all health care providers who deliver direct patient care or support personnel who come in direct contact with patients demonstrate competency in BLS every two years as evidenced by completing the American Heart Association Health Care Provider Course or the Heartsaver with Automated External Defibrillator Course - or its equivalent. This is to include all nurses, physicians, personnel in the Cardiopulmonary Laboratory, physical therapists, occupational therapists, speech pathologists, dietitians, diet technicians, phlebotomists, social workers, providers in Occupational/Employee Health, respiratory care providers (RCP’s), Transportation orderlies, technologists in Radiation Therapy and Radiology, Operating Room personnel, IV Team members, flight paramedics, receptionists, and Security officers. Electricians, electronics personnel, and Biomedical technicians must be competent in BLS according to Occupational Safety and Health Administration Standards because of the nature of their work. In addition, it is recommended that Auxiliary Volunteers who transport patients demonstrate competency in BLS.

IMPLEMENTATION POLICY

Each department will determine the categories of staff who are direct care providers or support personnel who come in direct contact with patients and must be trained in BLS. All designated persons will be trained in BLS within eight weeks of employment and will continue to demonstrate competence every two years.

A penalty may be imposed if BLS status is not current for an individual.

a. Attending staff are not granted admitting privileges unless BLS is current.

b. If a nurse, technologist, or technician is not retrained by the end of the following month after his/her BLS expiration date, he/she will be suspended without pay until competency is demonstrated. A contract for BLS retraining will then be established with the appropriate leadership person. If an employee is on leave of absence at the time his/her BLS expires, he/she is required to demonstrate competency within four weeks of returning from LOA.

c. If a house staff member is not retrained by the end of the following month after his/her BLS expiration date, he/she may lose medical staff privileges.

If a person is unable to perform the BLS skills due to a physical disability or medical condition, the BLS written test must be completed and written physician verification must be given to one's supervisor and reviewed annually.

11/04
Introduction
E-mail is a good method for quick and efficient communications among providers and, in a more limited way, among providers and patients. E-mail is easy and convenient, replaces telephone calls and reduces telephone tag. It can be posted and read at any time, and is an integral part of our business because, by increasing efficiency, it contributes to improved patient care.

Intent of This Document
The use of e-mail in clinical communication has many advantages, but there are also some potential risks that e-mail users should bear in mind. The intent of this document is neither to require nor prohibit the use of e-mail in clinical communications, but rather to set forth guidelines and warnings for its appropriate use. The advantages of using e-mail in patient care greatly outweigh the risks.

Patient Confidentiality
The same considerations of patient confidentiality apply to the use of e-mail in clinical communications as to any other clinical communication. (See below for some specific suggestions).

Warnings
E-mail communications (including “trash,” which can be retrieved from a hard disc) are discoverable by subpoena and may be used in legal proceedings.

Security is not assured. At this time DHMC e-mail is not encrypted (i.e., coded to prevent unauthorized viewing). Once sent, e-mail can be forwarded, changed, stored, or printed without the sender’s knowledge. E-mail communication is asynchronous, that is, the receiver picks up e-mail at a time of her/his choosing, not the sender’s. There may be no immediate feedback. E-mail systems may be down for unexpected and unpredictable periods of time. The emotional context and subtle nuances of communication are diminished, if not lost, through the use of e-mail technology. Some e-mail properly belongs in the medical record (see below), but practices and policies will vary from provider to provider or institution to institution. Be aware that the sender and receiver may have different rules about what is included in the medical record and that the same e-mail message may be incorporated in the medical record at one institution, and not at another. E-mail may be inadvertently sent to unauthorized recipients at the touch of button. Exercise every caution in making sure the e-mail transmittal is addressed to the right party and only to that party.

Guidelines
Use professional language, titles, content, and tone. If the text is for chart documentation, refer to only one patient in a message, and include the medical record number and name of the patient (but not in the header). Patient consent to use e-mail for communications is not necessary but in order to avoid misunderstandings a clinician may wish to document the circumstances under which a clinician and patient have agreed to communicate by e-mail. General e-mail protocols and courtesies should be observed (See the DHMC home page for general guidelines on e-mail use).

Use of E-Mail to Create and/or Distribute Medical Record Documentation. There is a function in the Clinical Information System (CIS) that was developed to facilitate e-mail transfer of clinical information between providers. This function is easy to use, has built-in privacy warnings to both sender and receiver, and there is an audit trail to document appropriate usage. This function should be used whenever possible. It is better to use the “Notes” function in CIS for documentation for the medical record than the e-mail system. “Notes” have the advantage that they are linked both to provider and to the patient record, thereby eliminating the need for the clinician to print, authenticate, and deliver a copy of the e-mail communication to Medical Records.

E-mail may be used by secretaries and transcriptionists to transmit already transcribed letters and reports from one provider to another provider, or, where appropriate, from provider to patient.

(Source: DHMC Information Systems Policies and Guidelines, 11-00 – www.hitchcock.org/intranet/IS/library/docs/email.htm)
Statement of Environmental Principles

In an effort to promote healthier communities both locally and globally, Dartmouth-Hitchcock Medical Center (DHMC) is committed to improving environmental management throughout the organization. DHMC will manage its operations in a manner demonstrably protective of environmental and human health.

DHMC will constantly seek new and innovative ways to meet its environmental goals through conservation, reduction, reuse and recycling programs, and through partnering with others in the community to safeguard the environment.

DHMC will apply these principles to achieve optimal environmental standards consistent with institutional goals and financial considerations.

In an effort to respect and protect the earth’s resources, and to minimize environmental damage, DHMC will:

- Manage, minimize and eliminate, whenever possible, the use of hazardous materials.
- Use renewable natural resources and conserve non-renewable natural resources through cost efficient use and careful planning.
- Use pollution prevention initiatives to reduce negative environmental impacts.
- Minimize the generation of waste through source reduction, re-use and recycling programs.
- Conserve energy and improve the energy efficiency of our operations and make every effort to use and promote environmentally safe, cost-effective and sustainable energy sources.
- Ensure the health and safety of our employees and house staff by promoting safe work practices, reducing exposure, using safe technologies, and implementing effective emergency preparedness programs.
- Provide employees and house staff with safety and environmental information through training and education programs in order for them to make work/practice decisions in support of these principles.

**HITS Manual Mission Statement**

DHMC maintains a *Hazardous Infectious Training Safety Manual* that outlines data sheets and procedures relative to a broad range of materials. *HITS* is available in a hard-copy form in all departments. It is also available online through the DHMC Intranet. Each area of the facility has a designated *HITS* coordinator.

The purpose of the *HITS Manual* is:

- To ensure policies, procedures and material safety data sheets are accessible and available at all times.
- To standardize the information available to employees.
- To facilitate the recognition of the *HITS Manual* in every area by standardization of the appearance of the binder.
- To facilitate the dissemination of information contained in the *HITS Manual* by designating a “*HITS Coordinator*” in each area.
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<tr>
<td>Vascular Surgery</td>
<td>Mary Biathrow</td>
</tr>
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