## RESIDENCY PROGRAMS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Program Director</th>
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<tbody>
<tr>
<td>Anesthesiology</td>
<td>Marc Bertrand, MD</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Kathryn Zug, MD</td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>Wayne Dysinger, MD, MPH &amp;</td>
</tr>
<tr>
<td></td>
<td>Carolyn J. Murray, MD, MPH</td>
</tr>
<tr>
<td>Family Practice</td>
<td>Kevin Shannon, MD</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Mary Margaret Andrews, MD</td>
</tr>
<tr>
<td>Internal Medicine / Psychiatry</td>
<td>B. Vincent Watts, MD</td>
</tr>
<tr>
<td>Neurology</td>
<td>Morris Levin, MD</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>David Roberts, MD</td>
</tr>
<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>Karen George, MD</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>Charles Carr, MD</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>J. Oliver Donegan, MD</td>
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<tr>
<td>Pathology</td>
<td>Jeffroy Brennick, MD</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Carole Stashwick, MD</td>
</tr>
<tr>
<td></td>
<td>Acting: Leslie Fall, MD</td>
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<tr>
<td>Primary Care Medicine</td>
<td>Kelly Kieffer, MD</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Ronald Green, MD</td>
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<tr>
<td>Psychiatry (Child &amp; Adolescent)</td>
<td>Robert Racusin, MD</td>
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<tr>
<td>Radiology / Diagnostic</td>
<td>Jocelyn Chertoff, MD</td>
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<tr>
<td>Surgery, General</td>
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<tr>
<td>Surgery, Plastic</td>
<td>Carolyn Kerrigan, MD</td>
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<tr>
<td>Urology</td>
<td>Elizabeth A. Gormley, MD</td>
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## FELLOWSHIP PROGRAMS

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<tr>
<td>Cardiology</td>
<td>Edward Catherwood, MD &amp; David Malenka, MD</td>
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<tr>
<td>Cardiology-Interventional</td>
<td>John Robb, MD</td>
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<tr>
<td>Cardiac Electrophysiology</td>
<td>Mark Greenberg, MD</td>
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<tr>
<td>Cardiovascular Interventional Rad.</td>
<td>Michael Bettmann, MD</td>
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<tr>
<td>Critical Care, Medicine</td>
<td>Howard Corwin, MD</td>
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<tr>
<td>Critical Care, Anesthesiology</td>
<td>Athos Rassias, MD</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Stuart R. Gordon, MD</td>
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<tr>
<td>Hematology / Oncology</td>
<td>Thomas Davis, MD</td>
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<tr>
<td>Infectious Disease</td>
<td>Jeffrey Parsonnet, MD</td>
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<tr>
<td>Neonatology</td>
<td>Robert Darnall, MD</td>
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<tr>
<td>Neuropsychiatry</td>
<td>Thomas McAllister, MD</td>
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<tr>
<td>Pain Management</td>
<td>Ralph Beasley, MD</td>
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<td>Pharmacology</td>
<td>David Nierenberg, MD</td>
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<td>Psychiatry, Forensic</td>
<td>A. M. Drukeinis, MD</td>
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<tr>
<td>Psychiatry, Addiction</td>
<td>Amy E. Wallace, MD</td>
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<tr>
<td>Psychiatry, Geriatric</td>
<td>Thomas Oxman, MD</td>
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<tr>
<td>Pulmonary / Critical Care</td>
<td>Thomas Prendergast, MD</td>
</tr>
<tr>
<td>Radiation / Oncology</td>
<td>Edward Van Dyk, MD</td>
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<tr>
<td>Sleep Disorders</td>
<td>Glen Greenough, MD</td>
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<td>Rheumatology</td>
<td>Lin Brown, MD</td>
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<tr>
<td>Spine</td>
<td>William Abdu, MD</td>
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<tr>
<td>Vascular Surgery</td>
<td>Jack Cronenwett, MD</td>
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<tr>
<td>X Sectional Imaging</td>
<td>Robert Harris, MD</td>
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## SECTION CHIEF AND/OR DEPARTMENT CHAIR

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<tr>
<th>Specialty</th>
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<tbody>
<tr>
<td>Anesthesiology</td>
<td>Alan Green, MD</td>
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<td>Dermatology</td>
<td>Gregory Holmes, MD</td>
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<td>Neurology</td>
<td>William Hickey, MD</td>
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<tr>
<td>Neurosurgery</td>
<td>Richard Dow, MD</td>
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<tr>
<td>Obstetrics &amp; Gynecology</td>
<td>Donald St. Germain, MD</td>
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<td>Richard Dow, MD</td>
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<tr>
<td>Primary Care Medicine</td>
<td>Blair Brooks, MD &amp; Mark Splaine, MD</td>
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<td>Psychiatry</td>
<td>Alan Green, MD</td>
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<td>Peter Spiegel, MD</td>
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<td>Richard Dow, MD</td>
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<td>Urology</td>
<td>Richard Dow, MD</td>
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*ldr 12-19-02*
Graduate Medical Education

Policies and Procedures for House Staff

Training Year 2003-2004

Mary Hitchcock Memorial Hospital
Dartmouth-Hitchcock Medical Center
One Medical Center Drive
Lebanon, NH 03756-0001

603-650-5748 (Voice)
603-650-5754 (Fax)

lisa.d.roderick@hitchcock.org
www.dartmouth-hitchcock.org/pages/GME/
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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 serve also 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's), 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 policy 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 provide 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 behaviors 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 on-line 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 supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and ongoing 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 is expanding 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, and 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 of the need to collaborate with others in caring for individual patients and in 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 programs. During the 2003-2004 training year opportunities will include:

- GME Cross-program Conference Series
- Biomedical Libraries Workshops and Grand Rounds
- Asynchronous On-line 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 7-day circulation reserve at the Matthew-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 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 (Institutional DIO), 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.

**Inpatient Settings at Night and on Weekends:** Faculty members are available at DHMC 24 hours per day (or generally present in-house but always 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 reviews 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 supervises 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 of Residents - Quality Assurance

Residency programs are considered to be an integral part of the medical center-wide quality assurance (QA) system. Performance evaluations of residents are coordinated and administered by Residency Program Directors (staff physicians within a particular specialty) as part of the DHMC quality assurance structure and process. Performance evaluations should offer critical and objective observations and comments concerning a resident’s clinical care of patients. Evaluations should also reflect clinical skills and quality academic knowledge, evaluations are considered to be confidential and privileged (by New Hampshire law RSA 151:13a).

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

11-12-02

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 on-going internal review processes to ensure continuous quality improvement.

(Source: ACGME Outcome Project)
Graduate Medical Education Residency Program Eligibility Requirements

It is a requirement of the New Hampshire Board of Medicine to have successfully passed USMLE Steps 1 and 2, or NBME Parts 1 and 2, or have obtained ECFMG Certification before incoming 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.

In addition to successful completion of USMLE Steps 1 and 2 (or NBME Parts 1 and 2), applicants must meet at least one of the following qualifications to be eligible for appointment to an accredited DHMC Residency program:

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

2. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

3. Graduate of a medical school outside the United States and Canada and meets the following qualifications:
   a. has received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or
   b. has a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are in training; and
   c. has the ability to obtain a J-1 visa (non-USA citizens only); and is
   d. fully competent in written and oral English; and is
   e. willing and able to appear for a personal interview.

4. In order to participate in an accredited Graduate Medical Education clinical training program at DHMC, foreign international medical graduates must seek ECFMG sponsorship as a J-1 exchange visitor. 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.

   Important visa note: The H-1B visa is not offered for training in accredited programs at DHMC. This visa status is considered appropriate for temporary workers holding professional level degrees, hired to work in specialty occupations, or for employment in a specified work place. It is not used at DHMC for GME accredited training programs.

5. Graduate of a medical school outside the USA who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
Selection Process for MHMH GME Accredited Residency Programs

1. Applicants can obtain program information on the World Wide Web at [http://www.dhmc.org](http://www.dhmc.org) and clicking the left-bar menu choice Residency/Fellowship Programs to access the DHMC Residency Directory. Programs will specify if they are utilizing ERAS Electronic Residency Application Service or if applications are accepted by mail. Based upon this information, applicants may call or write a specific Residency program and request the GME brochure, program brochure, general information sheet, and application form. Some programs allow applicants to use the Universal Application Form, but they must complete the GME application form as well. As of July 2002, 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, and Psychiatry.

2. The program must receive from the applicant: a completed application form, 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 New Hampshire Board of Medicine, successful completion of USMLE Steps 1 and 2, or NBME Parts 1 and 2, or have obtained ECFMG Certification 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 are 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 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 meeting all Eligibility Requirements and being physically present and medically able to begin training on the agreed upon date in the mutually signed GME Resident-Fellow Agreement of Appointment, and pending obtaining the appropriate training 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 certify that I understand and will meet these requirements.

__________________________________________
Name

__________________________________________
Date

GME / 10-24-02
Graduate Medical Education Fellowship Program Eligibility Requirements

It is a requirement of the New Hampshire Board of Medicine to have successfully passed USMLE Steps 1 and 2, or NBME Parts 1 and 2, or have obtained ECFMG Certification before incoming 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.

In addition to successful completion of USMLE Steps 1 and 2 (or NBME Parts 1 and 2), applicants must meet at least one of the following qualifications to be eligible for appointment to an accredited DHMC Residency program:

1. Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduate of a medical school outside the United States and Canada and meets the following qualifications:
   e. has received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment; or
   f. has a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction in which they are in training; and
   g. has the ability to obtain a J-1 visa (non-USA citizens only); and is
   h. fully competent in written and oral English; and is
   e. willing and able to appear for a personal interview.
4. In order to participate in an accredited Graduate Medical Education clinical training program at DHMC, foreign international medical graduates must seek ECFMG sponsorship as a J-1 exchange visitor. 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.
   Important visa note: The H-1B visa is not offered for training in accredited programs at DHMC. This visa status is considered appropriate for temporary workers holding professional level degrees, hired to work in specialty occupations, or for employment in a specified work place. It is not used at DHMC for GME accredited training programs.
5. Graduate of a medical school outside the USA who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
6. 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.
Selection Process for MHMH GME Accredited Fellowship Programs

1. Applicants can obtain program information on the World Wide Web at http://www.dhmc.org and clicking the left-bar menu choice Residency/Fellowship Programs to access the DHMC Fellowship Directory.

2. Programs will specify if applicants may call or write and request the GME brochure, fellowship program brochure, general information sheet, and application form. Applicants may use the Universal Application Form, but must complete the DHMC GME application form as well. The program must receive from the applicant: a completed application form, 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 New Hampshire Board of Medicine, successful completion of USMLE Steps 1 and 2, or NBME Parts 1 and 2, or have obtained ECFMG Certification no later than January 1st of the year in which he or she anticipates a June or July Fellowship start date.

4. Programs call applicants and make arrangements for interview with Program.

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

6. Written agreement outlining the terms and conditions of appointment to Fellowship program is mailed to new Fellows with new employment forms by GME.

7. Participate in mandatory GME and program orientations for all new Fellows.

8. New training year usually begins July 1.

9. Ability to be accepted and appointed for training is contingent upon meeting all Eligibility Requirements and being physically present and medically able to begin training on the agreed upon date in the mutually signed GME Resident-Fellow Agreement of Appointment, and pending obtaining the appropriate training 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 certify that I understand and will meet these requirements.

____________________________________________________________________________________________

Name            Date

GME / 10-24-02
Mary Hitchcock Memorial Hospital
DARTMOUTH-HITCHCOCK MEDICAL CENTER

Resident/Fellow Agreement of Appointment

This Agreement of Appointment is entered into between -------- , MD, and Mary Hitchcock Memorial Hospital for graduate training as a ------- Resident/Fellow 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 J--- -, 200- through J---- --, 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 Eligibility Requirements 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 radiological 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.

Non-Renewal 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.

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></td>
</tr>
<tr>
<td>Assistant Director, Graduate Medical Education</td>
<td></td>
</tr>
</tbody>
</table>

9/02 GME
II. 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 pre-requisite 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 FISCAL YEAR OCTOBER 1, 2002- SEPTEMBER 30, 2003

<table>
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<th>GL LEVEL</th>
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<tr>
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</tr>
<tr>
<td>GL-7</td>
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</tr>
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</table>

Medical Insurance

Health care coverage for house staff is administered through Comprehensive Benefits Administrator, Inc. (CBA) of South Burlington, VT. 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. The House Staff Summary Plan Description describes the benefits available to house staff members of GME training programs sponsored by the hospital.

1. If you marry, have a child or if you have a change in your 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 30 days of marriage, change of domestic partner status, birth, or adoption. 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, Comprehensive Benefits Administrators require notification of any additional dependents. It is your responsibility to inform Graduate Medical Education of this change.

2. Coverage starts on the first day of the month after the month in which you are hired. If you begin work on the first day of a month you will be covered for that month, if you begin on the 2nd day or later you will be covered as of the first of the following month. Coverage continues to the end of the month you finish your training in, plus one month, after which you can elect to pay for COBRA coverage or wait until your new medical coverage begins.

3. Your coverage includes an enhanced managed care program which requires you to call CBA 3 days prior to all non-emergency and non-maternity hospital admissions not in our network. Please refer to your Summary Plan Description for details.

4. We expect the coverage will be adequate to pay for any essential emergency room and hospital medical expenses for House Staff or your family. If your claim is refused and the GME Office considers that refusal unreasonable, the Hospital Accounting Office will actively pursue reversal of the decision. If your claim is still refused some accommodation will be made.

You will receive an identification card from Comprehensive Benefits Administrators about three weeks after your starting date. Your health care information is on one side and your pharmacy information is on the other side. If you have questions after reviewing your House Staff Summary Plan Description, call GME, ext. 5-5748.

For full details of the medical insurance benefit see House Staff Summary Plan Description of the Welfare Benefits for House Staff Employees of Mary Hitchcock Memorial Hospital.
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>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$120.12</td>
<td>$ 4.62</td>
</tr>
<tr>
<td>Double*</td>
<td>$224.90</td>
<td>$ 8.65</td>
</tr>
<tr>
<td>Family</td>
<td>$365.04</td>
<td>$14.04</td>
</tr>
</tbody>
</table>

(Double means: either for the employee and spouse or employee and one child)

Coverage is provided by Delta Dental, claims should be mailed to:

Northeast Delta Dental
One Dental Drive
P.O. Box 2002
Concord, New Hampshire 03302-2002

You may call 1-800-832-5700 about your coverage.

Please stop by GME and pick up forms before you go to the dentist. Any dentist who accepts 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 Benefits 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 Benefits 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 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 3 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 Benefits 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 Fridays, 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 and 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. MHMH is the common law employer of a resident with the right to direct and control the resident. Consequently, 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 anytime 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 4 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).

Holidays
Both the Hospital and the Clinic will observe holidays during the year 2003 as follows:

- New Year's Day: Wednesday, January 1, 2003
- President's Day: Monday, February 17, 2003
- Independence Day: Friday, July 4, 2003
- Labor Day: Monday, September 1, 2003
- Thanksgiving Day: Thursday, November 27, 2003
- Christmas Day: Thursday, December 25, 2003
- New Year's Day: Thursday, January 1, 2004

Holidays - Additional
Reasonable steps will be taken to allow house staff time off to observe additional religious or other holidays. If approved these may be taken as part of earned vacation, holiday time or personal days, or without pay. At least 2 weeks notice should be given by the house staff member.

Vacation
House staff at all levels are allowed three weeks time off per training year.
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

The Dartmouth Hitchcock Medical Center has an on site Child Care Center designed to care for the children of employees and house staff. It includes 8 classrooms, 2 large indoor play areas and 2 separate outdoor playgrounds. Adjacent to the Medical Center, it can accommodate children from 6 weeks through 5 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. If you are interested in this care, please apply as early as possible by calling 1-603-643-6504.

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

Lab coats are provided to all house staff. Two coats are provided at the beginning of training and additional two coats are available upon request each year or when coats become soiled and difficult to launder. We use the Angelica Brand coats (style 87008) sold by the Dartmouth Bookstore on the third level of the Medical Center. The sizes are unisex even coat sizes ranging from about 32 to about 52. If incoming house staffs are close by, sample coats are available at the bookstore to try on before deciding on size.

The bookstore also offers more expensive all-cotton coats. If these coats are chosen over the Angelica Brand coat style listed above, the GME Office will reimburse for the costs to GME purchased from Angelica plus embroidery for each coat, up to two a year.

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, sorted alphabetically by last name.

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 Benefits for House Staff Employees of Mary Hitchcock Memorial Hospital.

Dependent Care Assistance Program

The Hospital understands there is often an economic need for more than one wage earner in many families in today’s society. 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 Benefits for House Staff Employees of Mary Hitchcock Memorial Hospital.
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 MD’s, 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.

If you begin your training on June 26, you will attend the June 24 AND June 25 orientation. You must arrive by 6:30 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 a.m. in Auditorium F. You will finish each day at approximately 5:30 p.m.

GME Orientation Information and Topics

- Anti-Microbial Program
- Beepers and beeper codes
- Biomedical Libraries Information
- Charting Guidelines
- Communications
- Clinical Information Systems
- Core Curriculum
- Deceased Patient Coordination
- DHMC Intranet
- Discharge Summaries
- Laboratory Policies
- Laboratory Testing for: a positive titer for measles, German measles and varicella (chicken pox), if resident is not immune, s/he 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
- On-line Evaluations
- Organ Donor Information
- Payroll Information
- Pharmacy Information and DEA numbers
- Pharmacy and Therapeutic Committee
- Quality Assurance
- Respiratory Guidelines
- Risk Management
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

House Staff Association

The House Staff Association is comprised of 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, 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 General Competencies 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, 7 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 a 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 September 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 work load 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 enterprise and do not offer discounts.

If you have any problems, DO NOT DISCUSS THEM WITH THE CASHIERS, call Graduate Medical Education.
VI. 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 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 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 Residents 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: ____________________________

GL Level

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: ________________________________________________________________

Administrators 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

THIS SECTION MUST BE COMPLETED OTHERWISE FORM WILL BE RETURNED

[ ] License Obtained: ____________________________  If not, please explain: ____________________________

Date

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
VII. 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 do 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 retain 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.

Death in the Family

In the event of a death in the immediate family, the department director may approve up to 5 days bereavement leave with pay. Immediate family includes: spouse, parents, stepparents, grandparents, mother/father-in-law, brother, sister, child, and stepchild. 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 accepts that there may be other relationships, which have equal meaning to an employee, but can not provide bereavement paid time off for all such potential relationships. If it does not significantly impact departmental functions, directors should try to approve unpaid time off, vacation, or personal day requests for such non-covered situations.

Notary Public

There are two notary publics 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.
Reduction in Program, Loss of Accreditation, or Closing Program Policy
Approved by GMEAC 9/18/97

Commitment will be made by GME to ensure 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.

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 includes providing a lost and found department, assistance with ambulance security, transporting patients to and from aircraft into the hospital, unlocking doors, providing escorts to vehicles, and assisting with cars that will not start in the middle of the night.

Smoking

Mary Hitchcock Memorial Hospital and the 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 Hitchcock Clinic believe smoking is a serious health hazard and therefore is a smoke-free environment, including 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**

<table>
<thead>
<tr>
<th>Patient/Visitor</th>
<th>In back of Patient Tower East, Level 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Outside entrance to the corridor connecting Building 2 to the Power Plant</td>
</tr>
<tr>
<td>Employee</td>
<td>North side of Building 8</td>
</tr>
</tbody>
</table>

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 Hitchcock Clinic realize that it will be difficult for some employees to refrain from smoking in the work place. To this end, we will periodically offer smoking cessation and educational programs.

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.
VIII. GME Visa Policy

The GMEAC agrees with the AMA recommended J-1 status for training purposes in the DHMC Residency Training Programs.

If any program feels strongly the need, and wishes to offer a position to an IMG applicant with other than a J-1 visa status, approval must be given by the Director of GME, and will be for only such reasons as recognition of "extraordinary ability."

This policy voted as approved by GMEAC September 18, 1997.

Eligibility for ECFMG Sponsorship as a J-1 Exchange Visitor

Through its program of certification, the Educational Commission for Foreign Medical Graduates (ECFMG) assesses the readiness of graduates of foreign medical schools to enter residency or fellowship programs in the United States that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

ECFMG offers a variety of other programs and services to foreign-educated physicians and members of the international medical community. Detailed information on ECFMG certification and ECFMG's other programs and services are available at the ECFMG Web site and in the ECFMG Information Booklet.

If you are a student or graduate of a foreign medical school interested in ECFMG certification, you must refer to the ECFMG Information Booklet for detailed information and application procedures.

Foreign national physicians seeking ECFMG sponsorship as J-1 exchange visitors for enrollment in US graduate medical education programs must meet certain general requirements specified in the law and enumerated in regulations at 22CFR 514.27(b). The ECFMG, in consultation with DOS-EVP, details the requirements in their sponsorship information and application materials. Following are brief descriptions of the requirements. For further information contact the ECFMG or visit their Web site at www.ecfmg.org.

Medical Education. Must have graduated from a medical school or have otherwise met medical education requirements in the country where the education was obtained. Some countries grant degrees but require an additional period of training for recognition as a physician. Some countries require a medical license in addition to the degree. ECFMG sponsorship information contains a list of credentials required for each country; physicians who do not hold the required credentials are not eligible for sponsorship.

Educational and Cultural Environment. Must be able to adapt to the US educational and cultural environment. Although this requirement is somewhat subjective, the ECFMG Clinical Skills Assessment (CSA) provides a level of objective evaluation in a patient care environment, and GME program directors should consider the cross-cultural experience and adaptability of applicants in making decisions to offer positions.

Background and Experience. Must have background, needs, and experience appropriate to the proposed exchange visitor activity. This is a general requirement for all J-1 exchange visitors across all the categories. The usual interview and selection process by which programs identify qualified applicants for clinical training positions normally meets this requirement.

Examinations -- Medical Knowledge. Must have passed the United States Medical Licensing Examination (USMLE) Steps 1 and 2 or an earlier examination, acceptable for sponsorship purposes. At the time the statue was written the language of the INA required that the physicians pass either the National Board of Medical Examiners (NBME) Part I and II examinations or an examination determined to be equivalent to the NBME examinations by the Secretary of the US Department of Health and Human Services (HHS). The medical knowledge assessment tools have changed over the years. Past examinations that HHS has declared acceptable for J-1 exchange visitor sponsorship purposes include:

- NBME Part 1 and Part 2
- Visa Qualifying Examination Day 1 and Day 2
- Foreign Medical Graduate Examination in the Medical Sciences Day 1 and Day 2

Note that the former 1-day ECFMG examination does not meet the requirements for J-1 visa sponsorship, although it did meet the requirement for ECFMG certification at the time it was given.

Examinations -- English Language. Must have passed the ECFMG English examination or another English language proficiency examination acceptable to the ECFMG for ECFMG certification. Applicants frequently use the Test of English as a Foreign Language (TOEFL) as an alternative examination. See “ECFMG Certification” above or ECFMG-published information materials for details.

ECFMG Certificate. The foreign national physician must hold a valid Standard ECFMG Certificate or have met all requirements for that certificate prior to commencement of training. See “ECFMG Certification” above.
Home Government Letter. The physician must provide a written statement of need from the Ministry of Health in the country of nationality or last legal permanent residence. The statement must provide written assurance that the country needs specialists in the area in which the exchange visitor will receive training. It also serves to confirm the physician's commitment to return to that country upon completion of training in the United States as required by INA 212(e), as amended. Note that if permanent residence is in a country other than that of citizenship, the Ministry of Health letter must come from the country of last legal permanent residence. The law makes the “home government letter” mandatory and the regulations specify the language the latter must contain. Some countries will write these letters to cover the full duration of the training, while others will write letters of less duration. If the home country declines to write the letter or refuses to use the required language, then the ECFMG is not permitted to issue Form IAP-66 for sponsorship. Similarly, if a country writes the letters for less than program duration and chooses not to extend or reissue the letter, then the ECFMG is not permitted to issue Form IAP-66 for continuation of sponsorship beyond the period covered by the letter.

Training Contract. The physician must have a contract or an official letter of offer to train in an accredited graduate medical education program that is affiliated with a Liaison Committee on Medical Education (LCME)-accredited medical school or affiliated hospital. Programs that are directly associated with accredited programs may also be acceptable for sponsorship. The physician must first have an appointment before getting ECFMG sponsorship. The physician cannot get sponsorship and then look for an appointment.

Upon establishing an applicant’s eligibility, the ECFMG issues Form IAP-66, Certificate of Eligibility for Exchange Visitor (J-1) status. Associated training/employment authorization is specific to approved sponsorship stated on Form IAP-66. A Form IAP-66 obtained for a particular program may be used only for that program and is not transferable to another institution or program.

Federal Regulations That Govern Exchange Visitor Physicians and Their Activities

Physicians who accept J-1 exchange visitor status to engage in graduate medical education programs that accept these physicians also accept the regulations and limitations that attend that status. Congress has been very clear regarding its desire to allow appropriate training for J-1 physicians, while eliminating or severely limiting concurrent or subsequent opportunities outside or beyond the training. Following is a brief review of the federal regulations affecting exchange visitor physicians.

Duration of Participation. The duration of participation for exchange visitors in graduate medical education is the “time typically required” to complete the program. The director of the DOS-EVP establishes the limits on training duration. The phrase “time typically required” generally refers to the medical specialty and subspecialty certification requirements published by the American Board of Medical Specialties (see Appendix B). The maximum duration of participation is further limited to 7 years, provided the exchange visitor physician progresses through a program or programs of graduate medical education. The director of the DOS-EVP may grant extensions beyond 7 years if the exchange visitor physician can demonstrate exceptional need in the home country. Program training directors should pay close attention to the time limitations. Note that “time typically required” takes precedence over “7 years,” and extension beyond 7 years must show exceptional need. For example, if the program typically requires 4 years for completion, then the limit is 4 years, not 7. Similarly, if a program such as neurosurgery or cardiothoracic surgery typically requires more than 7 years, the physician will not be allowed to complete the program unless the home country is willing to document exceptional need. Neither the desire of the physician to receive training or the desire of the program to offer training meets the “exceptional need” criterion.

Two-year Home Country Physical Presence Requirement. The 2-year home country physical presence requirement, commonly called the home residence requirement, specified in INA 212(e), as amended, automatically applies to exchange visitor physicians sponsored by the ECFMG to enter the United States for the purpose of graduate medical education (and all accompanying J-2 dependents). Being subject to the home residence requirement means that the exchange visitor must reside and be physically present in the country of citizenship or of most recent legal permanent residence for an aggregate of at least 2 years prior to obtaining H (temporary worker), L (intracompany transferee), or LPR (lawful permanent resident “green card,” or immigrant) status. The INA 212(e) also truncates the avenues for waiver of the home residence requirement for physicians. Congress's stated intent in making all physicians subject to the requirement and making waivers more difficult to obtain was to allow for the training of foreign physicians while discouraging or preventing them from remaining in the United States to practice after completion of training.

Change of J-1 Category. Other than “alien physician,” the categories most often used by foreign national physicians are “professor,” “research scholar,” “short-term scholar,” and “student.” J-1 exchange visitor status physicians who enter the United States in a J-1 visa category other than the trainee category of “alien physician” under ECFMG sponsorship may not change their J-1 via category to alien physician” to allow them to engage in graduate medical education sponsored by the ECFMG. For example, physicians entering the United States in J-1 status under the category of “research scholar” may not change to the “alien physician” category for clinical training, nor may physicians entering under the “alien physician” category for clinical training, nor may physicians entering under the “alien physician” category change to the “research scholar” category. The ECFMG, as the proposed new sponsor, may petition the DOS-EVP for change of category on behalf of the physician. The request must demonstrate unusual and extenuating circumstances. Processing times for such requests may take several months and may ultimately fail. Similarly, an attempt to exit in a non-clinical J-1 category and return under ECFMG sponsorship for clinical training is likely to be unsuccessful. Although the DOS-EVP has not published a change in its regulations, its policy
statements and discussions with the ECFMG indicate that the ECFMG must withhold J-1 sponsorship from physicians who have held J-1 status in another category during the year immediately preceding the beginning of the intended training program.

**Training Authorization vs. Employment Authorization.** Federal regulations at 22 CFR 514.16 specifically permit compensation for activities that are part of the exchange visitor program and specifically prohibit work, training, and/or financial compensation for activities that are outside the approved exchange visitor program. The J-1 physician “...who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.” [22CFR 514.16(b)]. In accredited GME programs, the program curriculum is generally established by the Residency Review Committee of the Accreditation Council of Graduate Medical Education (ACGME). The J-1 physician may engage only in RRC-approved training activities for compensation directly related to those activities. In practical terms this means that J-1 physicians generally cannot engage in elective activities such as taking extra call, dictating or reviewing charts, or other similar extra work for extra compensation, even if other physicians (citizens or residents of other visa classes) in the GME programs typically choose to do so. For programs associated with accredited programs, but not yet accredited themselves, the J-1 physician may only engage in those activities specified and described in the program description submitted to the ECFMG as part of the application for sponsorship for the alien physician. No other elective activities for additional compensation are permitted.

(Source: AMA/ACGME, Graduate Medical Education Directory 2000-2001)
IX. DHMC PROFESSIONAL CONDUCT 
POLICIES AND PROCEDURES

Code of Professional Conduct
Approved by the Board of Governors, September 9, 1999

The Dartmouth-Hitchcock Medical Center (DHMC) and its component institutions are committed to excellence in: 1) patient care; 2) education and training of medical students, graduate students, house officers, nurses, and other health professionals; 3) continuing education of staff members; and 4) research. 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, other health professionals, students, other trainees, and the public.

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, and research. "Ideals" refer to desirable professional behaviors that professionals at all levels should attempt to acquire because they enhance professional excellence.

The Code applies to all professionals at DHMC involved in the clinical, teaching, research, and administrative activities of the Center. Because of its broad reach, certain portions of the Code will be more directly applicable to some disciplines than to others. For example, the clinical portions apply to medical students, physicians, nurses, physician's assistants, nurse practitioners, and all other professionals engaged in patient care. Similarly, those portions pertaining to teaching and research apply to all professionals engaged in teaching and research regardless of discipline or level of training. The portions pertaining to students apply to trainees at all levels. The general portions of the Code which discuss confidentiality, conflicts of interest, interpersonal relations, and the professional ideals apply to all DHMC professionals.

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 also may 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 patients, colleagues, other health professionals, students and teachers with the same degree of respect you would wish them to show you.
   - Treat patients with kindness, gentleness, and dignity.
   - Respect the privacy and modesty of patients.
   - Do not use offensive language, verbally or in writing, when referring to patients or their illnesses.
   - 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. Respect for 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 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 justifications.
   - Do not invite or permit unauthorized persons into patient care areas of the institution.
   - Do not share your confidential Clinic Information System or VA computer system passwords with unauthorized persons.
   - Do not look up confidential data on patients without a professional "need to know."
   - Do not misuse electronic mail.

3. 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., making unauthorized long-distance telephone calls.
4. 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.

5. 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.
- Students and other trainees should 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.

6. Deportment as a Professional
- 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.

7. Avoiding Conflicts of Interest
- Resolve all clinical conflicts of interest in favor of the patient.
- Do not accept non-educational gifts of value from drug companies or medical equipment vendors or suppliers.
- 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.

8. Responsibility for 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.

9. 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.

10. 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.

11. 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.
B. Professional Ideals

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

2. Conscientiousness
   - Fulfill your professional responsibilities with conscientiousness.
   - Notify the responsible supervisor if something interferes with your ability to perform clinical tasks effectively.
   - Learn from experience and grow from the knowledge gained from errors 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
   - Cooperate with other members of the health care team in clinical activities and with other members of the research team in research activities.
   - 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.

*Behaviors that also may violate federal or state laws.

Approved by the Board of Governors: 9/9/99
Reviewed: 10/02 by Dr. Judith Frank
X. GME POLICIES

GME Fair Hearing Policy
As revised and adopted by GMEAC, December 2000

I. Purpose
The purpose of this policy is to delineate confidential due process procedures available to residents who are placed on probation and/or recommended for dismissal or non-renewal from a program due to academic deficiency, non-academic deficiency or behavior incompatible with the role of the physician.

II. Probation 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 Probation: A resident whose academic performance does not meet departmental standards is generally entitled up to a three month probation. The goal of this probation is to allow the resident to improve academically in order to remain in the program.

Procedure:
1. The resident shall be informed of any academic deficiency in writing in a private meeting with the Program Director or her/his designee. At this meeting or as soon thereafter as possible, the resident shall be provided with a copy of this policy.
2. Probation begins on the date that written notification of probation is delivered to the resident. The Program Director shall submit written notification of the probationary status to the resident and the Director of Graduate Medical Education and the Medical Director of the Veteran's Affairs Hospital (White River Junction, Vermont) where appropriate.
3. The Program Director shall provide the resident with written suggestions for improving academic performance. In addition, the Program Director may arrange for the resident to receive advice, tutoring or other aids to academic improvement.
4. At any time within probation, the Program Director may remove the resident from probation if the resident's performance has improved to the Program Director's satisfaction.
5. If the resident has been on probation for up to three months, the Program Director must either

(a) remove the resident from probation,
(b) extend the probation for a specific period, the duration of which shall be communicated in writing to the resident and to the Director of Graduate Medical Education, or
(c) recommend dismissal of the resident.
6. If the Program Director recommends dismissal, the resident shall be notified in writing, and shall have five business days from the date of delivery of this written notification to either (a) submit a resignation, effective at a mutually acceptable date within the context of these guidelines or (b) request a review of the case from the Director of Graduate Medical Education.
7. If the resident requests a review, the Fair Hearing Process described infra shall be followed.

B. Non-academic Deficiency

Definition:
Medical 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, probation should generally be offered at an early stage, when a change in career direction will be least disruptive to the resident.
Length and Goal of Probation:

A resident whose non-academic performance does not meet department standards is generally entitled up to a three month probation. The goal of this probation is to assist the resident in correcting non-academic deficiencies or, if correction is not deemed feasible by the Program Director, exploring career alternatives and finding a position more in keeping with the resident's abilities and talents.

Procedure:

1. The resident shall be informed of documented non-academic deficiencies in writing in a private meeting with the Program Director or her/his designee. At this meeting or as soon thereafter as possible, the resident shall be provided with a copy of this policy.

2. Probation begins on the date that written notification of probation is delivered to the resident. The Program Director shall submit written notification of the probationary status to the resident, the Director of Graduate Medical Education and the Medical Director of the Veteran's Affairs Hospital (White River Junction, Vermont) where appropriate.

3. The Program Director may arrange for the resident to receive counseling, technical training or assistance with career alternatives where appropriate.

4. If the resident has been on probation for the defined time of up to three months, the Program Director must either

   (a) Remove the resident from probation,
   (b) Extend the probation for a specific period, the duration of which shall be communicated in writing to the resident and to the Director of Graduate Medical Education, or
   (c) Recommend dismissal of the resident.

5. If the Program Director recommends dismissal, the resident shall be notified in writing of the recommendation and reasons for dismissal and shall have five business days from the date of this written notification to either:

   (a) Submit a resignation, effective at a mutually acceptable date within the context of these guidelines or
   (b) Request a review of the case from the Director of Graduate Medical Education.

6. If the resident requests a review, the Fair Hearing Process described infra shall be followed.

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 may recommend the resident's dismissal without an intervening probationary period.

Length and Goal of Probation:

There is no right to probation under these circumstances.

Procedure:

1. The resident shall be informed of the allegations and of the recommendation for dismissal in a private meeting with Program Director or 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 allegations and recommendation for dismissal to the resident, the Director of Graduate Medical Education and the Chairman of the Veteran's Administration (White River Junction, Vermont) Residency Review Committee where appropriate. There will be no probation.

3. The resident shall have five business days from the date of this written notification to either:

   (a) submit a resignation, effective at a mutually acceptable date within the context of these guidelines, or
   (b) request a review of the case from the Director of Graduate Medical Education.

4. If the resident requests review, the Fair Hearing Process described infra shall be followed.
D. Non-Renewal

A recommendation of non-renewal may be made by the Program Director as a result of academic deficiency or non-academic deficiency. A recommendation of non-renewal will generally follow only after a resident has completed a period of probation. A recommendation of non-renewal by the Program Director may be appropriate in those circumstances that do not require immediate removal of a resident despite the failure of the resident to satisfactorily modify his/her performance at the completion of a probationary period.

If the Program Director recommends non-renewal the resident shall be notified in writing, and shall have five business days from the date of delivery of this written notification to accept the non-renewal notice or request a review of the case from the Director of Graduate Medical Education.

If the resident requests a review, the Fair Hearing Process described infra shall 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 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, but not less than 7 days, from the date of the resident's request for review.

3. All documentary evidence to be presented to the Committee by the Program Director shall be provided to the resident and the Committee at least two business days prior to the hearing. The specification of reasons for dismissal 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 prepare to address reasons not included in the notice.

4. All documentary evidence to be presented to the Committee by the resident shall be provided to the Program Director and the Committee at least two business days prior to the hearing. The Committee may, 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.

5. The resident shall attend the scheduled hearing to present evidence and witnesses 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 re-scheduled at the Committee's sole discretion if the resident presents good cause for failing to appear or proceed.

6. The Program Director or his designee shall attend the hearing to present evidence and witnesses in support of the recommendation for dismissal.

7. The Program Director and 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.

8. Hearings scheduled under these Guidelines may be postponed only for good cause and at the sole discretion of the Committee.

9. The hearing may be tape-recorded at the request of the resident or the Program Director or the Chair of the Committee.

10. The Chair of the Committee 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.

11. The hearing need not be conducted strictly according to the rules of evidence relating to the examination of witnesses or the presentation of evidence. Any relevant information shall be considered.
12. 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 recommendation for dismissal. The resident shall be responsible for representing evidence which contradicts the Program Director's evidence or indicates that the Program Director's decision was arbitrary, unreasonable or capricious. Generally, witnesses will be sequestered. The resident and Program Director may be present throughout the hearing. The resident and Program Director may ask questions of all witnesses after each witness presents information.

13. The resident, the Program Director and the Committee shall be entitled to consult with legal counsel in preparation for the hearing or with regard to other related matters. A separate hearing officer appointed by the Committee may be an attorney.

14. Neither the resident nor the Program Director shall normally be represented at the hearing by an attorney. The resident, however, may request such representation, and in that event both the resident and the Program Director may be represented by an attorney who may present evidence and ask questions of witnesses. Cross-examination by counsel, however, will not be permitted unless special need for it appears at the hearing.

15. 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, interview additional witnesses or consultation. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

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

4. In the event the Committee concurs with the Program Director's recommendation for dismissal of the resident for academic or non-academic deficiency, the resident may be placed on a leave of absence with pay and benefits for up to a period of three months, or for such fraction thereof as the resident may elect in a written resignation. The said period shall begin with the date of the resident's written notification of the Program Director's recommendation for dismissal.

5. In the event the Committee concurs with the Program Director's recommendation for dismissal of the resident for behavior incompatible with the role of physician, the resident may, in the Committee's sole discretion, be placed on a leave of absence with pay and benefits for up to three months, or for such fraction thereof as the resident may elect in a written resignation. The said period shall begin with the date of the resident's written notification of the Program Director's recommendation for dismissal. Otherwise, the resident shall be given 24 hours to resign. If no written resignation has been received by the Program Director within 24 hours, the dismissal shall become effective and the resident's appointment shall be terminated as of that date.

6. In the event the Committee concurs with the Program Director's recommendation of non-renewal, the resident shall be permitted to complete his/her period of appointment with such limitations as the Committee may direct; or at the resident's option, may be placed on a leave of absence with pay and benefits for a period of up to three months, or for such fraction thereof or the resident may elect in a written resignation. The said period shall begin with the date of the resident's written notification of the Program Director's recommendation for non-renewal. Otherwise, the resident shall be given 24 hours to resign. If no written resignation has been received by the Program Director within 24 hours, the said period shall begin with the date of the resident's written notification of the Program Director's recommendation for non-renewal.

7. In the event the Committee should not concur with the Program Director's recommendation for dismissal of the resident, the Program Director shall 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.

8. Should the resident choose not to remain in the program, the Committee shall, if appropriate, make reasonable efforts to assist the resident in securing appointment in another department or in an accredited or approved residency training program elsewhere. The resident shall be placed on leave of absence with pay and benefits for up to three months or until another appointment is secured, whichever occurs first.
GME Concern Policy
As revised and adopted by 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 has 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 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 and 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.

Policy Statement on the Confidentiality of Patient Information

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I. Statement of Purpose

It is our intent to establish policies on the confidentiality of patient-related information and to provide guidelines for the security and appropriately controlled release of such information.

We support the patient's right to confidentiality (that is, the right to keep information about himself/herself inaccessible to others) 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 the information is appropriate under certain circumstances, such as providing for continuity of care, participating in approved research and education activities, complying with the laws and assuring reimbursement for services provided, and that such releases provide benefit to the patient or to society.
II. Scope and Definition of Terms

The policy statement applies to all personnel of the Dartmouth Hitchcock Clinic, the Mary Hitchcock Memorial Hospital, and the Dartmouth Medical School, as well as anyone participating in medical educational programs within these organizations.

This policy statement applies to all types of patient-related information: any item containing information about a patient that reasonably could directly or indirectly identify the patient, whether in electronic or hard copy 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 also covers items regardless of storage medium or location. Also covered are operating schedules, registration forms, 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 confidentiality guidelines to these as they come into use in our facilities.

Types of release covered by this policy statement 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 repository.

III. General Principles

1. Patients own their personal healthcare information, and with the exception of (in some states) mental health notes, have a reasonable right to access their own healthcare information and to correct or comment on information contained in the medical record.

Dartmouth Hitchcock Clinic and Mary Hitchcock Memorial Hospital, or, in some instances, Dartmouth Medical School, own the medium on which the information is kept: paper records, videos, photographs, electronic storage media, etc. We recommend that patients be informed of their rights and obligations regarding their own information whenever possible.

2. Whenever possible, we will release patient information only with patient consent, but we will proceed without consent when conditions require, such as for continuity of care, medical emergencies, or when required by law. We believe that patients should be informed as much as possible about the release and use of their information and that, when required, patient consent should be obtained in writing.

3. Individual Dartmouth Hitchcock Clinic, Mary Hitchcock Memorial Hospital, and Dartmouth Medical School employees are accountable to read, know, and understand this policy statement, to adhere to approved specific policies and procedures for confidentiality of patient-related information, and to exercise care and good judgment in accessing, using, or disclosing such information.

4. In all circumstances, only the minimum amount of information will be released to those individuals or entities with a need or right to access such information.

IV. Statement on Patient Consent

1. We believe that the patient should be informed as much as possible about the release and use of his/her information and that, whenever possible, patient consent should be obtained in writing. We recognize that it may not be possible to obtain the patient's consent in an emergency. A person other than the patient may give consent for access to or release of the patient's information only when granted by a competent patient, parent or guardian or a minor child, the patient's attorney, or by a court order.

2. 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.

V. Statements of Specific Situations

1. Continuity of Care

Medical information shared for the patient's ongoing care is assumed to be in the patient's best interest. To facilitate a patient's treatment, disclosure of information may occur among providers. Patient information will be released to non-Dartmouth Hitchcock Clinic and Mary Hitchcock Memorial Hospital healthcare providers without written consent when appropriate to do so, such as in a medical emergency and when providing test results and/or reports to referring physicians. We suggest that the patient also be informed that attending physicians, consultants, and referring physicians may have access to their medical record.
2. Release of Information for Financial Purposes
When possible, we suggest that patients be informed about the following:

- that their medical records data 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 for utilization review purposes, or may review the medical record on the premises.

3. Release of Information for Administrative Reasons
Patient information is essential to many corporate functions. These functions include administrative activities such as surveys by accrediting bodies and evaluations of clinical outcomes. We recommend that non-patient specific and non-diagnostic information be used whenever possible. In all cases, we recommend that only the minimal amount of information be accessed and only by those with a need to know the information.

Quality assurance functions are 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.

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

5. Release Under Law or State Regulation
In accordance with state law, certain diagnoses and circumstances require disclosure without patient consent. Each regional medical record department policy will explicitly describe these situations with references to the applicable statutes and regulations.

6. Release and Use of Information for Medical Research
The release and use of information for medical research must be approved by the appropriate Institutional Review Board. Articles, papers, copies or 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.

7. 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 regional medical record department policy will describe how to handle these situations.

8. Release and Use of Information for Education
We recognize the necessity of sharing patient-related information to fulfill our educational mission.

VI. Computerized Patient Record
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 and disclosure of patient-related information on the computer or in hard copy will be considered part of the medical record, so that by definition the Dartmouth Hitchcock Clinic/Mary Hitchcock Memorial Hospital record contains information in both paper and electronic formats.

All confidentiality rules and security precautions set up for the paper record also apply to the computerized patient record.
VII. Regional Health Data Networks

We support the development of regional health data networks if those organizations promote public health and provided that they enforce explicit policies for the protection of data against unauthorized access or release.

Any department, section, or provider wishing to release patient-related information from Dartmouth Hitchcock Clinic, Mary Hitchcock Memorial Hospital, or the Dartmouth Medical School database to an outside entity must obtain approval from the appropriate Medical Records Committee.

VIII. Communications by e-mail, Cellular Telephone, Modem or Fax

Our intention is not to discourage the appropriate use of electronic media for patient care but to draw attention to the need to manage the different security issues arising from the use of new technologies.

Technologies such as electronic mail ("e-mail") and cellular or cordless telephones which are used to communicate patient information between providers or between providers and patients are less secure than the computerized patient record because of the nature of the technology or the place in which they are used.

Cellular and cordless telephones communicate by broadcasting radio signals which can be overheard through various electronic means, such as scanners, without the user's knowledge.

E-mail messages can be inadvertently sent to the wrong party, forwarded by the recipient, or accessed through computers left logged-on and unattended. In addition, "trash" messages remain retrievable by third parties under certain circumstances. It is possible for e-mail messages to be forwarded or printed without the sender's or recipient's knowledge or permission. Furthermore, e-mail messages may be used as evidence in court.

Access by modem makes the information available in remote environments. Screens must not be left logged-on in unsecured areas. Passwords must be kept secure. When in the company of others, in an airport or in private homes, for example, care must be taken to protect the information from unsecured viewing.

Facsimile (fax) transmissions can be inadvertently sent to the wrong party and/or left unattended for long periods at unsecured locations. Therefore, when these technologies are used, extra precautions must be taken.

IX. Review/Amendment of this Document and the Implementation Policies

Specific policies will be adopted that implement this policy statement. Because of the rapidly changing healthcare environment and technologies, we anticipate that this policy statement as well as the implementation policies can represent only the current thinking and law at any point in time and, therefore, will need periodic reviewing and updating. The appropriate governing bodies or their designees will coordinate this review.

X. Review and Approval History

The Lahey Hitchcock Clinic System Board of Governors - June, 1996

The Regional Board of Governors for the Dartmouth Medical School, the Lahey Hitchcock Clinic (Northern New England Region), and the Mary Hitchcock Memorial Hospital - March, 1996

Reviewed by the Task Force on Patient Confidentiality - April, 1997

Reviewed and approved by the DHMC Medical Record & Informatics Committee-May 1999

Approved by the DHMC Board of Governors - July 1999
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
   - Being cursed or sworn at

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 becoming a physician
   - Excessive work load
   - 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

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.
XII. EMERGENCY COURSE REQUIREMENTS

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 ventilation
Bag-valve Mask
Automated External Defibrilation

Requirement: a. Required for every physician who is a direct care provider
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; retraining available every May thereafter
b. Provider training held second Wednesday of every month from 9 to 5 p.m. in CPR Lab
c. CPR Blitz for Providers every Jan/Feb; watch for poster

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

B. Advanced Cardiac Life Support (ACLS)

Course content: Advanced airway management (intubation)
Pharmacological intervention
Cardiac rhythm disturbances
Defibrillation
Cardiac rhythm disturbances
Acute coronary syndrome
Acute ischemic stroke

Requirement: a. Required for Internal Medicine, Anesthesia, and Pediatric house staff, GL 2 & 3
b. 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; watch for Life Support Program poster

Cost of course: No charge to CPR Team members

Others: $100 for Provider Course (texts included) & $50 for Provider Recertification Course ($33 for texts)

C. Pediatric Advanced Life Support (PALS)

Course content: Airway management in children and infants
Pharmacological intervention in children and infants
Cardiac rhythm disturbances
Fluid resuscitation
Defibrillation
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; watch for Life Support Program poster

Cost of course: No charge to CPR Team members; others: $225 for Provider Course (texts included) & $75 for Provider Recertification Course ($33 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. Advanced Trauma Life Support

Course content: Airway management
   Fluid resuscitation
   Surgical skills
   Orthopedic skills

Requirement: Required for all Surgical GL 1 house officers each year

Length of recognition: Four years

Course schedule: Two courses in spring each year; see poster

Cost of course: No charge to Surgical house officers; others: $475

F. Defibrillation Competency

Course content: Zoll PD 2000 defibrillator/external pacemaker operation

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

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 for these courses and sign up, call Life Support Program, ext. 5-7089.

(Source: JB hand.Emer Courses 1/28/02)
The following excerpt from the 2000 "Policies for Cardiopulmonary Resuscitation" written by the CPR Committee and approved by the Board of Governors relates to the institutional policy for training in life support:

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 CPR. 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 Course C for Health Care Providers, the American Heart Association Heartsaver Plus course, or the American Red Cross Professional CPR Course. 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, Transportation orderlies, technologists in Radiation Therapy and Radiology, Operating Room personnel, IV Team members, flight paramedics, clinic 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.

So that victims might receive defibrillation as quickly as possible, any care providers trained in defibrillation (manual or automatic) may perform defibrillation as needed, even prior to the arrival of the CPR Team. Defibrillators are standardized throughout DHMC to improve competence and efficiency. All persons who operate defibrillators within their roles must demonstrate competency when a new defibrillator is purchased for the institution and at least every two years (except for attending physicians).

In order to insure that ACLS is provided to the adult victim as quickly as possible following cardiopulmonary arrest, priorities for training ACLS providers have been determined. It is required that the following persons be trained in ACLS: 1) Internal Medicine, Pediatric and Anesthesia junior and senior residents be trained in ACLS; 2) all RNs in the CCU, CT ICU, PACU, ICU, ED, FICU, and ICCU; 3) all DHART flight RNs and flight paramedics; 4) all MICU transport RNs and transport RCPs, and 5) all nurse anesthetists (CRNAs). It is desirable that all RCPs be trained in ACLS.

It is required that the following persons be trained in PALS: 1) all Pediatric SARs, JARs and interns; 2) all RNs in the PICU and PACU; 3) a sufficient number of ED RNs in order to provide back-up coverage of the Pediatric CPR Team nurse pager; 4) all respiratory care providers; 5) Pediatric attending staff who lead resuscitations; 6) all neonatal nurse practitioners, 7) all DHART flight nurses and paramedics; and 8) all MICU transport RNs and transport RCPs. Completion of the Emergency Nursing Pediatric Course is an acceptable alternative for ED and DHART nurses. It is recommended that clinical nursing staff in the P&A unit be trained in PALS.

It is required that the following persons be trained in the NRP: 1) all Pediatric SARs, JARs, and interns; 2) all ICN and Birthing Pavilion RNs; 3) all RCPs who care for or transport neonates; 4) all Neonatal attending staff; 5) all members of the neonatal transport teams; 6) all MICU transport RNs and transport RCPs, and 7) all neonatal nurse practitioners.

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

b. If a nurse, technologist, or technician is not retrained by the end of the following month after her/his BLS expiration date, she/he 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 her/his BLS expires, she/he is required to demonstrate competency within four weeks of returning from LOA.

c. If a house staff member is not current in BLS, he/she will ultimately lose his/her medical staff privileges. After a warning period of one month, revocation of medical staff privileges will occur unless BLS certification is forthcoming.

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.

(Source: JB HO Life support training policies.doc 12/29/00)
XIII. DHMC HOUSE STAFF LEAVE POLICY

DHMC House Staff Leave Policy
Effective July 1, 1993
Reviewed and Approved by the Graduate Medical Education Committee June 10, 1993

1. GENERAL ISSUES RELATED TO LEAVE (apply to all types of leave)

a. Advance Notification: Whenever possible, the house staff member requesting a leave should inform the Program Director, Department Chairperson and Section Head at least two (2) months in advance unless circumstances preclude such advance notice. Since alteration in schedules may result from a leave, it can have indirect consequences for the other house staff in the program. This notification should be in writing and state the purpose of the leave, anticipated starting date, length of leave and any other documentation required to substantiate the reason for the leave. (Use GME Leave of Absence Request Form.)

b. Program Director's Response: After receiving a request for leave, the Program Director should provide the house staff member with a written approval/disapproval letter. This letter should contain a statement as to whether the leave time must be made up by the house staff member and whether it is paid or unpaid. If such time is to be made up, it should be made clear to the house staff member whether this additional time will be with or without pay. (This is indicated on the Leave of Absence Form.)

c. Call Responsibilities: Satisfactory resolution of problems caused in the on-call schedule are the responsibility of the resident and the Program Director, and should be settled by balancing the needs of the resident requesting the leave, the welfare of all the residents in the program, and the program needs as a whole.

d. Specialty Board Requirements: Each specialty board, residency review committee (RRC) and/or intramural residency program has its own unique requirements related to becoming board-eligible or completing the program. Should there be a limit on absence from training specified by any of these bodies, the house staff member may be required to make up the missed time. In general, if the house staff member was paid during his/her leave, this additional time will be served without pay. If leave was without pay, when the house staff member returns to duties, the pay scale will be identical to the pay scale in force during the leave and not at a higher level.

2. MATERNITY LEAVE POLICY

a. Standard Maternity Leave: The standard maternity leave policy includes six (6) weeks of leave with full pay and benefits. This leave shall begin and end in conjunction with consultation between the house staff and her physician responsible for her obstetrical care. Date on which the maternity leave commences, whether it be pre or post-natal, shall be the date upon which the house officer's physician certifies that the house officer is no longer able to perform her duty because of the problems of pregnancy. If a nurse midwife has been caring for the house staff member, the midwife's collaborating physician will be involved in the recommendation to begin, conclude or extend leave. Leave may extend to 12 weeks from date of birth.

b. Extended Maternity Leave: A maternity leave extension of up to an additional six (6) weeks with pay and benefits may be granted with a written request for such an extension with reasons from the house staff member's physician. Typically such an extension is needed due to a complication of pregnancy or delivery. A request for extension should be directed to the Department Chairperson, Section Head and Program Director at least one (1) week before the leave extension is to commence.

c. Prolonged Maternity Leave: Should more than twelve (12) weeks of maternity leave be required because of the mother's medical problems, the house staff member must apply for disability benefits through the Office of Graduate Medical Education at least two (2) weeks before beginning such disability leave. In addition, the house staff member must notify the Department Chairperson, Section Head and Program Director that such disability leave is being requested.

3. PATERNITY LEAVE POLICY

A house staff member requesting a paternity leave will schedule such leave with the Program Director and Chief Resident. Paternity leave will not be given until after the child is born. House staff member may utilize available vacation time for this leave. Should the house staff member choose not to utilize vacation time, this leave will be unpaid and pursuant to the Family and Medical Leave Act and can continue for up to 12 weeks. All the conditions in Section 1 above apply to paternity leave.

Program Directors are encouraged to be flexible in allowing house staff members to use vacation days for paternity leave.
4. ADOPTION LEAVE POLICY

A house staff member requesting adoption leave will schedule such leave with the Program Director and Chief Resident, as early as possible. It is suggested that the Program Director be notified as soon as adoption procedures are initiated so that adequate planning can ensue. Adoption leave will not be given until the house staff member receives the adopted child. It may be requested that the house staff member will utilize available vacation time for this leave. Should the house staff member not have any vacation time remaining and request adoption leave, this leave will be unpaid and pursuant to the Family and Medical Leave Act and can continue for up to 12 weeks. All the conditions in Section 1 above apply.

Program Directors are encouraged to be flexible in allowing house staff members to use vacation days for adoption leave.

5. FAMILY LEAVE POLICY

a. Background: In January 1993 the Family and Medical Leave Act was passed by Congress and became law in August 1993. This Act entitles employees to a total of twelve (12) work weeks of leave from their employment annually for certain purposes. In general, this Act applies to the birth of a child, adoption of a child, the need to care for an ill spouse, child or parent or because of a serious health condition in the employee. The following policies are based upon the January, 1993 Leave Act. There is no requirement that such leave be paid and at the DHMC only maternity leave is paid. When family leave is requested to care for an ill child, spouse, parent or yourself, certification may be requested from the involved physician to substantiate the need for leave. Should a house staff member request family leave, the request should be made to the Office of Graduate Medical Education as well as the Department Chairperson, Section Head and Program Director. Ideally, at least one (1) month notice should be given before starting any approved family leave unless circumstances make it impossible due to the acute onset of an illness.

b. Reasons To Request Family Leave:

1. The birth of a son or daughter of the house staff member and to care for such son or daughter.

2. The placement of a son or daughter with the house staff member for adoption or foster care.

3. To care for a spouse, son, daughter or parent of the house staff member, if such spouse, son, daughter or parent has a serious health condition.

4. A serious health condition that makes the house staff member unable to perform the functions of the position of such house staff member.

c. Definition of Serious Health Condition: A serious health condition means 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.

d. Pay and Benefits During Family Leave: In general, any family leave granted to the house staff member will be without pay. Benefits will be continued during approved family leave, however, if the house staff member fails to return from leave, the employer can recover the expenses related to benefit coverage during the leave from the house staff member who fails to return.

Program Directors may request that a house staff member use paid vacation, personal or sick leave for any part of the 12 week period. Family leave may be taken on an intermittent or reduced hourly schedule basis if the Program Director agrees with the arrangement.

If spouses employed by the same employer wish to take leave to care for a newly arrived child or a sick parent, their aggregate leave is limited to 12 weeks. If the leave is requested because of the illness of a child or of the other spouse, each spouse is entitled to 12 weeks of leave.
GRADUATE MEDICAL EDUCATION LEAVE OF ABSENCE
REQUEST FORM FOR HOUSE STAFF

To be filled out by house staff member and submitted to program director two months in advance (if possible) after reading the House Staff Leave Policy.

Name: ____________________________________  Program: ____________________________________

Request for leave from training program for the following purpose (circle number):

1. A health condition that makes the house staff member unable to perform functions as required by the training program.
2. The birth of a son or daughter of the house staff member and to care for such son or daughter.
3. The placement of a son or daughter with the house staff member for adoption or foster care.
4. To care for a spouse, son, daughter or parent of the house staff member, if such spouse, son, daughter or parent has an illness or serious health condition.
5. Military obligation.
6. Vacation.
7. Other:

Leave will begin on: ___________________________ Anticipated return: ___________________________

Leave with pay from: ___________________________ through finish date of: ___________________________

Leave without pay from: ________________________ through finish date of: ________________________

Number of days with pay: _______________________ Number of paid vacation days: _______________

Number of days without pay: ___________________

Seven or more consecutive days off need be reported to GME. If leave is for illness, before return of house staff member to program, program director must receive physician provider letter stating house staff member is "physically and mentally able to resume requirements of the training program", to be kept in house staff file. If illness is anticipated to extend beyond 90 days, house staff member must apply with GME for long-term disability insurance coverage by the end of 60 days of illness, if possible.

I understand that any leave of absence granted me is in accordance with the terms and conditions stated in the MHMH 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

Program Director must fill out following:

Will house staff member need to make up rotations caused by leave?  YES  NO

If yes, how many rotations: __________________ How many months to complete: __________________

Name of rotations: ________________________________________________________________

I have reviewed this request with named house staff member. I approve the request.  YES  NO

If no, please explain. Comments or special instructions: ______________________________________

________________________________________________________________________________________
______________________________________________________________________________________________

Program Director signature Date

Response to request for leave of absence must be given house staff member within one or two business days after receipt of request. Keep one copy of signed request in house staff file and send one copy to GME.
Request for part-time training in residency or fellowship program 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.

**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 (includes 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 MHMH 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

*Please attach the note from your physician.*

**Program Director Approval:**
Will house staff member need to make up rotations caused by part-time training? YES NO
If yes, how many rotations:_________________ How many months to complete:_________________
Name ____________________________________________ I have reviewed this request with named house staff member. I approve the request. YES NO
If no, please explain. Comments or special instructions:_____________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

__________________________________________________________
Program Director signature Date:

Response to request for part-time training must be given house staff member within one or two business days after receipt of request. Keep copy of signed request in house staff file and send copy to GME.

9/00GMEdole
XIV. MOONLIGHTING

Dartmouth-Hitchcock Medical Center
Mary Hitchcock Memorial Hospital
Moonlighting Policy

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 MHMH training program.

General

1. Mary Hitchcock Memorial Hospital neither encourages nor discourages moonlighting. The Program Director must approve this activity in writing and maintain this information as part of the resident's file.

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 position and may restrict moonlighting based upon training program considerations.

Nov02/Review & Addition by C. Dole, GME
Dartmouth Hitchcock Medical Center
Mary Hitchcock Memorial Hospital
GME Resident/Fellow MOONLIGHTING REQUEST FORM

Request for permission to work for compensation outside responsibilities and stipend of training program. This form must be sent to GME for all moonlighting regardless of location.

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: ________________________________

Name of supervisor: _______________________________________________________________________

Describe work to be performed____________________________________________________________________

___________________________________________________________________________________________

Inpatient or outpatient work__________________________________________________________

Moonlighting assignment start date: ___________ finish date: ______________________

Will the facility bill for your services? Yes/No

I understand it is my responsibility to obtain the appropriate license, credentials, 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 not under a visa status that prohibits work outside of training. I am responsible for any billing done in my name.

Resident signature:_____________________________ Date:__________

Program Director (circle 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:__________

THIS FORM WILL BE RETAINED IN GME RESIDENT MOONLIGHTING FILE

Graduate Medical Education Use Only

Received request form for moonlighting Date:______________

DHMC packet given to resident/fellow Date:______________

Copy of request form sent to Risk Management Date:______________

GME/dole/1/00
XV. LOAN DEFERMENT AND REVOLVING LOAN FUND

Loan Deferments

GME helps fill out loan deferment 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 instructions concerning deferment categories and 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 deferments.

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, your patience, and we'll try and help you.

Regulations for the Resident's Revolving Loan Fund

THE HITCHCOCK FOUNDATION

1. Loans shall be restricted to full-time Residents and Fellows in the Dartmouth affiliated hospitals.

2. Loans to an individual shall not total more than $2,000; such loans shall be made only for living expenses incidental to the period of training.

3. Applicants with credit card debt in excess of $5000 must arrange for credit counseling prior to the distribution of the loan.

4. Loans may be made for varying periods of time not to exceed three years from completion of training at Dartmouth-Hitchcock Medical Center. Loans may be repaid in part or in full at any time.

5. For short term loans, interest shall be charged at the rate of 12% per annum beginning the day after the loan is due. For loans written for the maximum allowable period, interest shall not be charged until one year after the completion of training at Dartmouth-Hitchcock Medical Center; thereafter simple interest shall be charged at the rate of 12% per annum. Loans shall be completely repaid with interest within three years from completion of training at Dartmouth-Hitchcock Medical Center.

6. Applications shall be made on the official form supplied by the Foundation. The applicant must secure the signature of his or her department chairman prior to submission of the application for consideration by the Foundation.

7. When the application is approved by the loan review committee, the borrower shall sign an official, non-negotiable contract (promissory note) supplied by the Foundation.

8. All repayments and interest on loans shall be returned to the Revolving Loan Fund, thus to perpetuate the Fund and its benefits for future applicants.

9. Upon default, the borrower shall pay all costs of collection including attorney's fees.

10. As provided by Public Law 105-244 (10/98), an amendment to section 523 of the Bankruptcy Reform Act of 1978, this education loan is not dischargeable in a bankruptcy proceeding.

11. The Foundation must be notified in writing of changes of address during the period of the loan.

(Source: The Hitchcock Foundation, 07-01)
APPLICATION FORM
RESIDENTS’ REVOLVING LOAN FUND

1. ______________________________________________________ (Name of applicant in full)

2. ______________________________________________________ (Home address)

3. ______________________________________________________ (Other address, if any, for current correspondence - department extension and beeper #)

4. Social Security Number ________________________________ Citizen of: ________________________________ (Country)

5. ______________________________________________________ Occupation: _________________________________

6. ______________________________________________________ (Full name of parent or next of kin)

7. ______________________________________________________ (Permanent address of parent or next of kin)

8. Name and age of dependents: ____________________________

9. Name of medical school: _________________________________ Date of Graduation: ________________________

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

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

11. DHMC residency training in: _____________________________

12. Inclusive dates of residency at DHMC: ____________________

13. Household Income: Applicant___________________ Spouse_______________ Other________________

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

_____________________________________________________________________________________________

15. To whom are you already indebted, for what amounts? (All debt, including credit cards)

Educational Loans____________________________________ Credit Cards________________________________

____________________________________________________ _____________________________________________

____________________________________________________ _____________________________________________

Other Debt___________________________________________

Monthly Household Expense__________________________ Auto Loans____________________________________
15. 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):

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

16. General summary of the purpose and need for this loan:

___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________
___________________________________________________________________________________________

17. Amount of loan desired: $ _________________________

18. By what date do you need this loan? __________________________________________________________

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

___________________________________________________________________________________________  Date  _________________
(Signature of applicant)

APPROVED  __________________________________________ Date  _________________
(Department Chairman)

APPROVED  __________________________________________ Date  _________________
(Revolving Loan Fund Committee Chairman)

Submit your application to:

The Hitchcock Foundation
Dartmouth-Hitchcock Medical Center
One Medical Center Dr.
Lebanon, NH 03756.

07-01
XVI. ENVIRONMENTAL PRINCIPLES

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 on-line 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.
**XVII. ELECTRONIC COMMUNICATIONS**

**Guidelines for the Use of E-Mail in Clinical Communication**

**Introduction**

E-mail is a good method for quick and efficient communications between providers and, in a more limited way, between 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 which 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) which 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 and to printing in Medical Records, 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)
XVIII. 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.

All house staff at GME Orientation and in the Red Book provided annually 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.

Employee/House Staff 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 Crisis and Brief Treatment Services of Outpatient Psychiatry.

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 a 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.
XIX. DRUG AND ALCOHOL POLICY

Drug and Alcohol Policy

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 work place 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 work place, 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 work place 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 a 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, other individuals working at the hospital or its property.

Any supervisor or manager who has reasonable suspicion to believe that an employee or house staff member violated this policy, immediately remove the employee working, 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.
## CONTACTS AND TELEPHONE NUMBERS

**DHMC 650-5000**  
Emergencies 5-5555  
Rotunda Information Desk 5-5245

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<tr>
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<tr>
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<td>Computer Help Desk</td>
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<td>House Staff Assistance (EAP)</td>
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<td>Libraries</td>
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<td>Baker (Dartmouth College)</td>
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<td>New Hampshire Board of Medicine</td>
<td>603-271-6935</td>
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<td>Occupational Medicine</td>
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<td>Security</td>
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<td>USLME (Exam Hot Line)</td>
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<td>Vermont Board of Medical Practice</td>
<td>802-828-2674</td>
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<tr>
<td>Anesthesiology</td>
<td>Lisa Wirth/Lisa Mills</td>
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<tr>
<td>Cardiology</td>
<td>Mary Beth Adams</td>
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<td>Cardiology (&amp; Intervent')</td>
<td>Nancy J. Smith</td>
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<td>Critical Care</td>
<td>Mauri Schwartz</td>
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<td>D-H Leadership Preventive Medicine</td>
<td>Lisa C. Johnson</td>
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<td>Dermatology</td>
<td>Jane Fearon</td>
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<td>Diag Radiology (&amp; X Scot Im) (CVIR)</td>
<td>Jill Grodan</td>
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<td>Sandra Billings</td>
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<td>Tara Madden</td>
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<td>Ann Richardson</td>
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<td>Heidi Westerberg</td>
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<td>Vascular Surgery</td>
<td>Marcy A. Nott</td>
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