Contents

I. INTRODUCTION 1

II. MOUNT SINAI SCHOOL OF MEDICINE CONSORTIUM FOR GRADUATE MEDICAL EDUCATION 5
   A. Bylaws 5
      1. Mission Statement 5
      2. Membership 5
      3. Responsibilities 5
      4. Objectives 6
      5. Commitment to Diversity 9
      6. Structure 9

III. ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION 11
   A. Accreditation Status for Core Programs 11
      1. Withheld Accreditation 11
      2. Initial Accreditation 12
      3. Continued Accreditation 12
      4. Probationary Accreditation 12
      5. Withdrawal of Accreditation 12
   B. Accreditation Status for Subspecialty Programs 12
      1. Withheld Accreditation 13
      2. Accreditation 13
      3. Accreditation with Warning 13
      4. Accreditation with Warning, Administrative 13
      5. Withdrawal of Accreditation 13
      6. Withdrawal of Accreditation, Administrative 14
   C. ACGME Requirements for All Residency Programs 14
      1. Web Accreditation Data System (WebADS) and Other GME Data Collection Systems 14
2. Correspondence with RRCs 14
3. Core Competencies 15
4. Curriculum 19
5. Program Letter of Agreement 19
6. Internal Reviews 19

IV. New York State Requirements 25
A. New York State Education Law 25
   1. Licensure 25
   2. Limited Permits 26
   3. Practice of Medicine within the State without Either a License or Limited Permit 26
B. Professional Misconduct 28
   1. Types of Misconduct 28
   2. Additional Reporting Requirements 29
C. New York State Hospital Code Section 405 30

V. Institutional Requirements and Policies 31
A. Health Insurance Portability and Accountability Act of 1996 (HIPAA) 31
B. Drug-Free Workplace 32
C. House Staff Duty Hours 32
   1. ACGME Requirements 33
   2. ACGME Work Hours Exceptions 34
   3. New York State Requirements 35
   4. New York State Required Documentation 35
D. Moonlighting 36
E. Supervision 37
   1. New York State Requirements 38
   2. Mount Sinai Requirements 38
F. Privileging 39
   1. New York State Requirements 39
   2. Mount Sinai Requirements 39
G. Medicare Billing and Residents’ Responsibilities 40
   1. 1998 Audit 40
   2. Billing Requirements 41
H. Interactions with Outside Vendors 41
   1. Gifts 42
   2. Vendor Support for Medical Center Educational Events 43
   3. Vendor Support for Off-Campus Educational Events 45
   4. Pharmaceutical Samples 47
I. Compliance Program 47
J. Disasters Affecting One or More Residency Program 48
K. Visiting Residents from Non-Consortium Hospitals 49

VI. RESIDENCY PROGRAM MANAGEMENT 51
A. Recruitment of House Staff 51
   1. Resident Selection 51
   2. Resident Eligibility 52
B. Residency Data Management 53
   1. Consortium Resident Information Form 53
   2. New Innovations Residency Management Software 54
C. Rotation of Residents from Consortium Hospitals
to The Mount Sinai Hospital 55
D. Alteration in Size or Type of Residency Training Program 56
   1. ACGME-Approved Programs 56
   2. Non-ACGME-Approved Programs 58
E. Contracts 59
F. Reappointment 59
G. Leaves of Absence 59
H. Supervision 60
I. Evaluations 61
   1. Evaluation of the House Staff Officer 61
   2. Evaluation of Faculty 62
   3. Evaluation of the Program 62
J. Monitoring Educational Outcomes 63
K. Issuance of Discipline or Academic Advisements
to House Staff 64
   1. Types of Intervention 64
   2. Job Retention 64
   3. Administrative Suspension 65
   4. Investigation and Documentation 65
   5. Communication to the House Staff Officer 65
   6. Reporting Disciplinary Action 66
   7. Institutional Support 67
L. Disciplinary Action 67
M. Program Closure or Reduction and Adverse Accreditation Actions 70
N. Physician Impairment 70
O. The International Medical Graduate 71
   1. Educational Commission for Foreign Medical Graduates (ECFMG) 71
   2. Visas 72
   3. Exchange Visitor J-1 Visa 72
   4. Temporary Worker H-1B Visa 73
   5. Student F-1 Visa 74
   6. Persons of Extraordinary Ability O-1 Visa 74
   7. Lawful Permanent Resident (Immigrant) 74
   8. International Personnel Office 74

VII. GME RESOURCES 77
   A. The House Staff Manual 77
   B. House Staff Representation 77
   C. Institute for Medical Education 78
      1. Mission Statement 78
      2. Goals and Benefits of Membership 79
      3. Current Programs 80
   D. Program Directors Travel Fund 81
   E. Visiting Electives Program for Students
      Underrepresented in Medicine 82
   F. Academic Program in the Medical Specialties
      for Visiting Physicians 82
      1. Certificate Program 83
      2. Diploma Program 83
      3. Tuition 83
      4. Application Process 84
   G. Fifth Pathway Program 84
   H. The GME Web Site 84
   I. Jobsite 85

VIII. APPENDICES (DOWNLOADS)
   Appendix 1: List of Useful Web Addresses
   Appendix 2: Residency Program Directors Contact List
   Appendix 3: Program Letter of Agreement (Affiliates)
   Appendix 4: Program Letter of Agreement (Non-Affiliates)
   Appendix 5: Resident Work Hours Limits: Comparison Guideline
   Appendix 6: Request for Duty Hours Exceptions
   Appendix 7: Moonlighting Approval and Attestation
   Appendix 8: Visiting Physician (Resident/Fellow) Agreement
   Appendix 9: New House Staff Registration Form
Appendix 10: Mount Sinai House Staff Rotator Form
Appendix 11: Request to Fill an ACGME Position with Non-Hospital Funds
Appendix 12: Request to Fill a Non-ACGME Position with Non-Hospital, Non-School Funds
Appendix 13: Program Directors Travel Fund Request Form
I. Introduction

In the past, being a Residency Program Director was an enjoyable and, in general, an easily manageable task. One could pursue clinical practice, research activities, and teaching responsibilities while functioning as a Program Director with little difficulty. Today, while directing a residency program is still not considered a full-time job, the requirements and responsibilities of this position represent an ever-greater share of a Program Director’s work activities (Tables 1-3). It is for this reason that most ACGME Residency Review Committees require Program Directors to dedicate at least 50% (20 hours per week) of their professional effort to administration and education within their programs.

The requisite knowledge base of a Residency Program Director has expanded, and the administrative paperwork has mushroomed. In addition, the Program Director is now accountable to a number of individuals and organizations, including the Department Chairperson; Hospital Administration; Mount Sinai School of Medicine (as institutional sponsor of many Consortium residency programs) and its Designated Institutional Official; the Mount Sinai Consortium for Graduate Medical Education and its GME Committee; the Joint Commission on Accreditation of Health Care Organizations (JCAHO); and the appropriate Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME). It is the ACGME that develops standards for most graduate medical education programs, assesses programs’ compliance with Institutional Requirements, Common Program Requirements, and specialty-specific Program Requirements, and accredits training programs based on site surveys.

A Program Director’s effective time management becomes increasingly important, as does the ability to understand and comply with institutional, organizational, and governmental requirements and standards for postgraduate education.

The objective of this manual is to provide Program Directors with the information they need to accomplish the goals of the residency program.
effectively. Since many issues discussed here also appear in the House Staff Manual, this manual cross-references information when addressing a concern that also pertains to House Staff. The manual also refers to the ACGME Institutional and Program Requirements, which may be found on the ACGME website [http://www.acgme.org/].

As with any attempt at a comprehensive manual, there will undoubtedly be subjects that have not been addressed or issues that could be discussed more fully. Please feel free to share your comments and concerns so that the next edition may be of even greater assistance.

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ADMINISTRATIVE RESPONSIBILITIES OF PROGRAM DIRECTORS</strong></td>
</tr>
<tr>
<td>• Annual, documented review of educational program with faculty and resident representatives</td>
</tr>
<tr>
<td>• Appointment of Chief Resident</td>
</tr>
<tr>
<td>• Compliance with ACGME (or other accrediting organization) and specialty board requirements</td>
</tr>
<tr>
<td>• Development of curriculum and goals and objectives that are delineated by rotation and year of training</td>
</tr>
<tr>
<td>• Duty hours monitoring</td>
</tr>
<tr>
<td>• Confirmation of resident eligibility, including certification, visas, and licensure</td>
</tr>
<tr>
<td>• Fellowship placement assistance</td>
</tr>
<tr>
<td>• House staff scheduling and assignments</td>
</tr>
<tr>
<td>• Implementation of residency management software</td>
</tr>
<tr>
<td>• Letters of recommendation for residents</td>
</tr>
<tr>
<td>• Maintenance of resident files, including documentation of resident evaluations, privileges, procedures</td>
</tr>
<tr>
<td>• Office management</td>
</tr>
<tr>
<td>• Orientation manual preparation</td>
</tr>
<tr>
<td>• Preparation for accreditation site visits</td>
</tr>
<tr>
<td>• Preparation of recruiting brochures</td>
</tr>
<tr>
<td><strong>SUPERVISORY RESPONSIBILITIES OF PROGRAM DIRECTORS</strong></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>• Advisement and Discipline</td>
</tr>
<tr>
<td>• Career Counseling</td>
</tr>
<tr>
<td>• Conflict Resolution</td>
</tr>
<tr>
<td>• Credentialing</td>
</tr>
<tr>
<td>• Evaluation and Feedback</td>
</tr>
<tr>
<td>• Faculty Qualifications and Professional Development</td>
</tr>
<tr>
<td>• Mentorship</td>
</tr>
<tr>
<td>• Personnel Activities</td>
</tr>
<tr>
<td>• Research and Scholarly Activity</td>
</tr>
<tr>
<td>• Residency Program Administration</td>
</tr>
<tr>
<td>• Stress Identification and Management</td>
</tr>
<tr>
<td>• Visiting Residents</td>
</tr>
<tr>
<td>• Work Hours</td>
</tr>
<tr>
<td>Table 3</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>MAJOR CHALLENGES INHERENT IN DIRECTING A RESIDENCY PROGRAM</strong></td>
</tr>
<tr>
<td>• Need to report to many individuals and organizations within and</td>
</tr>
<tr>
<td>outside of the hospital</td>
</tr>
<tr>
<td>• Greater pressure to manage costs of program</td>
</tr>
<tr>
<td>• Need to balance service to hospital with maintaining optimal</td>
</tr>
<tr>
<td>educational environment for residents</td>
</tr>
<tr>
<td>• Increasing complexity of accreditation process</td>
</tr>
<tr>
<td>• Compliance with Section 405 of New York State Health Code and</td>
</tr>
<tr>
<td>ACGME requirements concerning resident duty hours</td>
</tr>
<tr>
<td>• Financial constraints of hospitals</td>
</tr>
<tr>
<td>• Increasing inability to devote sufficient time to program director’s</td>
</tr>
<tr>
<td>research and clinical activities</td>
</tr>
<tr>
<td>• Ensuring that residents’ service responsibilities do not exceed the</td>
</tr>
<tr>
<td>educational goals of the program</td>
</tr>
</tbody>
</table>
II. Mount Sinai School of Medicine Consortium for Graduate Medical Education

A. BYLAWS

1. Mission Statement

The Consortium for Graduate Medical Education is dedicated to the centralization, enhancement, and oversight of the quality of education provided to House Staff at all participating institutions, and to maintain and to improve its graduate medical education programs. At present, the 15 participating hospitals (Table 4) train over 2,200 residents in over 130 ACGME-approved residency programs.

2. Membership

The Consortium for Graduate Medical Education, hereafter referred to as “the Consortium,” will consist of Mount Sinai School of Medicine (“the School”), The Mount Sinai Hospital, and all affiliated institutions that have established an academic affiliation with the School for sponsorship of residencies and/or participation in joint graduate medical education (“GME”) programs.

3. Responsibilities

All members of the Consortium agree: a) to abide by agreed-upon rules of governance; b) to adhere to both academic and educational standards; c) to adhere to the “Mission Statement” of the Consortium (above); and d) to provide appropriate educational and financial support for Consortium activities and for the human resources necessary to maintain high-quality residency programs.

While it is recognized that residency programs will be subject to member institutions’ policies and procedures, all programs must meet the departmental standards established by the respective Chairs at the School and the institutional standards set by the School. In addition, all participating hospitals and residency programs must comply with ACGME Institutional and Program
Requirements and applicable special requirements. Affiliation agreements between the School and each participating institution will remain in place and will be reviewed regularly.

### Table 4

**MOUNT SINAI CONSORTIUM FOR GRADUATE MEDICAL EDUCATION**

<table>
<thead>
<tr>
<th>New York City</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabrini Medical Center</td>
<td>Elmhurst Hospital Center</td>
<td>Jamaica Hospital—Family Practice Residency Training Program</td>
</tr>
<tr>
<td></td>
<td>James J. Peters (Bronx) Veterans Affairs Medical Center</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maimonides Medical Center</td>
<td>The Mount Sinai Medical Center</td>
</tr>
<tr>
<td></td>
<td>North General Hospital</td>
<td>Queens Hospital Center</td>
</tr>
</tbody>
</table>

| New Jersey             | Englewood Hospital and Medical Center | Jersey City Medical Center |
|                        | Morristown Memorial Hospital       | Newark Beth Israel Medical Center |
|                        | Overlook Hospital                  | Saint Barnabas Medical Center |
|                        | St. Joseph’s Regional Medical Center |                            |

4. **Objectives**

a. Enhance the quality of education, regardless of specialty, for all residents at all participating institutions.

i. Monitor and evaluate the quality of education within each sponsored residency program in the Consortium. Internal Reviews will be conducted for each sponsored residency program at the midpoint between RRC site surveys to ensure compliance with ACGME and institutional standards. Additional reviews may be conducted between the midpoint and the RRC site visit if Internal Reviews find areas of noncompliance. The results of Internal Reviews and RRC site surveys as well as any major changes to sponsored residency programs will be reviewed at monthly meetings of the Consortium’s GME Committee (“GMEC”).
ii. Develop a general educational curriculum across all departments and institutions, which will include discussions of:

1) cultural diversity;
2) alcoholism and substance abuse;
3) medical ethics;
4) care of the elderly;
5) physician-patient relationships;
6) preventive medicine;
7) physician impairment;
8) pain control;
9) sleep deprivation in residency training;
10) leadership;
11) practice in a managed care environment;
12) teaching Core Competencies;
13) use of the ACGME Core Competencies in evaluation and educational outcomes; and
14) scholarly activity

iii. Develop methods of assessing clinical competence.

iv. Expand the academic educational network by implementing a database for resident tracking and evaluation through web-based software provided by New Innovations. This system will facilitate:

1) the collection of demographic data;
2) the credentialing of house staff;
3) the completion of evaluations;
4) the measurement of compliance with New York State and ACGME duty hours standards; and
5) the transfer of data to IRIS for Medicare reimbursement.

b. Alter current distribution of graduate training positions to meet changing societal needs.
Program Directors Manual

i. Achieve a 50% distribution of generalists and specialists in the aggregate of Consortium residency positions.

ii. Revise structure of all Pediatrics and Internal Medicine programs to allow them to meet criteria for providing sufficient training in primary care.

iii. Monitor Consortium educational resources to allow residents at participating institutions to benefit from resources available at other participating institutions.

iv. Develop (if needed) ambulatory care sites for residency training within communities served by Consortium members.

v. Combine separate educational programs when necessary.

c. Meet the needs of communities served by Consortium members.

i. Enhance residency program recruitment of minorities underrepresented in medicine.

ii. Encourage house staff to practice in underserved communities upon completion of training through development of loan forgiveness programs.

iii. Develop evaluation techniques to measure outcomes with respect to ultimate practice location, specialty, and ability to pass certifying examinations.

d. Establish uniform administrative policies.

i. Establish uniform policies for residents in such areas as benefits, evaluation and advancement, and due process.

ii. Act as forum for discussion between administration, house staff, and faculty on all matters pertaining to GME.

iii. Establish quality assurance programs to diminish adverse incidents by residents and house staff.

iv. Assure appropriate house staff credentialing.

v. Insure that a forum exists at each institution and within each residency program to allow house staff to express their educational concerns.
5. Commitment to Diversity

Mount Sinai School of Medicine is committed to promoting diversity in all working and learning environments and to providing appropriate resources to all of our students, residents, faculty, and staff as well as the communities we serve.

6. Structure

The GMEC will be chaired by the Dean for Graduate Medical Education, who will hold the position of ACGME Designated Institutional Official (DIO) and will be charged with assuring that all Consortium objectives are met.

The GMEC will be composed of the Dean and Associate Deans for GME, four chairs or program directors from the School, and one or two representatives responsible for GME administration at each affiliate institution, and at least six, but not more than twelve, peer-selected residents in ACGME-accredited positions. All members will have voting rights.

The GMEC will meet at least monthly and will appoint ad hoc committees as needed. There will be two standing subcommittees that will meet as deemed appropriate:

a. Internal Review

This committee will consist of the Dean and Associate Deans for GME, GMEC members, faculty members with experience in GME, and resident representatives. Its charge will be to perform Internal Reviews of all residency and fellowship programs at the midpoint between RRC site surveys.

b. ACGME Core Competencies

This committee will be charged with defining methods of integrating the Competencies in the residency curriculum, including the implementation of Competency-based instruction and evaluation and the development of outcome measures linked to the Competencies.

The GMEC is accountable and will report to the Dean of the School and the Chief Executive Officer of The Mount Sinai Medical Center. Each representative of each participating institution will report to the Chief Executive Officer of his or her respective institution. All recommendations will be forwarded to the Dean and Chief Executive Officer of each member institution. If a recommendation is not unanimous, a dissenting opinion may also be forwarded.
III. Accreditation Council for Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME) is a private, nonprofit council that evaluates and accredits residency programs in the United States. There is a Residency Review Committee (RRC) for each approved specialty. Accreditation of a residency program indicates that it is judged in substantial compliance with the Essentials of Accredited Residencies in Graduate Medical Education (hereafter referred to as the “Essentials”), including Institutional Requirements and Program Requirements.

In 2005-2006, there were 8,186 ACGME-accredited programs training 103,367 residents in 120 specialties; RRCs proposed adverse actions for 9.2% of all programs surveyed.

Program directors may respond to the adverse actions described below for both general and subspecialty programs when they are proposed. The rebuttal process can be located in the “Essentials” and should be acted on promptly upon notification of a proposed adverse action. It should be emphasized that if an adverse action is confirmed, all residents in the program must be notified.

It should also be noted that in addition to the adverse actions below, accreditation with warning may be issued by the RRC to advise a Program Director of serious concerns about the quality of the program. Because this is not considered to be an adverse action, it is not subject to rebuttal.

A. ACCREDITATION STATUS FOR CORE PROGRAMS

Subsequent to a visit from the RRC, the ACGME confers an accreditation status on the program and identifies areas of noncompliance with Institutional and/or Program Requirements. Types of accreditation actions are listed below.

1. Withheld Accreditation

Accreditation is withheld when an RRC determines that the application for a new program does not demonstrate substantial compliance with the requirements.
2. Initial Accreditation

Accreditation is conferred initially when an RRC determines that a proposal for a new program substantially complies with the requirements.

3. Continued Accreditation

Accreditation is continued when an RRC determines that a program has demonstrated substantial compliance with the requirements. Typically, the maximum length of the cycle awarded by the RRC is five years. Cycle length is based upon the accreditation status, issues identified by the RRC, and areas of noncompliance.

4. Probationary Accreditation

Probationary accreditation is conferred when an RRC determines that a program has failed to demonstrate substantial compliance with the requirements. The length of the review cycle for this status may not exceed two years.

5. Withdrawal of Accreditation

An RRC may withdraw accreditation of a program under probationary accreditation when it determines, following a site visit and review, that a program has failed to demonstrate substantial compliance with the requirements.

Regardless of a program’s accreditation status, an RRC may withdraw the accreditation of a program in an expedited process based on clear evidence of noncompliance with accreditation standards due to a catastrophic loss of resources, including faculty, facilities, or funding, or egregious noncompliance with accreditation requirements.

B. ACCREDITATION STATUS FOR SUBSPECIALTY PROGRAMS

The accreditation status of a subspecialty program that is required to function in conjunction with an accredited specialty program is related to, or dependent upon, the status of that program. Because of this dependency, only a limited number of accreditation actions are appropriate.
1. **Withheld Accreditation**

An RRC may withhold accreditation when the application for a new subspecialty program does not substantially comply with the requirements. The policies and procedures on withheld accreditation of specialty programs also apply to the actions concerning subspecialty programs.

2. **Accreditation**

An RRC may grant accreditation when the dependent subspecialty program has demonstrated substantial compliance with the requirements.

3. **Accreditation with Warning**

An RRC may grant accreditation with warning when the dependent subspecialty program has been found to have one or more areas of noncompliance with the requirements that are of sufficient substance to require prompt correction. In such cases, a resurvey is conducted within two years.

4. **Accreditation with Warning, Administrative**

An RRC may grant administrative accreditation with warning, administrative, when a specialty program to which a subspecialty program is attached has been granted probationary accreditation. This constitutes an administrative warning of potential loss of accreditation to a subspecialty program.

5. **Withdrawal of Accreditation**

An RRC may withdraw accreditation if, following a site visit and review, the accredited dependent subspecialty program does not substantially comply with the requirements and has received a warning about areas of noncompliance. The policies and procedures on withdrawal of accreditation for specialty programs also apply to the actions concerning subspecialty programs.
6. Withdrawal of Accreditation, Administrative

If a specialty program has its accreditation withdrawn, the accreditation of any subspecialty program that is attached to the general specialty program is administratively withdrawn simultaneously.

C. ACGME Requirements for All Residency Programs

The ACGME maintains requirements not only for institutional sponsorship of programs but also for specific training programs in general and subspecialty areas. These Institutional and Program Requirements may be found on the ACGME website. These requirements supplement the policies and procedures of the Consortium and of the institution at which the program is based. Program Directors should also refer to the House Staff Manual for additional policies. The following information is intended to assist Directors in meeting ACGME requirements efficiently and comprehensively.

1. Web Accreditation Data System (ADS) and Other GME Data Collection Systems

The Web Accreditation Data System (WebADS) is a secure Internet-based data collection system on the ACGME’s website that collects and maintains data on residents, program structure and leadership, RRC activity for the program, and sponsoring institutions. Similar information is to be posted to the AAMC’s GME Track Census, which also feeds into the AMA’s FREIDA online system.

The GME Database Administrator may assist programs in uploading basic resident data from New Innovations to WebADS. However, each program must log in to both New Innovations and WebADS to update general program information and to accept/approve the uploaded records. User names and passwords are provided directly to Program Directors by the ACGME and the AAMC.

2. Correspondence with RRCs

As Designated Institutional Official, the Dean for Graduate Medical Education at Mount Sinai School of Medicine must cosign all correspondence to an RRC. Program directors are required to communicate with the RRC when information is requested or before major changes are made to a program. Types of submissions to the RRC include:

a. accreditation applications for new programs
b. changes in resident complement

c. major changes in program structure or length of training

d. additions and deletions of participating sites

e. appointments of new program directors

f. progress reports requested by any RRC

g. responses to all proposed adverse actions

h. requests for exceptions of resident duty hours

i. voluntary withdrawal of accreditation

j. requests for an appeal of an adverse action

k. appeal presentations to a Board of Appeal or the ACGME

It should be noted that complement change requests and new program director appointments must now be submitted through WebADS.

The Office for Graduate Medical Education is available to provide assistance in composing correspondence to an RRC.

3. Core Competencies

The ACGME now mandates that a residency program must require its residents to obtain competence in the six areas listed below to the level expected of a new practitioner. Programs must define the specific knowledge, skills, behaviors, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate:

a. Patient Care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:

   i. communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families

   ii. gather essential and accurate information about their patients

   iii. make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment

   iv. develop and carry out patient management plans

   v. counsel and educate patients and their families
vi. use information technology to support patient care decisions and patient education

viii. perform competently all medical and invasive procedures considered essential for the area of practice

ix. provide health care services aimed at preventing health problems or maintaining health

x. work with health care professionals, including those from other disciplines, to provide patient-focused care

b. Medical Knowledge about established and evolving biomedical, clinical and cognate (i.e. epidemiological and social/behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

i. demonstrate an investigatory and analytic thinking approach to clinical situations

ii. know and apply the basic and clinically supportive sciences which are appropriate to their discipline

c. Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Residents are expected to:

i. analyze practice experience and perform practice-based improvement activities using a systematic methodology

ii. locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems

iii. obtain and use information about their own population of patients and the larger population from which their patients are drawn

iv. apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

v. use information technology to manage information, access on-line medical information; and support their own education

vi. facilitate the learning of students and other health care professionals
d. **Interpersonal and Communication Skills** that result in effective information exchange and collaboration with patients, their families, and other health professionals. Residents are expected to:

i. create and sustain a therapeutic and ethically sound relationship with patients

ii. use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills

iii. work effectively with others as a member or leader of a health care team or other professional group

e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

i. demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development

ii. demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices

iii. demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities

f. **Systems-Based Practice**, as manifested by actions that 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:

i. 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

ii. know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
iii. practice cost-effective health care and resource allocation that does not compromise quality of care

iv. advocate for quality patient care and assist patients in dealing with system complexities

v. 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

Table 5

<table>
<thead>
<tr>
<th>General Competencies</th>
<th>Evaluation Tools Used or in Development by the Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>Developing OSCE, Mini CEX, Patient Surveys, Procedure Logs</td>
</tr>
<tr>
<td>Medical Knowledge</td>
<td>Chart-Stimulated Recall, Oral Exam, Written Multiple-Choice Exam</td>
</tr>
<tr>
<td>Interpersonal and Communication Skills</td>
<td>Developing 360-Degree, Patient Surveys, Standardized Patients</td>
</tr>
<tr>
<td>Professionalism</td>
<td>360-Degree, Checklist</td>
</tr>
<tr>
<td>Practice-Based Learning</td>
<td>Resident Portfolios, Developing Oral Exam, Record Review</td>
</tr>
<tr>
<td>Systems-Based Practice</td>
<td>Developing Resident Portfolios, Developing 360-Degree</td>
</tr>
<tr>
<td></td>
<td>Other Tools Designed by the Program?</td>
</tr>
</tbody>
</table>

There are a number of ways to teach and assess the Competencies (Table 5). Program Directors are encouraged to utilize the materials that best suit the program’s needs. During Internal Reviews by the Office for Graduate Medical Education, the Internal Review Committee reviews the progress that has been made in implementing the Core Competencies, including corrective plans for residents who have demonstrated deficiencies in any of the Competencies.

Program directors should also read Section VI.J in this Manual for information about assessment methods for attainment of the Competencies.
4. **Curriculum**

Each residency program must establish and distribute to residents a curriculum containing goals and objectives for the residency. Goals and objectives must be delineated by rotation and by year of training. Before the beginning of each rotation, program faculty must review the rotation’s goals and objectives with each resident. Program faculty and resident representatives must have annual, documented meetings to review the curriculum as described below in Section VII.

5. **Program Letter of Agreement**

The ACGME requires that a Program Letter of Agreement be developed for each institution to which residents rotate. This Agreement is distinct from a Master Affiliation Agreement signed by Mount Sinai School of Medicine and an affiliated institution.

The Program Letter of Agreement must contain the following information:

a) the names of all faculty who will assume both educational and supervisory responsibilities for residents; b) faculty responsibilities for teaching, supervision, and formal evaluation of residents; c) the duration and content of the educational experience; and d) the policies and procedures that will govern resident education during the assignment. The required form for Program Letters of Agreement for rotations within the Consortium is Appendix 3 to this Manual. The form for rotations to non-Consortium institutions is Appendix 4. All other signatures should be obtained before forwarding to the Dean for Graduate Medical Education for signature. *It should be noted that Program Letters of Agreement are not needed for ambulatory care facilities or for rotations to physicians’ offices, unless specifically requested by an RRC in its program requirements.*

6. **Internal Reviews**

The Internal Review Committee (IRC) of the Graduate Medical Education Committee (GMEC) is responsible for conducting regular reviews of all residency programs of institutions within the Consortium to ensure their compliance with general, as well as program, requirements of the Accreditation Council for Graduate Medical Education (ACGME).

The review will be scheduled at the midpoint between the effective date of the most recent ACGME accreditation status and the next scheduled RRC program site visit. If necessary, more frequent reviews will occur.
The review shall be conducted by members of the IRC and follow the procedures outlined below. Subsequent to the review, a report shall be made to the GMEC containing the findings and recommendations of the IRC.

a. Composition

The IRC will be drawn from members of the GMEC and shall include the following:

i. *Administration*: At least one of the deans for GME, who shall serve as IRC Chair.

ii. *Faculty*: At least one faculty member from departments other than the program being reviewed.

iii. *Residents*: At least one resident from a sponsored residency program in the Consortium.

b. Review of Documents

Prior to the actual meeting of the IRC, each committee member and each representative of the program interviewed by the IRC will be provided with the following materials and data:

i. The pertinent section from “Essentials of Accredited Residencies in Graduate Medical Education.”

ii. The previous ACGME Accreditation letters and subsequent correspondence.

iii. The previous Internal Review report.

iv. Results of the ACGME Resident Survey.

In turn, the program is responsible for compiling the following written information for review by the IRC:

v. Goals and objectives for each year of training and for each rotation.

vi. Departmental policies regarding the supervision of residents.

vii. Minutes of the most recent curriculum review by faculty and resident representatives.

viii. Curriculum vitae for key program faculty. (In core programs, a list of representative publications will suffice.)
ix. Samples of all evaluation forms used in residency education, including evaluations of residents, faculty, rotations, and the program.

The program may be asked to provide supplemental information (e.g., resident portfolios) at the time of the Internal Review.

c. Meeting with Program Director

A meeting with the Program Director, Chairman, and key faculty will address the following issues:

i. Educational objectives of the program.

ii. Instructional plans formulated to achieve these objectives that encompass the six general competencies: Patient Care, Medical Knowledge, Interpersonal and Communication Skills, Professionalism, Practiced-Based Learning, and Systems-Based Practice:

1) Assessment whether each program has defined, in accordance with the relevant Program Requirements, the specific knowledge, skills, and attitudes required and provides educational experiences for the residents to demonstrate competency in the following areas: patient care skills, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice.

2) Provision of evidence of the program’s use of evaluation tools to ensure that the residents demonstrate competence in each of the six areas.

3) Appraisal of the development and use of dependable outcome measures by the program for each of the general competencies once the program has had experience with these tools over a period of time.

4) Appraisal of the effectiveness of each program in implementing a process that links educational outcomes with program improvement.

iii. Adequacy of available resources to meet these objectives.

iv. Effectiveness of the program in:

1) Utilizing resources provided.
2) Supervising residents.

3) Addressing recommendations of previous Internal Reviews.

4) Addressing recommendations of previous ACGME surveys.

5) Developing a program to evaluate ACGME Core Competencies that will include:

6) Implementing a process that links educational outcomes with program improvements.

    v. Residents’ performance on internal examinations and certifying board examinations.

    vi. Compliance with ACGME duty hours standards.

    vii. Adequate scholarly activity by residents and faculty as defined in ACGME Common Program Requirement IV.B.

    viii. Process and documentation of evaluations of the residents, faculty, and curriculum.

d. Meeting with Residents

   The IRC will meet with resident representatives (one from each year of the program) in the absence of program faculty to review their perceptions of the strengths and weaknesses of the program, utilizing a similar format to that noted above.

   Specific information will be obtained concerning:

   i. The systems used to improve the work environment and educational program.

   ii. The processes used to address resident concerns in a confidential and protected manner.

   iii. The means of redress for complaints and grievances that could result in dismissal from the program.

   iv. Supervision of residents during all clinical activities.

   v. Residents’ access to their files (including evaluations).

   vi. Residents’ confidential evaluations of the faculty, rotations, and the educational program.
vii. Instruction and support to provide compassionate, appropriate, and effective patient care and to meet the training objectives inherent in the ACGME Core Competencies.

e. Final Report

Within two weeks of review, a final Internal Review report will be forwarded to the Program Director, with copies to the Dean of Mount Sinai School of Medicine, the Chairperson of the department under review, and the Chief Executive Officer of the institution. This report will contain:

i. Verification of the existence of a curriculum with goals and objectives delineated by rotation and year of training.

ii. Assessment of the program’s methods for evaluating the residents, faculty, and curriculum.

iii. A summary of the tools being developed and implemented by the program for instruction and assessment concerning the ACGME Core Competencies.

iv. Confirmation of appropriate supervision of residents in the program.

v. An evaluation of scholarly activity as defined in the ACGME Common Program Requirements (IV.B).

The report will be presented for review by the GMEC at a subsequent meeting. A summary of the final recommendations will be provided to the GMEC for discussion. The GMEC, upon receipt of this information, will consider the recommendations and take appropriate action to make certain the issues raised are addressed by the Program Director and the institution.

f. Progress Report by Program Director

The program director must submit to the Dean for Graduate Medical Education (also the Designated Institutional Official, or DIO) a progress report detailing the program’s progress in correcting areas of noncompliance with ACGME standards and concerns raised by residents during the Internal Review. The progress report is due within three months of receipt of the Internal Review report. The DIO will present the progress report to the GMEC for review. If the response is not considered adequate by the GMEC, another Internal Review may be scheduled.
IV. New York State Requirements

A. NEW YORK STATE EDUCATION LAW

1. Licensure

Graduates of American, Puerto Rican, and Canadian medical schools who have passed all parts of the United States Medical Licensing Examination (USMLE) can apply for licensure in the State of New York after satisfactorily completing one year of residency training in an ACGME-accredited program. Graduates of foreign medical schools who have passed all parts of the USMLE and who have received ECFMG certification may also apply for licensure after three years of training in an ACGME-accredited residency program. Physicians in ACGME-accredited residency programs who practice medicine under supervision are not specifically required by New York State to have a license or a limited permit.

The Mount Sinai Hospital, however, requires graduates of American, Puerto Rican, and Canadian medical schools to apply for a New York State license or a limited permit after their first postgraduate year (see House Staff Manual). International Medical Graduates (IMGs) must apply for a New York State limited permit after their PG-3 year and must show the limited permit or license by the middle of their PG-4 year to be eligible for reappointment for the PG-5 year. An exception is an IMG who is to be a Chief Resident or a Fellow in the PG-4 year. These residents will need to obtain the New York State limited permit while still in their PG-3 year to be appointed to that position. In accordance with the regulations of The Mount Sinai Hospital, all Fellows and Clinical Fellows must have a New York State limited permit or permanent license before they can be appointed, regardless of New York State Education Department regulations.
Failure to obtain a license by the required time will not prevent a resident from advancing to the next postgraduate year, but the resident’s salary level will remain at the previous level until the license is granted.

2. **Limited Permits**

A limited permit allows an individual to practice medicine only under the supervision of a licensed physician and only in a public, voluntary, or proprietary hospital. The limited permit is valid for only two years but may be renewed biannually at the discretion of the department.

In accordance with Article 131, Section 6525 of New York State Education Law, the following individuals are considered eligible for a limited permit:

   a. A person who fulfills all requirements for a license as a physician except those relating to the examination and citizenship or permanent residence in the United States;

   b. A foreign physician who holds a standard certificate from the Educational Commission for Foreign Medical Graduates or who has passed an examination satisfactory to the State Board for Medicine and in accordance with the commission’s regulations; or

   c. A foreign physician or a foreign intern who is in the country on a non-immigration visa for the continuation of medical study, pursuant to the exchange student program of the United States Department of State.

The fee for each limited permit and for each renewal is $105.

3. **Practice of Medicine within the State without Either a License or Limited Permit**

It is possible to be exempt from having either a license or a limited permit in accordance with New York State Education Law, Article 131, Section 6526. Under the following limitations, a person may practice medicine within the State without a license:

   a. Any physician who is employed as a resident in a public hospital provided such practice is limited to such hospital and is under the supervision of a licensed physician;

   b. Any physician who is licensed in a bordering state and who resides near a border of this state, provided such practice is limited in this state to the vicinity of such border and provided such physician does not
maintain an office or place to meet patients or receive calls within this state;

c. Any physician who is licensed in another state or country and who is meeting a physician licensed in this state for purposes of consultation, provided such practice is limited to such consultation;

d. Any physician who is licensed in another state or country, who is visiting a medical school or teaching hospital in this state to receive medical instruction for a period not to exceed six months, or to conduct medical instruction, provided such practice is limited to such instruction and is under the supervision of a licensed physician;

e. Any physician who is authorized by a foreign government to practice in relation to its diplomatic, consular, or maritime staffs, provided such practice is limited to such staffs;

f. Any commissioned medical officer who is serving in the United States Armed Forces or public health service, or any physician who is employed in the United States Veterans Administration, provided such practice is limited to such service or employment;

g. Any intern who is employed by a hospital and who is a graduate of a medical school in the United States or Canada, provided such practice is limited to such hospital and is under the supervision of a licensed physician;

h. Any medical student who is performing a clinical clerkship or similar function in a hospital and who is matriculated in a medical school that meets standards satisfactory to the department, provided such practice is limited to such clerkship or similar function in such hospital;

i. Any dentist or dental school graduate eligible for licensure in the state who administers anesthesia as part of a hospital residency program established for the purpose of training dentists in anesthesiology;

However, consistent with Section 405.4 of the New York State Health Code, residents who are unlicensed, even those with limited permits, must be appropriately monitored. As such, the Program Director must:

j. review the licensure, education, training, physical and mental capacity, and experience of individuals practicing under the provisions of this subdivision;
k. based on written criteria, recommend privileges that are specific to treatments and procedures for each individual prior to delivery of patient care services;

l. continuously monitor patient care services provided by such individuals to assure provision of quality patient care services within the scope of privileges granted; and

m. take disciplinary action or other corrective measures against the individual providing service and/or the attending/ supervising physician when services provided exceed the scope of privileges granted.

Additional information regarding licensure is available on the New York State Department of Education website.

B. PROFESSIONAL MISCONDUCT

1. Types of Misconduct

New York State law defines the parameters of misconduct. The following is a summary of the most significant types of professional misconduct that must be reported. The complete text of this act can be found in Article 131-A (Definitions of Professional Misconduct Applicable to Physicians, Physician Assistants, and Specialist Assistants) of New York State Law.

a. Obtaining the license fraudulently

b. Practicing the profession fraudulently or beyond its authorized scope

c. Practicing the profession with negligence on more than one occasion

d. Practicing the profession with gross negligence on a particular occasion

e. Practicing the profession with incompetence on more than one occasion

f. Practicing the profession with gross incompetence

g. Practicing the profession while impaired by alcohol, drugs, physical disability or mental disability

h. Being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects, except for a licensee who is maintained on an approved therapeutic regimen which does not impair the ability to practice, or having a psychiatric condition which impairs the
licensee’s ability to practice
i. Being convicted of committing an act constituting a crime
j. Being found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was made would, if committed in New York State, constitute professional misconduct under New York State law
k. Accepting and performing professional responsibilities that the practitioner knows s/he is not competent to perform
l. Delegating professional responsibilities to a person when the practitioner knows or has reason to know such person is not qualified to perform them
m. Performing professional services that have not been duly authorized by the patient or his or her representative
n. Altering or falsifying medical records in such a way that needed information for patient care is omitted or falsified
o. Fee splitting

2. Additional Reporting Requirements

In addition to the requirement that a physician be reported for conduct described above, any licensed health care professional and any physician in training must be reported if the following should occur:

a. The suspension, restriction, termination, or curtailment of the training, employment, association, or professional privileges of a licensed health care practitioner, or medical resident, related in any way to:
   i. alleged mental or physical impairment;
   ii. incompetence;
   iii. malpractice;
   iv. misconduct; or
   v. impairment of patient welfare.

b. The denial of certification or completion of training of any individual for reasons related in any way to I.A-E above.
c. The voluntary or involuntary resignation or withdrawal of association, or of privileges, to avoid the imposition of disciplinary measures.

d. The receipt of information that indicates that any licensed health care professional or medical resident has been convicted of a crime.

e. The denial of staff privileges to a physician if the reasons for such denial are related to I.A-E above.

C. New York State Hospital Code 405.4

In the late 1980s, in response to the untoward death of a young woman in New York Hospital, the Bell Commission was formed to make recommendations concerning work hours and supervision of residents. In 1989, the New York State Hospital Code Section 405.4 was established, setting requirements for resident work hours and supervision. Although all hospitals in the State were expected to comply, compliance was variable; surgical programs were the least compliant.

Compliance was not pursued by the State until 1997, when, at the request of the New York City Public Advocate’s Office, inquiries into compliance began, and, in 1998, the State Health Department announced its intention to ascertain compliance of Section 405 through routine audits.

It is absolutely essential that all Program Directors make certain that their residents are in compliance with Section 405 of the New York State Hospital Code as well as all ACGME requirements. Principal parts of Section 405 are described in Section V.D-G.
V. Institutional Requirements

Institutional requirements will vary with each institution within the Consortium. In many instances institutional requirements will be identical to the material presented in the section on the ACGME. Many requirements are also printed in the House Staff Manual, which should be consulted when questions arise with respect to residents enrolled in training programs. The material provided below complements the information provided in Section III of this manual and in the corresponding sections of the House Staff Manual.

A. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed primarily to improve the efficiency and effectiveness of the health care system, while including the principles of fraud and abuse prevention. It also required Congress to enact comprehensive rules regarding privacy, security, and universal identifiers.

The Privacy Rule, which applies to all protected health information (PHI) regardless of format, went into effect on April 14, 2003.

The Security Rule, which applies to PHI in electronic format only (or ePHI), went into effect on April 23, 2005.

The National Provider Identifier (NPI) Rule, which requires that every provider who bills or plans to bill electronically apply for and use a single, lifetime NPI, went into effect in May 2007.

All members of the MSMC workforce must receive an annual HIPAA refresher training. The training is currently provided during Orientation and will soon be available on the Intranet. Additional targeted training is provided as appropriate.

Breaches of either the Privacy or Security Regulations must be reported to the Chief HIPAA Officer and will be investigated. Sanctions will be applied,
if appropriate, in accordance with institutional policy. (See HIPAA Sanctions Policy, H-17, on the HIPAA website.)

NPI applications and queries to the NPI database may be made by accessing the CMS website.

To ensure protection of both PHI and ePHI, HIPAA also requires that covered entities such as MSMC enter into a Business Associate Agreement (BAA) with its Business Associates (BAs). A Business Associate is any entity that handles PHI on the institution’s behalf. It is the Program Director’s responsibility to ensure that a HIPAA compliant agreement is signed with any such BA. An example of a BA is any residency oversight entity that requires PHI in order to certify a residency program. The BA agreement format, institutional HIPAA policies and HIPAA compliant forms are available on the Mount Sinai Intranet under Core Services/HIPAA.

B. DRUG-FREE WORKPLACE

The Mount Sinai Medical Center has always, to the best of its ability, tried to ensure that the work environment remains free from hazards to patients, employees, and visitors. In keeping with the mandates of the New York State Department of Health, the Joint Commission on Accreditation of Health Care Organizations, and the Drug-Free Workplace Act, all new employees, including house staff, are required to complete a health screening process before beginning work.

The adverse impact of substance abuse on workplace safety, efficiency, and productivity has been well documented and continues to be a primary concern to employers, employees, and the public. Toward that end, since July 1997, all incoming house staff have had urine toxicology testing included as part of their health screens. The testing screens for amphetamines, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates, and phencyclidine. All initial positive specimens are confirmed by gas chromatography and then reviewed by a certified Medical Review Officer. The results of any information relating to the drug screening are confidential, and a strict chain of custody is followed.

In general, there has been support of all groups within the institution, including house staff, for this position. It is anticipated that this policy will assist us in continuing to provide the best possible medical care.

C. HOUSE STAFF DUTY HOURS

Hours that residents are permitted to work are regulated by two separate agencies: the New York State Department of Health and the Accreditation Council for Graduate Medical Education (ACGME). Although their
Institutional Requirements and Policies

requirements are similar, Program Directors should be aware of the differences (Appendix 5).

Effective October 15, 2007, all House Staff Officers at The Mount Sinai Medical Center must log their time, including moonlighting and non-work periods, in the Duty Hours module of the New Innovations residency management software. This log replaces previous work hours monitoring systems. Please note that residents who rotate to or from Mount Sinai will also be required to log their time in New Innovations while on rotation.

In addition to monitoring duty hours in New Innovations, each department must maintain a duty hours policy that is compliant with all ACGME, New York State, and institutional requirements.

In cases where the ACGME and New York State requirements are not identical, Program Directors of ACGME-accredited programs based in New York State must follow the more restrictive requirement. For instance, where the ACGME rules specify that residents and fellows must receive 10 hours of rest between scheduled work periods and New York State only requires 8 hours of rest, these Program Directors must follow the 10-hour rule. See Appendix 11 to this Manual for a detailed comparison of the ACGME and New York State requirements.

1. ACGME Requirements

All 7,800 residency programs in the United States must comply with the ACGME’s duty hours standards, which, among other restrictions, limit resident duty hours to a maximum of 80 hours per week. These standards are intended to balance the needs of patient care, resident well-being, and academic and clinical education.

Although it is up to each program to develop methods for ensuring compliance with the duty hours standards, many programs and institutions have added physician assistants and nurse practitioners to their staff and created night float schedules to comply. Programs must also educate faculty and residents about the effects of sleep deprivation and provide residents with adequate back-up support.

The ACGME monitors compliance with the standards using multiple methods, including confidential resident surveys; interviews with program directors, staff, and residents during accreditation site visits; and ACGME Monitoring Committee assessment of the performance of Residency Review Committees for all specialties in applying and enforcing the accreditation standards. The ACGME communicates with all residents in accredited programs, informing them that it takes the new standards seriously and plans on rigorous monitoring and enforcement. As with all resident complaints,
RRCs will keep confidential any resident complaints about duty hours violations. Programs that violate duty hours standards must correct the problem immediately. ACGME field staff may conduct follow-up site visits to programs to ensure compliance.

Residency programs that fail to comply with the duty hours standards and do not correct the deficiency are subject to adverse accreditation actions, including probation or withdrawal of accreditation.

In addition to the weekly duty hour limit, the standards also include provisions for rest periods and days free from resident duties. Duty hours are defined as time spent on educational and clinical activities related to the residency program, including patient care, administrative duties related to patient care, and academic activities. Specific provisions include:

a. Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks. In certain cases, residency programs are allowed to increase duty hours by 10 percent if doing so is necessary for optimal resident education and the program receives approval from the appropriate RRC.

b. Residents must be given one day out of seven free from all clinical and educational responsibilities, averaged over four weeks.

c. Residents cannot be scheduled for in-house call more than once every three nights, averaged over four weeks.

d. Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care, or participate in educational activities.

e. Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.

f. Both internal and external moonlighting counts toward the weekly limit of 80 hours. In addition, Program Directors must ensure that moonlighting does not interfere with the House Staff Officer’s achievement of the program’s educational goals and objectives.

2. **ACGME Work Hours Exceptions**

An RRC may grant exceptions to a program for up to 10% of the 80-hour limit. This exception must be based on a sound educational rationale. Prior permission from the GME Office is required before a request can be made to a Residency Review Committee (Appendix 6).
3. New York State Requirements

The number of hours worked per week should not exceed 80 hours per week, averaged over a four-week period unless night call is infrequent and the physician rest time is adequate. Trainees should not be scheduled to work more than 24 consecutive hours. Assignment to the Emergency Room cannot be longer than 12 consecutive hours.

a. For Surgery residents, the average number of hours worked per week can exceed 80 if:

   i. Documentation exists that residents are generally resting and interruptions for patient care are infrequent when on call;

   ii. Night-call duty is followed by a non-working period of no less than 16 hours, with night call no more often than every third night; and

   iii. Policies and procedures are developed to relieve a resident when fatigue is observed.

b. There are no exemptions available for these specialties: Anesthesiology, Family Practice, Internal Medicine, Pediatrics, and Obstetrics/Gynecology.

   i. Residents cannot be scheduled to work for more than 24 consecutive hours unless they meet the above criteria.

   ii. On-call duty is scheduled for no more than every third night unless night call is infrequent and physician rest time is adequate.

   iii. Residents shall have at least one 24-hour period of scheduled non-working time per week.

   iv. The Hospital shall adopt and enforce specific policies governing dual employment (moonlighting). Each trainee must notify the Hospital of hours worked. Residents are prohibited from working more than the maximum hours (80 hours/week).

4. New York State Required Documentation

There must be documentation of the following:

a. During night shifts, interruptions for patient care are infrequent and residents are generally resting.
b. The Clinical Department is notified of moonlighting and of number of hours worked.

D. MOONLIGHTING

“Moonlighting” is defined as any professional activity outside the course and scope of a resident’s approved training program.

Mount Sinai House Staff may not moonlight if the work entails care for inpatients at Mount Sinai. They may moonlight in an outpatient department or in the Emergency Department at Mount Sinai if i) they complete a moonlighting agreement; ii) they are appropriately credentialed via the medical staff office; and iii) they have approval from their program director to moonlight.

However, residents who provide additional service by working as residents (i.e., performing the same duties but in excess of their rotation schedules) in compliance with all ACGME and New York State duty hours requirements may work in the inpatient services with the written approval of their program. Because these residents are not considered to be moonlighting, appropriate reimbursement may be sought in accordance with Section V: Medicare Billing and Resident Responsibilities in the House Staff Manual.

House staff may also moonlight at another institution if i) they receive approval of their department or division chief at Mount Sinai; ii) they are credentialed at the other institution; and iii) they have their own malpractice insurance coverage that covers them at the institution where they will moonlight.

Residents are not required to moonlight. Because residency education is a full-time endeavor, the Program Director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. The Program Director must comply with the institution’s written policies and procedures as outlined in the House Staff Manual. In addition, moonlighting must be counted toward the 80-hour work week.

Working as a licensed physician for payment when not on duty as a resident is a privilege, not a resident’s right. House Staff Officers must notify their respective Program Directors of their intent to work additional hours outside the Hospital as physicians providing professional patient care services. Regulations on maximum work hours have been set forth in Part 405.4 of the New York State Health Code. The House Staff Officers have the sole responsibility of guaranteeing that they are in compliance with these hours. For more information regarding Part 405.4 of the New York State Health Code, see the House Staff Manual (Work Hours). It is the obligation of the
House Staff member seeking dual employment to gain written, prospective permission from his/her Program Director. Program directors must place this written permission in the resident’s file. It is at the discretion of the Program Director to place further constraints on “moonlighting” for his/her House Staff Officers as he/she deems appropriate. Permission to moonlight may be withdrawn at any time at the Program Director’s discretion if it is perceived that moonlighting adversely affects the resident’s performance. It must be emphasized that residents cannot bill for services they provide when moonlighting if such services are in the same field as that for which they are in training. It is the Program Director’s responsibility to curtail moonlighting if it interferes in any way with a physician’s ability to function appropriately as a resident.

At The Mount Sinai Medical Center, the Compliance Department tracks the hours that House Staff Officers work, inclusive of all moonlighting activities, to ensure that each Department is compliant with the regulations set forth under the Bell Commission.

Each Mount Sinai resident engaging in moonlighting must complete an approval and attestation document (Appendix 7) before engaging in any work outside his or her training program. A copy of any signed moonlighting approval must be submitted to the Director of Hospital Compliance at Box 1619.

E. SUPERVISION

Effective January 1, 2002, the Joint Commission on Accreditation of Health Care Organizations (JCAHO) introduced standards addressing the supervision of residents by medical staff which require effective communication among committees responsible for Professional Graduate Education, the Medical Staff, and the governing body of the institution.

Medical Staff must assure that each participant in the professional graduate education program is supervised in his/her patient care responsibilities by a physician who has been granted clinical privileges. Descriptions of the roles, responsibilities, and patient care activities of participants in graduate medical education programs provided to the Medical Staff must include identification of the mechanisms by which the participant supervisor and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities. On a regular basis, the Graduate Medical Education Committee and Medical Staff communicate about the safety and quality of patient care, including the educational and supervisory needs of all residents in professional medical education programs.
1. **New York State Requirements**

As required by the New York State Hospital Code 405, the following criteria must be met:

a. 24-hour on-site Emergency Room supervision by a licensed physician.

b. 24-hour supervision by a Board-Certified/Qualified attending physician is required to supervise residents in Anesthesiology, Medicine, Obstetrics, Pediatrics, Psychiatry, and Surgery (including subspecialties). If not on-site, the attending must be available to come in to the Hospital within 30 minutes.

c. If the attending is immediately available by phone and readily available in person, on-site supervision can be provided by senior residents (minimum PGY-4).

d. An attending physician must personally supervise all surgical procedures requiring general anesthesia outside the office or in the operating room.

To assure continuous compliance, all hospitals are required to perform internal audits on a regular basis to make certain all programs are in compliance. Residents will be asked to fill out time schedules on designated weeks, which will be reviewed by the Office of Regulatory Affairs.

2. **Mount Sinai Requirements**

It is the responsibility of every attending physician of The Mount Sinai Hospital (including Manhattan and Queens campuses) to document the care provided to each patient in the patient medical records in every hospital venue (e.g., inpatient, clinic, OR, DTC).

If the patient care is personally performed by the attending, the patient’s medical record must include the following:

a. The attending physician’s name, signature, title, date, dictation number and department, the diagnosis; and

b. a statement regarding the medical decision making of the service provided to the patient.

If the attending supervises residents or fellows, the patient’s medical record must include the following:
c. the attending physician’s name, signature, title, date, dictation number, department; and

d. a linking statement that establishes the presence of the attending during the key critical portions of the service. The “linking” statement must establish that the attending physician examined the patient with a resident or independently. In addition, the personal notation by the attending physician must indicate direct involvement in the management (medical decision making) of the patient and confirm the resident’s/fellow’s documented findings.

A co-signature only by an attending physician supervising residents and fellows is not acceptable to demonstrate compliance with the federal (Medicare) and state (Medicaid) requirements associated with the teaching physician rules.

All attending physicians must follow the above clinical documentation requirements as a condition of maintaining clinical privileges at The Mount Sinai Hospital. Failure to comply with these requirements may result in Hospital discipline. Federal and state payers may also impose quality sanctions that may jeopardize clinical licensure.

F. PRIVILEGING

1. New York State Requirements

Each department is expected to have a documented plan describing supervision and privileging for its House Staff. The regulations require that House Staff be supervised at all times. A distinction is made between:

   a. Direct Supervision: A resident may only perform a procedure in the physical presence of the supervising physician.

   b. Indirect Supervision: Once the resident has been assessed, and it is determined that he/she has achieved competency in a given task, the resident may perform the task without the supervisor being physically present as long as the supervisor is readily available.

The competencies of each resident must be regularly assessed and privileges granted accordingly.

2. Mount Sinai Requirements

Use of the New Innovations Procedure Logger module is mandatory for compliance with JCAHO regulations stating that House Staff privileging
information must be available to clinical staff at all times. This module is now considered the official audit record for resident privileging at The Mount Sinai Hospital.

G. **MEDICARE BILLING AND RESIDENTS’ RESPONSIBILITIES**

1. **1998 Audit**

One cannot bill Medicare and other federal health care programs for services performed by House Staff. However, until recently the method of documenting, to the satisfaction of Medicare, that an attending physician had actually performed these services remained unclear. Several years ago the Office of Inspector General (OIG) instituted the Physicians at Teaching Hospitals (PATH) Audit Program to determine compliance with standards for billing by teaching physicians.

During this audit medical records are reviewed to determine whether a teaching physician was physically present; how the teaching physician documented his/her involvement with the care of the patient; and whether the documentation supports the level of evaluation and management service (E&M services) billed.

The OIG found numerous instances of noncompliance, resulting in settlements by the inspected institutions to return funds of as much as $30 million. The PATH audit conducted at Mount Sinai in April 1998 resulted in a negotiated financial settlement of $2.263 million, as well as an agreement by Mount Sinai effective through October 31, 2004, to execute compliance programs geared toward training all faculty, residents, billing staff, and billing agents. This includes an annual “refresher” program for all current employees and a new employee orientation program (New Beginnings) within 45 days of hire. The details of these programs are provided to departments by the Faculty Practice Office of Compliance and Regulatory Policy Services.

The PATH audit reinforced the following observations:

a. Countersignatures on charts, as well as “seen and agree” statements, are not acceptable to establish the physical presence of a teaching physician.

b. Collateral documentation concerning the presence of a physician at the time the service is provided is not acceptable in the absence of physician documentation in the chart.

c. In order to bill for ancillary services, documentation must support medical necessity, and the report must be present in the medical record.
2. Billing Requirements

Although there are numerous rules and regulations that must be followed to document billing for appropriate services, specific issues to remember with respect to residents are as follows:

a. If a resident participates in a service in a teaching setting, the clinical documentation must support the presence of the teaching physician during the key portion of any service or procedure for which payment is sought.

b. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

c. On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

A complete manual concerning the documentation program can be obtained from the Faculty Practice Office of Compliance and Regulatory Policy Services.

H. INTERACTIONS WITH OUTSIDE VENDORS

Relationships between commercial entities and academic medical centers have become increasingly intertwined and complex. The substantial financial assets of corporations and the broad intellectual resources of academic centers create natural opportunities for joint pursuit of common objectives. Yet occasionally the commitments and fiduciary duties of industry may conflict with the core scientific and education missions of the Medical Center. Furthermore, while offers of “free” goods, gifts, donations or grants for teaching programs may serve a beneficial purpose, they may violate the federal Anti-Kickback Statute and similar New York State laws. These laws prohibit the knowing solicitation or receipt, offer or payment of anything of value in return for patient, product or service referrals and punish any violator with significant fines, jail terms and exclusion from federal and state health care programs. In light of these potentially conflicting missions and regulatory prohibitions, it is critical that all members of the Mount Sinai community remain acutely sensitive to avoiding any actual or perceived conflict of interest.

Mount Sinai does business with corporations associated with a wide range of activities, including but not limited to: the sale of products and services to
the institution; referral and receipt of patients for health care services; and sponsorship of scientific research. Vendors include: pharmaceutical, biotechnology, office supply, and medical device/supply companies; research supply and equipment companies; building contractors; consultants; medical service providers; billing and collection companies; and other service companies. For purposes of this policy, the term “vendor” encompasses all commercial entities that do business with Mount Sinai and its faculty, staff and trainees.

All decisions relating to purchasing or other business processes must promote the best interests of Mount Sinai without favor or preference based on personal considerations. All actions must reflect Mount Sinai’s commitment to the highest ethical standards of conduct as described in the Compliance Manual and the Code of Ethics and Business Conduct and must be consistent with all institutional policies, including but not limited to the Purchasing Policy, the Policy on Conflicts of Interest, and policies in the Faculty Handbook (e.g., Financial Arrangements with Extramural Entities and Use of Mount Sinai Name). Guidelines promulgated by the federal Office of the Inspector General (OIG) and the PhRMA Code must also be observed.

Maintaining rigorous practices will ensure our commitment to the well-being of our patients, the integrity of our research and the soundness of our educational programs.

The following excerpted guidelines apply to all faculty, staff, and trainees of Mount Sinai School of Medicine, The Mount Sinai Hospital, and The Mount Sinai Medical Center, and are designed to assist in avoiding potential conflicts of interest between Mount Sinai and industry. The full Vendor Interaction Policy may be viewed on the Mount Sinai Intranet.

1. **Gifts**

A gift is defined as anything of value that is given by a business or individual that does or seeks to do business with Mount Sinai to either the recipient or his/her close family members, and for which the recipient neither paid nor provided services.

Gifts from vendors are strictly prohibited regardless of value, including but not limited to:

a. Cash in any amount

b. Any product or service, or discounts on products or services

c. Prizes

d. Gift certificates
e. Tickets
f. Loans
g. Meals
h. Transportation
i. Hotel accommodations
j. Use of a company’s vehicles or vacation facilities
k. Stocks or other securities, or participation in stock offerings
l. *De minimis* gifts, e.g. trade show trinkets distributed to large numbers of people by vendor representatives. Excluded from this prohibition are materials of modest cost which have a clear educational value, such as patient-friendly booklets describing organ systems.
m. Group gifts from vendors meant to be shared by all members of the staff, e.g. flowers, chocolates, etc.
n. Vendor invitations to be their guests at charitable events sponsored by Mount Sinai, e.g., the Crystal Ball, to which the vendor has purchased tickets.

If unsolicited gifts arrive via the post office or private carrier, the department head or administrator will advise on the best method for returning the gift.

2. **Vendor Support for Medical Center Educational Events**

Vendor support for Mount Sinai-sponsored educational events, whether held on-campus or off-campus, will only be accepted in accordance with the following provisions:

a. Deposit to General Fund: With the exception of CME events (see Section C below), any vendor contribution must be in the form of a general educational grant paid directly to a School or Hospital fund. No direct payments may be made to any Mount Sinai faculty member, trainee, or employee. Mount Sinai shall retain exclusive responsibility for all aspects of educational events. Corporate sponsors may not make commercial exhibits, distribution of promotional materials, or the inclusion of company representatives a requirement for support. A letter of agreement outlining expectations and restrictions will be signed by both the Department Chair and the vendor.
b. Food and Beverages: Direct provision by vendors of food and beverages, or subsidies for food and beverages, is prohibited.

c. Continuing Medical Education: Vendor support for accredited continuing medical education (CME) programs must be submitted in accordance with the policies and procedures of Mount Sinai’s Page and William Black Post Graduate School for Continuing Medical Education. Vendor support for CME programs will be managed in accordance with the Standards for Commercial Support of the Accreditation Council for Continuing Medical Education (ACCME), including:

i. Independence from commercial interests in course goals, content and methods

ii. Resolution of personal conflicts of interest

iii. Bias-free content and format

iv. Disclosures relevant to potential commercial bias

v. Management of commercial promotion

d. Program Content: Programs must have true educational value and can never be designed to influence purchasing decisions. The Standards for Commercial Support of the Accreditation Council for Continuing Medical Education (ACCME) are applicable to all educational events, whether or not they fall under the auspices of the Postgraduate School; guidelines include:

i. Curriculum content, faculty selection and program quality will be the sole responsibility of Mount Sinai department management and/or faculty involved in the event.

ii. Speaker selection and educational content will be at the discretion of the department.

iii. Guest speakers must sign a standard disclosure statement indicating compliance with institutional conflict of interest policies.

iv. All presentations must be free of commercial bias for or against any vendor’s products or services. Generic rather than trade names of drugs must be used at conferences.

v. Vendor representatives may not address the audience unless specifically invited by the Mount Sinai event organizers.
Institutional Requirements and Policies

vi. Promotional materials from commercial sponsors may not be displayed in the room before, during or after the activity.

vii. Vendors may apply for exhibit space outside the room(s) in which the educational event is held. The granting of such requests is at the discretion of the conference organizers and fees may be levied. In the event that exhibit space is approved, exhibitors will be subject to gift restrictions as described in the full Vendor Interaction Policy, as well as to the PhRMA Code.

viii. Refreshments, study materials, and other materials should be appropriate to the event.

e. Acknowledgment of Vendor Support: Commercial support may be acknowledged in printed materials, but specific products may not be mentioned.

f. Vendor Support for Trainees: Vendor support can never be made directly to or earmarked specifically for an identified individual. Vendor support for trainee education, including salary support, must be in the form of educational grants to Mount Sinai.

g. Education and Training on Vendor’s Own Products: Vendor representatives from pharmaceutical, biotechnology and other industries may visit healthcare providers or researchers to talk about and demonstrate their new products. While generally acceptable as straightforward sales visits, an appointment is always required; representatives are not permitted on campus on a drop-in basis. Visits to health care providers must comply with Mount Sinai’s policy on Medical Sales Representatives. Sales representatives are not permitted in patient care areas and may not access any patient-specific information. Refreshments and gifts from vendors, however modest, are prohibited during visits by representatives.

Scheduled appointments are required for vendor visits to train physicians, researchers or others in device use or new technologies.

3. Vendor Support for Off-Campus Educational Events

Faculty and staff with special expertise may be invited to give lectures or otherwise participate in conferences and seminars in a variety of venues outside Mount Sinai, including other academic institutions, professional conferences, international symposia, expert training in device use or new technologies, and presentations to lay audiences. The Department Chair will
have overall responsibility for monitoring the frequency and nature of faculty and staff participation in these off-campus activities. In all cases, speakers must be aware of and abide by institutional policies on the Use of Mount Sinai Name.

If off-campus events are sponsored by industry, employees and trainees are encouraged to participate only when Continuing Medical Education (CME) credit is offered. For events that fall outside the realm of CME, following are guidelines for participation:

a. Educational Value of Event: Discretion must be employed in determining whether to attend, based on whether the event has a legitimate educational value. For example, industry sponsors often organize their own conferences and invite faculty or trainees to attend. It is incumbent upon the invitee and his/her Chair to determine whether it is truly a learning event or is designed primarily to influence participants to favor the vendor’s products. The setting for and cost of the event should be appropriate to its purpose.

b. Speaking Engagements: Lectures are often arranged through a corporate Speakers Bureau, and may involve compensation. Participation can be of value to the invited speakers as well as to conference attendees, and can enhance Mount Sinai’s reputation. At times, however, events sponsored by vendors are designed to influence participants in their relationship with the vendor. Further, participants in Speaker’s Bureaus may be asked to use materials prepared by the vendor. It is therefore essential that faculty and staff participate in such events only when there is a legitimate educational purpose and the individual’s role is meaningful and substantive and reflects his or her own work.

c. Paid Engagements: Faculty who receive compensation for participating in off-campus events outside the scope of CME will be subject to the MSSM Policy on Financial Arrangements With Extramural Entities, and must submit written agreements for approval by the Department Chair prior to participation. Faculty must also adhere to CME guidelines concerning disclosure. For engagements involving expert training, the individual must also abide by the guidelines of the relevant professional organizations.

d. Vendor Support to Participate in Events: Mount Sinai faculty, staff and trainees may not accept scholarships or other special funding directly from a vendor. Vendors may make donations a general departmental education fund; the department will use its own criteria to select
trainees to receive support for participation in educational events. Under no circumstances can a trainee be paid by a commercial sponsor to attend an educational event.

4. **Pharmaceutical Samples**

Physicians and staff may not accept pharmaceutical samples for their own personal use or for distribution to patients or family members. Distributing sample drugs would place physicians in a drug-dispensing role, subject to applicable laws and regulations.

There will be only two circumstances that warrant an exception to this prohibition:

a. If there is a compelling medical necessity to treat an urgent condition, where immediate treatment prior to leaving the physician’s office will alter the clinical outcome

b. If there is a need to demonstrate appropriate use of a product.

In these exceptional cases, the minimum possible sample should be given. Appropriate documentation of the medication dispensed or the device utilized must be entered in the patient’s medical record.

**I. Compliance Program**

In addition to the compliance program that addresses billing, Mount Sinai also established an enterprise-wide Compliance Program that includes:

a. A Mission Statement to ensure the Institution upholds its commitment to legal and ethical conduct by all faculty and staff.

b. Maintenance and update of the Medical Center’s Code Conduct and Business Ethics. The code maintains ten basic tenets of conduct ranging from compliance with legal requirements, respect for other employees, adherence to proper business practices, maintenance of accurate records through protection of occupational safety, and maintenance of a drug- and alcohol-free workplace. This is supplemented by a more detailed Compliance Manual.

c. A Helpline has been established for meeting these standards of conduct. Violation or questions about compliance with institutional policy can be answered by calling the confidential Compliance Helpline at 1-800-853-9212. Callers may remain anonymous and may follow the resolution of reported violations.
d. Employees of Mount Sinai are expected to bring immediately to the attention of their supervisor, The Chief Compliance Officer, the Office of Corporate Compliance or the Legal Department information regarding suspected improper conduct. Employees are also expected to cooperate fully in any investigation.

e. The Medical Center also maintains strict adherence to a policy of non-reprisal for bringing violations to the attention of Institutional management.

f. Mount Sinai also will take disciplinary action, including dismissal where appropriate, against any employee who violates any legal requirements or institutional policies. This includes anyone who fails to report violations or retaliates against someone reporting in good faith a possible violation.

g. There are policies also in furtherance of the Deficit Reduction Act as the Institution is committed to preventing and detecting fraud waste or abuse. Mount Sinai strives to educate staff to submit accurate claims and reports to the Federal Government. Although Mount Sinai requires employees bring their concerns to the Institution, it does not preclude individuals from bringing the same to the Federal or State Governments.

J. DISASTERS AFFECTING ONE OR MORE RESIDENCY PROGRAMS

A disaster is an event or set of events causing significant alteration to the residency experience at one or more residency programs.

If, because of a disaster, at least an adequate educational experience cannot be provided for each resident and/or fellow the institutional sponsor of the residency program(s) will:

a. arrange temporary transfers to other programs and/or institutions until such time as the residency and/or fellowship program can provide an adequate educational experience for each of its residents and/or fellows;

b. cooperate in and facilitate permanent transfers to other programs or institutions. Programs or institutions will make the keep or transfer decision expeditiously so as to maximize the likelihood that each resident will timely complete the resident year; and

c. inform each transferred resident of the minimum duration of his or her temporary transfer, and continue to keep each resident informed of the
minimum duration. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency year, it must so inform each such transferred resident.

The Designated Institutional Official (DIO) will call or email the Institutional Review Committee Executive Director with information and/or requests for information.

Similarly, the Program Directors will contact the appropriate Review Committee Executive Director with information and/or requests for information.

Residents should call or email the appropriate Review Committee Executive Director with information and/or requests for information.

Within ten days after the declaration of a disaster, the DIO of each sponsoring institution with one or more disaster-affected programs will contact ACGME to discuss due dates that ACGME will establish for the programs (a) to submit program reconfigurations to ACGME, and (b) to inform each program’s residents of resident transfer decisions. The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.

In the event of a disaster at non-Consortium programs or institutions, consideration will be given to accepting temporary or permanent transfers. If interested, programs must complete a form that may be found on the ACGME website.

K. VISITING RESIDENTS FROM NON-CONSORTIUM HOSPITALS

It is recognized that Mount Sinai is an educational resource for residents in training at other residency programs who are in need of specific rotations to fulfill their residency requirements, or who wish to enhance their training through elective rotations at Mount Sinai. In the past, residents could be accepted without difficulty. However, with the passage of the Balanced Budget Act of 1997, Mount Sinai is no longer able to accept all residents on an open-ended basis, as these residents are included in the total FTE count.

Requests to have residents from non-affiliated institutions come to the Medical Center must be made to the GME Steering Committee in writing and must contain the following information: a) specific reasons that demonstrate the importance of accepting the resident; and b) any advantage that might accrue to Mount Sinai based on this acceptance. The GME Steering Committee will respond to requests within two weeks.

In accordance with institutional guidelines, both Mount Sinai and the resident’s institution must sign a Visiting Physician (Resident/Fellow)
Agreement (Appendix 8) prior to acceptance of a resident from a non-affiliated institution. In addition, appropriate paperwork (see Section VI.C of this manual) must be forwarded to the House Staff Office at least one month before the resident’s arrival. In keeping with the institution’s policy of a drug-free campus, residents coming to Mount Sinai for the first time must have had a urine toxicology screening performed by his/her home institution, with confirmation of a negative result included in the material forwarded to the House Staff Office.
VI. Residency Program Management

A. Recruitment of House Staff

1. Resident Selection

The Consortium for Graduate Medical Education of the Mount Sinai School of Medicine is dedicated to attracting the highest quality House Staff as well as to maintaining cultural diversity among the resident body. The Consortium welcomes applications from all eligible physicians. Selection is based solely on the applicant’s demonstrable ability and qualifications for the job. In compliance with federal, state, and municipal laws and in observance of Mount Sinai’s well-established tradition of fairness, equal opportunity is given to all applicants without regard to race, creed, color, religion, national origin, age, gender, disability, marital status, sexual orientation, veteran status, or citizenship status.

Residents in all programs sponsored by Mount Sinai School of Medicine should be selected based on their qualifications and ability to benefit from the educational program to which they are appointed. Aptitude, academic credentials, personal characteristics, and ability to communicate should be considered in the selection.

All Mount Sinai School of Medicine residency programs, both sponsored and affiliated, must register with the Electronic Residency Application Service (ERAS), which is sponsored by the AAMC. Programs should require prospective House Staff to apply via ERAS. Use of this service allows for efficient management of data, including information on incoming House Staff that must be uploaded to New Innovations.

All residency programs sponsored by Mount Sinai School of Medicine should participate in the National Resident Matching Program (NRMP) for the selection of residents for first-year positions. Residency recruitment will be
reviewed on a yearly basis by the GME Committee, including residency positions filled outside of the NRMP.

2. **Resident Eligibility**

Applicants with any of the following qualifications are eligible for appointment to Mount Sinai School of Medicine-sponsored residency programs:

a. Graduates of medical schools in the United States and Canada accredited by the LCME.

b. Graduates of medical schools in the United States and Canada accredited by the American Osteopathic Association (AOA).

c. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
   i. have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG); or
   ii. have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

d. Graduates outside of the United States who have completed a Fifth Pathway Program provided by an LCME-accredited medical school.

e. Graduates from medical schools outside the United States and Canada who are United States citizens and do not meet the above qualifications, but who have successfully completed the licensure examination in a U.S. jurisdiction in which the law or regulations provide that a full and unrestricted license to practice will be granted without further examination after successful completion of a specified period of graduate medical education.

f. Graduates of medical schools in the United States and its territories not accredited by the LCME, but recognized by the educational and licensure authorities in a medical licensing jurisdiction, who have completed the procedures described in paragraph 5.

g. Graduates of schools of podiatry accredited by the Council on Podiatric Medical Education who are applying for podiatric residencies.

h. Graduates of dental schools accredited by the Commission on Dental Accreditation who are applying for dental residencies.
B. RESIDENCY DATA MANAGEMENT

Each institution and program in the Consortium must report data including demographics and privileging information on every House Staff Officer within the Consortium. The status of current and graduating House Staff must be provided in a timely manner. Information on incoming House Staff, a well as updates on the status of all residents, must be submitted each academic year. Program directors and coordinators must update this data as follows:

a. New residents: The process of gathering information on new residents starts immediately after the Match conducted by the National Resident Matching Program (NRMP). Programs download House Staff data from the Electronic Resident Application System (ERAS) website, add to that file the names of any new House Staff accepted outside of the Match, and forward a copy of the downloaded information as an e-mail attachment to Gaber Badran, the GME Senior Software Specialist (gaber.badran@mssm.edu).

b. Reappointments: Demographic records for reappointed House Staff must be reviewed in New Innovations to ensure proper promotion of program level and postgraduate year (total training years).

c. Terminations: Demographic records for House Staff who are terminated must be reviewed in New Innovations to ensure accuracy of data in the resident’s/fellow’s record at the time of departure.

1. Consortium Resident Information Form

A blank master registration form (Appendix 9) will be distributed to each institutional GME office and to program staff. Program directors should add the institution name at the top and provide program names and ACGME numbers at the bottom of the first page. These forms should be distributed with the contract offered to successful candidates to ensure early completion. Note that submission of this form does not relieve programs of the responsibility of entering data in New Innovations.

The deadline for submission of forms is July 31 of each academic year. Institutional GME offices and program staff should review each form to ensure that all fields are completed appropriately prior to submission to:

Mr. Gaber Badran
GME Senior Software Specialist
Mount Sinai School of Medicine
One Gustave L. Levy Place, Box 1076
New York, NY 10029
This form is the sole written documentation retained in the Consortium office for each resident. Once each resident’s data is entered in New Innovations, the program and the Consortium GME Office work together to ensure that all changes in status and privileges are recorded.

2. *New Innovations Residency Management Software*

The Consortium is implementing the *New Innovations* residency management software. This web-based application service provider assists Program Directors in managing information that must be reported to various institutions, organizations, and government agencies. The software also houses general information about Consortium residents. New Innovations is accessible via any computer with Internet access. A username and password must be provided to access the website, and the content that is visible varies with the defined role of the user, whether GME Administrator, Program Director, Residency Coordinator, House Staff Officer, or faculty member.

New Innovations provides a platform to report House Staff demographic information to the Consortium GME Office. Use of the following modules by all Consortium programs is mandatory:

a. *Personnel Data* for House Staff including basic demographics, education, visa information, and certifications.

b. *Block Schedules* for all resident assignments.

c. *Procedure Logger* for all privileges granted to House Staff after completion of satisfactory repetitions of procedures.

d. *Duty Hours* for logging all work hours (floor, clinic, call, moonlighting, etc.) as well as time off-duty or on leave. House Staff rotating through programs at The Mount Sinai Medical Center are required to log duty hours for the duration of the rotation. Use of the Resident Duty Hours Module is required at The Mount Sinai Hospital and encouraged at all Consortium member programs.

Through New Innovations, the Consortium GME Office has provided each program with templates for evaluations of House Staff by faculty, other personnel, and patients, as well as for evaluations of faculty, rotations, and the program by House Staff. Use of New Innovations to schedule and complete evaluations is strongly encouraged for all Consortium programs.

The use of New Innovations software is key to providing optimal service to Consortium members and to generating required statistics and reports throughout the academic year. As such, receipt of information that is
both complete and timely is emphasized and encouraged. The Consortium GME Office appreciates program directors’ cooperation in the collection and exchange of data within the Consortium.

C. ROTATION OF RESIDENTS FROM CONSORTIUM HOSPITALS TO THE MOUNT SINAI HOSPITAL

There are many opportunities for Consortium residents to complete rotations and electives in Mount Sinai training programs (Appendices). Approval to rotate residents to any of these programs should be obtained from the appropriate Program Director at The Mount Sinai Hospital one year in advance. Once the Program Director’s approval is obtained, the following process should be followed:

a. The clinical department at the Consortium institution organizes the following information:
   i. a completed Rotator Form (Appendix 10).
   ii. a copy of the Mount Sinai House Staff Application.
   iii. a copy of the medical school diploma, with English translation where applicable.
   iv. a copy of the final transcript. The transcript must list the graduation date.
   v. a copy of the current curriculum vitae (CV) and CV addendum form.
   vi. international medical graduates must include a copy of their ECFMG certificates. The ECFMG number and the date of issue should be clearly visible on the document.
   vii. a clearance letter for toxicology screening.
   viii. a copy of the House Staff Officer’s most recent delineation of privileges at the home institution, signed by the House Staff Officer and Chairperson.
   ix. a copy of the current New York State license or limited permit (if applicable).
   x. rotation definitions for New Innovations block schedules.

The above information should be forwarded to the receiving clinical department at The Mount Sinai Hospital. A directory of programs at
all Consortium hospitals, including Mount Sinai, may be found in the Appendices to this manual.

b. The clinical department at The Mount Sinai Hospital receives the above paperwork and reviews it for accuracy and completeness. The clinical department at The Mount Sinai Hospital then forwards the information to the House Staff Office, where the information is retained for reference and government reimbursement.

Questions regarding this process may be directed to Ms. Marie Alexis at (212) 241-6917.

D. ALTERATION IN SIZE OR TYPE OF RESIDENCY TRAINING PROGRAM

1. ACGME-Approved Programs

The Balanced Budget Act of 1997 placed a cap on the total number of residents in ACGME-approved programs to the baseline that existed within each institution as of 1996. This number, however, refers not to the actual number of residents in the program, but rather to the number of full-time equivalents (FTEs) at each institution participating in ACGME-approved training programs at that institution. This includes FTEs of residents from other training programs rotating to Mount Sinai. If an institution exceeds the 1996 cap, then reimbursement cannot be obtained from the Centers for Medicare and Medicaid Services (CMS) for the excess number. It is therefore necessary to keep careful track of the number of FTEs at the Medical Center over time. At Mount Sinai, the number of FTEs is monitored by a Graduate Medical Education (GME) Steering Committee consisting of representatives of both the School and Hospital.

Mount Sinai and many other Consortium institutions are currently above the 1996 limits. As of October 2007, The Mount Sinai Medical Center is 35.68 DME and 44.88 IME positions over its cap. As a result, The Mount Sinai Hospital cannot approve additional positions even in cases where the ACGME has agreed to increase a program’s resident complement. However, if the program has obtained an ACGME complement increase and it will support the salary and fringe with non-Hospital, non-School funds, a new position may be approved of the GME Office and House Staff Affairs Office using the forms described below.
a. Increasing the Number of Residents in ACGME-Approved Programs

Each ACGME Residency Review Committee (RRC) determines the maximum number of residents per year who may train in an accredited residency program. However, this number may not be approved by the hospital funding the residency programs. If a Program Director wishes to increase the resident complement of his/her ACGME-approved residency training program, a request must be made to the GME Steering Committee. This request should be accompanied by the following information: 1) whether the number of residents in the program will exceed the maximum number of residents permitted by the ACGME; 2) whether the increase in residents, if approved, would result in an increase in full-time equivalents at Mount Sinai or, due to the inclusion of another hospital in the rotation, the number of full-time equivalents at Mount Sinai would be maintained while increasing the total number of residents in the program; 3) justification for requesting such an increase, which must be based on educational value, not service needs; and 4) a statement of approval by the appropriate Department Chairperson.

The GME Steering Committee meets on a weekly basis and will respond to requests within two weeks with an approval, a denial, or a request for additional information.

b. Establishing a New ACGME-Approved Program

Should a Chairperson wish to establish a new ACGME-approved program, the following information should be submitted to the GME Steering Committee: 1) justification of the need for this program; 2) total number of residents requested per year; 3) total number of full-time equivalents that would be at Mount Sinai per year; 4) complete description of the residency program, including other participating institutions; and 5) approval of the Department Chairperson.

A request for establishment of a new ACGME-approved program should be made to the GME Steering Committee prior to requesting approval of the ACGME. Within two weeks the GME Steering Committee will respond with an approval, a denial, or a request for additional information.

c. Request to Fill an ACGME-Approved Position with Non-Hospital Funds

A request to fill an ACGME-approved residency/fellowship position with non-hospital funds requires completion of a request form
(Appendix 11), including designation of the fund covering the resident’s/fellow’s salary and benefits.

The Funding Commitment by the Department includes full salary per postgraduate level and benefits for the resident/fellow for the duration of training at Mount Sinai.

Fringe Benefits are calculated at 26.5% of salary for all Federal Grants and 27.5% of salary for all other grants. Payment for Fringe Benefits will be extracted automatically, along with salary, from the designated fund.

The following documents must be submitted to the House Staff Office, Klingenstein Pavilion, Suite 1, Box 1116, for review prior to final approval:

i. approved Request to Fill an ACGME-Approved Position with Non-Hospital Funds.

ii. completed P-111, indicating position, applicant name and funding source.

iii. completed House Staff Application and supporting documents.

2. Non-ACGME-Approved Programs

Requests for increasing the number of residents in an existing non-ACGME-approved program or to establish a new non-ACGME-approved program should be made to the GME Steering Committee and contain the following information: 1) for new programs, a justification for establishing such a program; 2) the number of residents requested; 3) a statement how the program will be funded as no institutional funds can be used for non-ACGME-approved programs; and 4) approval of the appropriate Department Chairperson.

a. Request to Fill a Non-ACGME Position with Non-Hospital/Non-School Funds

A request to fill a non-ACGME-approved residency/fellowship position with non-Hospital/Non-School funds requires completion of the request form (Appendix 12), including designation of the fund covering the resident’s/fellow’s salary and benefits.

The Funding Commitment by the Department includes full salary and benefits for the resident/fellow for the duration of training at Mount Sinai.
Fringe Benefits are calculated at 26.5% of salary for all Federal Grants and 27.5% of salary for all other grants. Payment for Fringe Benefits will be extracted automatically, along with salary, from the designated fund.

The following documents must be submitted to the House Staff Office, Klingenstein Pavilion, Suite 1, Box 1116, for review prior to final approval:

i. Approved Request to Fill a Non-ACGME-Approved Position with Non-Hospital/Non-School Funds.

ii. Completed P-111, indicating position, applicant name, and funding source.

iii. Completed House Staff Application and supporting documents.

E. CONTRACTS

Prior to employment each House Staff Officer receives a written contract (Appendices) that sets forth Mount Sinai’s commitment to the resident and his/her responsibilities to the Hospital. Examples of Consortium member contracts are posted on the GME Web site [http://www.mssm.edu/gme/] for review by applicants.

House Staff Officers who have July 1 appointments will be notified by November 15 (December 15 for Internal Medicine and Anesthesiology) if their contracts are not to be renewed for the next year of a given residency program. Contract nonrenewals are subject to the hearing rights specified in the House Staff Manual in the section entitled “Disciplinary Action.”

F. REAPPOINTMENT

Guidelines for reappointment are given in the House Staff Manual. It is important to realize that non-reappointment is subject to due process. All nonreappointment decisions should be reviewed by the Dean for Graduate Medical Education prior to notification of the resident.

G. LEAVES OF ABSENCE

Program Directors are responsible for the administrative management of leaves of absence. Each Consortium institution maintains its own policies for health and disability insurance, leaves of absence, vacation, parental leave, sick leave, and the effects of leaves on satisfying criteria for program completion. Program Directors at Mount Sinai should refer to Human
Resources policies on Leaves of Absence (Policy 3.18) on the Mount Sinai Intranet.

Most specialties require that a resident complete a minimum number of months actively caring for patients to receive credit for the residency. If a period of disability or leave combined with vacation time results in a failure to meet this time requirement, the resident will be allowed to remain on the House Staff until the time requirement is met, assuming he/she is in good standing. It is essential for the Program Director to make certain that the resident has been placed on disability or leave as soon as the leave period has begun. This will allow funds to be made available to compensate the resident for the leave period. Periods of disability or leaves of absence must be logged in New Innovations.

**H. SUPERVISION**

All attending physicians responsible for the education of House Staff are also responsible for their supervision. However, it is the Program Director who has the responsibility of ensuring that a) supervision is appropriate, with the residents not only learning but also delivering quality patient care, and b) attending physicians in their department are functioning at a high level as supervisors. Each program must develop written policies and procedures for the supervision of residents. These policies should provide for the following:

a. Definition of the clinical responsibilities of residents at all levels of postgraduate training. Supervision must be consistent with the educational needs of the residents. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations.

b. Progressive responsibility appropriate to residents’ level of education, competence, and experience.

c. Initial and ongoing assessment of a resident’s clinical judgment and skills.

d. A system to ensure that appropriate supervision by a qualified physician is readily available and provided. Residents must be provided with rapid, reliable systems for communicating with supervising faculty. Faculty schedules must be structured to provide residents with continuous supervision and consultation.

e. Adequate supervision of residents as they assume progressive responsibility based on education, ability, and experience.
f. Timely, effective electronic communication with clinical staff of the level of clinical responsibility accorded each resident. (At Mount Sinai, this is accomplished through the mandatory use of the Procedure Logger module of New Innovations.)

g. A mechanism for informing the Program Director when it is determined that a resident is providing substandard clinical treatment.

h. A method for ensuring the safety and effectiveness and for determining the quality of patient care services provided by residents.

i. Formal review of each resident’s evaluations as they are received, with early negative evaluations carefully reviewed by the Program Director and, after verification of the information submitted, discussion with the resident. It should be emphasized that evaluations cannot be “averaged.” One negative evaluation must not be ignored in the face of many positive evaluations. Careful review and discussion with the involved resident are mandatory.

I. EVALUATIONS

The Consortium GME Office has provided resident, faculty, and program evaluation templates to all programs through the New Innovations residency management software. These evaluations are compliant with ACGME requirements and may be customized to suit the needs of each program.

1. Evaluation of the House Staff Officer

The performance of each House Staff Officer must be evaluated during each educational assignment (i.e., each rotation). A comprehensive performance evaluation must be completed for each House Staff Officer at least semiannually and residents must be given access to this evaluation. (Even when House Staff are given access to their evaluations online, this does not replace these semiannual reviews.) Program Directors must also complete an exit evaluation for each graduating House Staff Officer that attests to whether the House Staff Officer is competent to practice without direct supervision.

Evaluations must be structured to measure residents’ attainment of all six Core Competencies. 360-degree evaluations are also available in New Innovations. Each program must establish a policy according to which residents may have access to the evaluations in their resident portfolio.

Many physicians are hesitant to be frank in their assessment of a resident for fear of subsequent legal problems. However, frank reviews are an essential component of the training process and, if necessary, the disciplinary process.
Legal problems can be avoided, and House Staff and the institution will benefit most, when: a) adequate documentation exists; b) inconsistent positive or negative evaluations are reconciled to the extent possible prior to review with the resident; and c) the resident is counseled should any adverse evaluations be submitted. Program Directors who issue academic advisements and disciplinary action based on adverse evaluations must be sure to follow the procedures outlined below.

2. Evaluation of Faculty

At least annually, the program must evaluate faculty performance as it relates to the educational program. These evaluations must include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities, as well as written, confidential evaluations by the residents.

Residents must complete confidential, written evaluations for all supervising faculty involved in their training at the end of each rotation (at least quarterly for rotations of more than three months).

When evaluations indicate that faculty performance could be improved, it is the responsibility of the Program Director to review evaluations with the faculty member and to develop a plan to resolve any concerns that have been identified.

3. Evaluation of the Program

The program must document formal, systematic evaluation of the curriculum at least annually. Information to be considered during these reviews must include resident performance, faculty development, graduate performance, including performance of program graduates on the certification examination, and program quality.

One standard question RRC site visitors ask residents is, “How have your evaluations improved the program?” Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually. Residents should also complete an evaluation of each scheduled rotation. If evaluations indicate concerns with a particular rotation, the Program Director should meet with residents to review those concerns and to develop corrective plans if necessary.

The program must consider residents’ evaluations as well as periodic ACGME Resident Surveys as part of their annual curriculum review.
J. **Monitoring Educational Outcomes**

Educational outcomes should be monitored by program directors as follows:

a. Where applicable, programs should track residents’ performance and pass rates on In-Service examinations and Board-certifying and -recertifying examinations.

b. Programs should generate reports from New Innovations to:
   i. track each resident’s performance over time.
   ii. compare individual each resident’s performance to that of his or her peers.

Residents should be evaluated while on wards, on electives, and in continuity clinic, and should be evaluated by faculty, junior residents, and students. A peer evaluation process should be considered.

c. Programs should foster resident self-assessment, utilizing standardized forms as well as outside resources (e.g., the Pedialink program of the American Academy of Pediatrics).

d. Programs should use charts or electronic medical records reviews to track patient outcomes. Examples include:
   i. management of diabetes, hypertension or asthma.
   ii. use of screening tests/tools for breast cancer, domestic or child abuse, depression.
   iii. immunization rates.

e. Direct observation of resident performance, along the lines of the Internal Medicine CEx, should be considered.

f. Programs should keep records of their graduates’ publications.

g. Programs should use the National Practitioner Data Bank to monitor adverse outcomes.

In addition to the above methods of monitoring outcomes, Program Directors should consult the ACGME Outcomes Project for additional information.
K. ISSUANCE OF DISCIPLINE OR ACADEMIC ADVISEMENTS TO HOUSE STAFF

The information provided below supplements School policy for “Disciplinary Action.” In issuing Discipline or Academic Advisement, one must act in accordance with the “Disciplinary Action” policy in the Mount Sinai House Staff Manual. Any questions concerning this issue or the imposition of Discipline or Academic Advisement should be directed to the Dean for Graduate Medical Education ((212)241-6694) and the Director of Graduate Medical Education (at affiliate institutions).

1. Types of Intervention

The proper level of intervention should be selected:

   a. An Academic Advisement (or “academic alert”) is issued when a House Staff Officer’s academic performance does not meet departmental standards but is not sufficiently below standard to warrant disciplinary action.

   b. Disciplinary Action may include, but is not limited to, a written warning, probation, suspension, or termination. The type of discipline will depend upon the circumstances of each case.

2. Job Retention

A House Staff Officer may be terminated from his or her residency program for failure to abide by the By-laws, Rules, and Regulations, or policies of the Medical Center or of the medical staff; for falsification of any Medical Center document; for any activity that may threaten the safety or welfare of a patient, employee, or other physician; or for any action that may be detrimental to Medical Center operations.

   As stated above in “Disciplinary Action,” a House Staff Officer may be disciplined up to, and including, termination of his or her residency program for failure to abide by the House Staff Manual, By-Laws, Rules and Regulations, or policies of the Medical Center; for falsification of any medical center document; any conduct that may threaten the safety or welfare of a patient, employee, other physician, or visitor; or any other conduct that may be detrimental to Medical Center operations.
3. **Administrative Suspension**

Operative reports are to be dictated as soon as possible after surgery. Discharge summaries are to be completed immediately following discharge. If a resident has not completed his/her medical records at the time of the patient’s discharge, he/she should obtain the record for completion in the chart completion area of the Medical Records Department. House Staff will be notified by mail of chart deficiencies. Charts not completed within 30 days (including signatures) are deemed delinquent. The Medical Board has approved suspension of admitting and operating privileges of physicians with delinquent medical records. Department Chairpersons will be notified of any delinquent records.

When a resident is on rotation at an affiliate hospital, it is his/her responsibility to complete dictation of all his/her medical charts before rotating to another affiliate or returning to Mount Sinai. **Department Chairpersons should notify affiliate hospitals of any delinquent records.**

4. **Investigation and Documentation**

Whenever possible, Academic Advisement or Discipline should be issued after a full investigation, which may or may not include an interview with the House Staff Officer.

The Program Director should maintain documentation of any incidents or issues that may ultimately lead to Academic Advisement or Discipline in order to provide evidence of the House Staff Officer’s conduct and any measures taken by the program. Documentation is often critical to due process if the House Staff Officer challenges the action taken. Because Disciplinary Action should be considered if the House Staff Officer does not meet the requirements of an Academic Advisement, Academic Advisement should also be fully documented.

To this end, performance evaluations should be complete, candid, timely, and precise. Contemporaneous memoranda and other correspondence are also helpful. Note, however, that in some instances when it is not possible to document all issues, Disciplinary Action may still be appropriate.

5. **Communication to the House Staff Officer**

Communication is an important part of Academic Advisement or Disciplinary Action. Where possible, it is recommended that the type of intervention, the reasons for it, and any expected corrective action, are first communicated to the House Staff Officer in person. At that time, or immediately thereafter, written notice of Academic Advisement or Disciplinary Action should be
provided. To ensure receipt and compliance with the policies set forth in the House Staff Manual, it is recommended that notice be hand-delivered or sent by Certified Mail with return receipt requested. If the notice is hand-delivered, it may be helpful to make the delivery in the presence of a witness and to have the House Staff Officer sign a document indicating receipt. If the House Staff Officer refuses to sign, the witness should document the refusal. Appropriate language is available from the Labor Relations Division of Human Resources.

Written notice of an Academic Advisement must specify the nature of the problem as well as the steps the House Staff Officer must take to remedy the problem. Written notice of Disciplinary Action must specify the action taken or the type of discipline; the terms of any monitoring, probation, or other restrictions; and the reasons for imposing discipline. Any relevant documentation (as described in the House Staff Manual) may be useful in preparing the notice.

Notices of Academic Advisement should be signed by the Department Chairperson and/or Program Director. Notices of Disciplinary Action should generally be signed by the Department Chairperson, Hospital Director, or other appropriate person. In some instances, a Chief of Service may sign the notice. (Affiliated institutions may have differing or additional requirements.)

Where Disciplinary Action short of termination is imposed, it is appropriate to advise the House Staff Officer of the possible consequences of his or her failure to comply with the corrective action (for example, that similar future conduct may result in termination).

The notice should inform the House Staff Officer of his or her right to a hearing, and should include a description of due process, as provided in the House Staff Manual. One may also wish to include a copy of the House Staff Manual’s provisions concerning Disciplinary Action. Note that the resident has a right to a hearing when Disciplinary Action includes the nonrenewal of his or her contract.

6. **Reporting Disciplinary Action**

While policies may vary at affiliated hospitals, it is not necessary to report Academic Advisement to institutional administration at The Mount Sinai Medical Center. However, Disciplinary Action must be reported to the House Staff Affairs Office, the Director of Graduate Medical Education, and the Labor Relations division of the Human Resources Department. Copies of the notice of Disciplinary Action should be placed in the House Staff Officer’s departmental and personnel files.

As stated in Section IV of this manual, New York State Law requires that institutions report: a) the suspension, restriction, termination, or curtailment of
training, employment, association, or professional privileges, or the denial of the certification of completion of training for reasons related to alleged mental or physical impairment, incompetence, malpractice, misconduct, or impairment of patient safety or welfare; b) the voluntary or involuntary resignation or withdrawal of association or of privileges with the Hospital to avoid the imposition of disciplinary measures; c) the receipt of information indicating that a physician has been convicted of a crime; or d) denial of staff privileges for the reasons specified in a) above. Certain types of professional misconduct must also be reported. Separate regulations govern reporting to the National Practitioner Data Bank.

While Disciplinary Action is often reportable to the State, an Academic Advisement that does not include the actions described above is not reportable.

As noted above, Disciplinary Action should be reported immediately to the offices of the Hospital Director and General Counsel, as reportable actions must be communicated to the State promptly. Upon notification of Disciplinary Action, the Hospital Director, in consultation with the General Counsel, reports the relevant information to the State. One should contact the Dean for Graduate Medical Education of MSSM, the Hospital Director, the Labor Relations division of Human Resources, or the General Counsel of the institution at which the program is located to discuss reporting concerns before disciplinary action is taken. Once disciplinary action is taken, it must be reported to the Dean for Graduate Medical Education of the GME Consortium.

7. Institutional Support

One should consult with the Dean for Graduate Medical Education when evaluating what discipline to impose, how to impose it, or during any other steps of the process. The offices of the Hospital Director and General Counsel should be advised of any requests for a hearing following notification of Disciplinary Action.

L. DISCIPLINARY ACTION

a. Disciplinary Action: The Chief of Service, the Program Director, or the Hospital Director may take disciplinary action, including termination for cause, against any House Staff Officer who:

i. Fails to demonstrate an acceptable level of professional competence, clinical judgment in the treatment of patients, or professionalism.
ii. Commits an act that constitutes professional misconduct under the New York State Education Law or a breach of professional ethics.

iii. Fails to abide by the By-laws, Rules and Regulations, or policies of the Hospital or the Medical Staff.

iv. Engages in any activities that are a threat to the welfare or safety of patients, employees, other physicians, or the Hospital. The Chief of Service or Hospital Director shall send the House Staff Officer written notice of the disciplinary action together with a statement of the reasons therefor. If no request for a hearing is made by the House Staff Officer pursuant to Section II below, the disciplinary action shall become effective and final.

b. Notice: Notice of disciplinary action shall be in writing and shall include the action taken and the basis therefore.

c. Right to a Hearing: Any House Staff Officer who has received notice of proposed disciplinary action may request, in writing, a hearing before the House Staff Affairs Committee of the Medical Board within ten days from receipt of such notice. Requests should be directed to the President of the Medical Board in care of the Medical Staff Office at Box 1116. Should you have any questions, call x46114 or x46917. The nonrenewal of a contract is subject to a hearing by the House Staff Affairs Committee of the Medical Board.

d. Hearing

i. The House Staff Affairs Committee shall hold a hearing no sooner than 15, and no later than 45 days, from the date the written request for the hearing is received. The House Staff Officer shall be entitled to be present at the hearing, to present relevant evidence and witnesses on his or her behalf, and to question witnesses appearing in support of the charges made.

The scope of the hearing shall be limited to determining whether there is sufficient evidence to demonstrate that the adverse action taken by the Department was not arbitrary and capricious. All testimony at the hearing shall be under oath, and a transcript of the hearing shall be made. The rules of evidence shall not apply, and the decision shall be based on a preponderance of the evidence.

At the hearing, the staff member or applicant may be represented by an attorney or other person of his or her choice. The role of this representative or department’s attorney shall be limited
to: (1) providing advice and counsel to the Staff Member or applicant; and (2) addressing the members of the Hearing Committee. The role of the representative shall not include the presentation of evidence or the examination or cross-examination of witnesses. The Hearing Committee may, in its discretion, further define, expand or limit the role of any such representative.

A majority of members of the House Staff Affairs Committee shall constitute a quorum. The House Staff Affairs Committee shall make such additional rules as it deems necessary to assure prompt, fair, and expeditious handling of the matter. The House Staff Affairs Committee may take whatever action, consistent with Hospital policy, it considers appropriate.

ii. Within 30 days of the conclusion of the hearing, the House Staff Affairs Committee shall make a written report of its findings and decision to the Director of the Hospital, the Chief of Service and the House Staff Officer.

e. Appeal: The decision of the House Staff Affairs Committee may be appealed by the House Staff Officer, the Chief of Service or Hospital Director to the Executive Committee of the Medical Board within 15 days of receipt of notice of the decision of the House Staff Affairs Committee. If no request for an appeal is made, the decision of the House Staff Affairs Committee shall be final. The appeal shall be limited to the record of the proceedings before the House Staff Affairs Committee, and the scope of review shall be limited to determining whether there is a reasonable basis on which to support the findings and conclusions of the House Staff Affairs Committee. Within 30 days after the conclusion of the appeal, the Executive Committee shall send notice of its decision to the House Staff Officer, the Chief of Service, and the Hospital Director. The decision of the Executive Committee shall be final.

f. Summary Suspension: A House Staff Officer may be summarily suspended from his or her duties and responsibilities without a hearing where his or her continued presence is deemed a risk to the Hospital or its patients. Following such action either by the Chief of Service or by the Hospital Director with the concurrence of the Chief of Service, the House Staff Officer shall have the right to an immediate appeal to the House Staff Affairs Committee. A summary suspension of a House Staff Officer pending termination shall be a suspension without pay. If the House Staff Officer requests a hearing before the House Staff
Affairs Committee, and is subsequently reinstated, he or she may be entitled to full or limited back pay at the discretion of the House Staff Affairs Committee.

M. PROGRAM CLOSURE OR REDUCTION AND ADVERSE ACCREDITATION ACTIONS

Program Directors must notify each affected House Staff Officer immediately:

a. of a decision to discontinue any training program for any reason; and/or

b. upon receipt from the Accreditation Council for Graduate Medical Education or the Commission on Dental Accreditation of any confirmation of an adverse accreditation action.

If a decision is made to significantly reduce the size of a residency program or to close a program, Program Directors must inform the affected House Staff Officers of this decision as soon as possible. In such cases, the Program Director must allow House Staff Officers already in the program to complete their education if possible, or must assist the House Staff Officers in enrolling in ACGME-accredited programs within the Consortium or at other institutions.

N. PHYSICIAN IMPAIRMENT

The Physician Wellness Committee at The Mount Sinai Hospital investigates physicians who are suspected of impairment. Impairments can be of many etiologies, including drug abuse, psychiatric impairment, personality disorders, and physical limitations affecting patient care and/or collegial behavior. If impairment is suspected, the Program Director (or other faculty or staff) must report this physician, regardless of status, to the Impaired Physician Committee for evaluation. (The source of the report is kept confidential.) Timely reporting is necessary to avoid medical errors and harm to patients and/or staff. The Hospital has a legal and moral obligation to ensure the safety and quality of the medical care it provides, and to assist the impaired physician in seeking treatment and rehabilitation, by evaluating physicians suspected of impairment.

The stresses inherent in residency training may often cause some House Staff to experience increased anxiety and difficulty in functioning. In addition, either before or during residency training, a resident may have resorted or will resort to the use of mood-altering drugs to sustain his/her functioning. It is the responsibility of the Program Director to make residents aware of the signs
and symptoms of impairment, and to be knowledgeable of the proper steps to take when impairment is detected.

Information is provided to the House Staff in the House Staff Manual concerning physician impairment. However, from the perspective of the Program Director, it is essential that a House Staff Officer’s difficulty in functioning is identified as quickly as possible and addressed expeditiously. This provides the most help to the resident and helps to prevent any adverse events with respect to patient care. If a resident seems depressed or overly anxious or if his or her function seems otherwise impaired, an administrative psychiatric evaluation may be requested. In such cases, the report concerning the resident’s ability to participate in program activities will be filed with the Program Director. If it is felt that an administrative evaluation is not necessary, a recommendation should be made to seek psychotherapy. At Mount Sinai, Dr. Kathy Berkman, Director of the Residency Mental Health Consultation Service, will provide an initial consultation free of charge to any resident with appropriate referrals.

A Program Director may suspect a physician of using mood-altering drugs based on certain behaviors associated with drug use. However, a urine toxicology screen must be obtained to confirm drug use. Consistent with institutional guidelines, an employee’s refusal to give a spot urine sample for analysis (for cause) is grounds for immediate suspension and possible termination. Instances of physician impairment due to drug use should be reported to the Quality Control Committee (QCC) as well as the Physician Wellness Committee. Dr. Arthur Figur chairs this committee and should be notified of suspected impairment. The Physician Wellness Committee can meet with the resident and subsequently make recommendations to treat impairment.

O. THE INTERNATIONAL MEDICAL GRADUATE

1. The Educational Commission for Foreign Medical Graduates (ECFMG)

All candidates for residency training who are foreign-born International Medical Graduates must receive certification by the ECFMG regardless of their visa eligibility. The United States Information Agency has designated the ECFMG as the only organization authorized to sponsor foreign national physicians to engage in graduate medical education or training.

The ECFMG will only provide certification to qualified individuals who are entering ACGME-approved residency programs. Foreign-born IMGs who wish to enter non-ACGME-approved programs will not routinely be able to
receive ECFMG approval. However, ECFMG approval can, on an exception basis, be given to foreign national physicians who wish to enter the United States for advanced training in programs involving observation, consultation, teaching, or research, with or without patient contact, without necessarily having received the ECFMG certificate. These visitors may remain in the United States for a maximum of three years, with a possible six-month extension under specific circumstances. They cannot, however, be engaged in residency training or be involved in the treatment of patients.

It should be noted, however, that this regulation is distinct from the New York State Health Code (see below), which allows physicians licensed in their own country to enter the United States without ECFMG certification to engage in clinical training under appropriate supervision for a period not to exceed six months. Unfortunately, although this is permitted by the State of New York, the ECFMG will not routinely give certification to allow residents to do this unless they have already received the ECFMG Certificate, and the United States Citizenship and Immigration Service (USCIS) will not issue J-1 or H-1B visas without ECFMG certification.

2. **Visas**

   Available visa classifications are:
   
   a. Exchange visitor (J-1),
   b. Temporary worker (H-1B, O-1),
   c. Valid employment authorization card “EAD” issued by USCIS, or
   d. Student visa (F-1)

3. **Exchange Visitor J-1 Visa**

   All hospitals should require foreign-national physicians to use the J-1 visa when entering residency training. ECFMG sponsorship is required for issuance of the J-1 visa. ECFMG sponsorship is routinely given to individuals who have ECFMG certification and are accepted into ACGME approved programs or programs recognized by the American Board of Medical Specialties.

   In general, the J-1 visa is good for the time required to meet the educational requirements for certification as recognized by the ACGME.

   However, exception is now made if the American Board of Medical Specialties requires an extra year of research beyond the accredited length recognized by the ACGME. In addition, visa extensions can be obtained if the
resident is appointed Chief Resident, providing such an appointment is competitive, responsibilities are clearly defined, and the position is eligible for Health Care Financing Administration (HCFA) reimbursement. Upon termination of the J-1 visa, as per immigration regulations, the physician is required to return to his/her home country for a period of two years. If the physician wishes to remain in the United States upon completion of the time allotted by ECFMG, he/she may apply for a J-1 Waiver of the two-year home residency requirement.

4. Temporary Worker H-1B Visa

The H-1B visa is a nonimmigrant visa issued to workers coming to the United States to perform work within one of the designated “specialty occupations.” The H-1B category allows specialty workers to enter the United States to work for a period of up to six years. A “specialty occupation is defined as an occupation requiring the alien to possess theoretical and practical application of a body of highly specialized knowledge. In order to meet this requirement, immigration regulations require the applicant to have a bachelor’s degree or its equivalent in an enumerated specialty for entry into the United States in that occupation.

Foreign medical doctors applying to a clinical employer or residency training program for H-1B classification must additionally show:

a. a state medical license;

b. passing scores of USMLE 1, 2 & 3;

c. English language proficiency as documented by ECFMG certification or a medical school diploma from a U.S. accredited school; and

d. an M.D. or equivalent foreign degree or unrestricted foreign Clinical Medical License. If a FMG has obtained a J-1 waiver of the two year home residency requirement, J-1 doctors may change their status to that of an H-1B.

It is important to note that the H-1B visa is employer-specific. If the H-1B employee is terminated, the employer is responsible for reasonable return transportation costs. Upon termination, the employer will notify the immigration service that they wish to withdraw the H-1B petition since the employee is no longer working for the employer.
5. **Student F-1 Visa**

In general, these visas are issued to undergraduate or graduate students entering schools in the United States for additional training. However, it appears to be possible for physicians coming into the United States for training in a specific residency program—if the training is part of a defined university curriculum rather than an ACGME-approved program—to be eligible for F-1 visa status for postdoctoral studies. This is authorized for the time of the educational program. The individual must be matriculated in a university designated to participate in this program. ECFMG certification is not needed; however, New York State Education Law only permits such an individual to engage in clinical activities for up to six months.

6. **Persons of Extraordinary Ability O-1 Visa**

This classification is reserved for persons of extraordinary ability demonstrated by sustained national or international acclaim. It is rarely given at the resident level. It is necessary to file an O-1 petition on behalf of an individual with the USCIS for a particular GME program at a particular location, with employment limited to work for the employer who filed the petition in the capacity described. Unlike the J-1 and H-1B visas, no special examination requirements apply.

7. **Lawful Permanent Resident (Immigrant)**

This status is given to individuals who hold green cards. These individuals are permitted to remain in the United States permanently and to accept any employment for which they qualify (including appointment to a residency program).

8. **International Personnel Office**

On several recent occasions departments have asked International Personnel to accept foreign nationals without the appropriate visas into an MSSM-sponsored program. As all Program Directors should be aware, International Personnel cannot accommodate such a request without placing the institution in violation of federal regulations and in danger of receiving substantial fines and penalties.

This section offers a reminder of some of the ground rules governing our responsibility to our immigration program. International Personnel is responsible for ensuring continued compliance with all applicable Homeland Security, U.S. Department of Labor, and U.S. Department of State regulations.
as they relate to our foreign national employees. In a continuing effort to ensure The Mount Sinai Medical Center’s compliance, the following procedural guidelines must be followed:

a. Under no circumstance is any foreign national allowed to work, study, observe, or volunteer at The Mount Sinai Medical Center without an appropriate visa. The process should begin at least 45 days prior to the anticipated arrival of the foreign national by filing the appropriate application with the International Personnel Office.

b. Departments may not request a change in an employee’s immigration status in an effort to reflect a more positive tax analysis.

c. Employees seeking waivers must speak with International Personnel at least one year prior to the expiration of their current visa status.

d. All foreign national employees seeking permanent resident status must have written approval from the Chairperson/Division Chief, Immediate Supervisor, Department Administrator, and Senior Vice President of Human Resources prior to Medical Center sponsorship. Employees are not permitted to use outside counsel for employment-based immigration petitions unless exigent circumstances exist. Additionally, employees must obtain permission to work with outside counsel from the Director of International Personnel.

Please note that immigration regulations change from time to time. Updates to immigration changes at The Mount Sinai Medical Center are available from Human Resources.

Any questions or requests for more information should be directed to the Director of International Personnel at (212) 731-7744.
VII. GME Resources

A. THE HOUSE STAFF MANUAL

The House Staff Manual informs House Staff of their rights, benefits, and responsibilities while working at Mount Sinai or its affiliated hospitals, and makes them aware of the policies and procedures that apply to their training. It should be emphasized to all House Staff that it is important for them to be familiar with the Manual’s content and to refer to it when any questions arise concerning policies and benefits. The House Staff Manual may be accessed by faculty and House Staff on the GME website.

B. HOUSE STAFF REPRESENTATION

As the objective of our residency training programs is to train physicians in the practice of medicine at the highest possible level, the relationship between residents and Mount Sinai may sometimes resemble that of employer and employee, or teacher and student. Feedback from residents provides a vital means of improving their training, and there are a number of forums where residents may share their ideas.

The ACGME requires House Staff representation on all appropriate institutional and departmental committees. In the GME Consortium, House Staff representation exists on the GME Committee and its subcommittees. In The Mount Sinai Hospital, residents serve on the Harassment Committee, the Executive Committee of the Medical Board, the Medical Board, the Executive Clinical Review Committee, the Care Center Quality Council, the Clinical Access Committee, the House Staff Affairs Committee, and the Medical Records Committee. Each affiliated hospital is responsible for creating forums for residents to exchange information and for encouraging resident participation in its institutional committees.

Program Directors also play a critical role in assuring that residents are familiar with and utilize our established internal mechanisms to present and
discuss issues, and to serve on appropriate departmental committees. The administration relies upon Program Directors to address and resolve issues the residents raise and to bring appropriate issues to the administration’s attention. It is also essential that Program Directors explain to residents and fellows why it may not always be possible to implement their requests. Program Directors’ use of resident input is assessed in the Internal Review of the residency program. Effective two-way communication by the Program Directors with their residents is essential in assuring that Mount Sinai provides an environment conducive to high-quality residency training.

C. INSTITUTE FOR MEDICAL EDUCATION

In 2001, The Institute for Medical Education (IME) was created at MSSM to establish an administrative entity devoted entirely to the advancement of teaching skills and the support of educators who fuel our teaching community. Nationally, there are approximately 20 Academies/Institutes of Educational Excellence. The IME at MSSM was one of the first in the United States and its medical education leaders have become a national presence in the world of Medical Education.

1. Mission Statement

The IME serves the vital need of educating, mentoring, and retaining the best educators for students, residents and faculty. Fostering the success of educators includes recognizing and rewarding those who display dedication and excellence in their work, providing programs that develop and reinforce their teaching skills and their success in the promotions process, and creating a community of dedicated educators who contribute their knowledge and experience back to this community by serving as teachers and mentors.

The IME is a distinct entity within the Department of Medical Education that provides an interdisciplinary, interdepartmental, and inter-institutional context where teachers across departments and at affiliated hospitals can interact, learn from, and support each other’s efforts to provide outstanding education, to collaborate on research, and to develop an academic career track.

The IME is an inclusive organization that fosters a sense of academic community and support for faculty who see teaching as the major focus of their academic career. Membership is available to all educators and a more advanced level of membership (Fellowship) is being developed to identify the best among teaching faculty and to use this smaller cadre of IME Fellows to support and sustain the IME’s goals.
2. **Goals and Benefits of Membership**

a. Recognition/Reward for Excellence in Education:
   i. Monetary Awards
   ii. Teaching Awards
   iii. Fellowship level of membership for selected students, resident and faculty
   iv. Faculty development (teaching skills, leadership skills)
   v. Opportunities to present scholarly work

b. Support for Promotion on Educator Track:
   i. Access to mentors
   ii. Faculty Development (CV and portfolio writing workshops)
   iii. Appointments & Promotions letters of support for fellows
   iv. Support development of scholarship

c. Support and development in teaching/education:
   i. Stimulate innovation
   ii. Access to mentors
   iii. Share curricula, ideas, time, resources
   iv. Communication and networking opportunities
   v. Access to national professional development programs
   vi. Identify excellence benchmarks
   vii. Master Clinician teaching programs

d. Support and development of scholarship:
   i. Help with development and implementation of educational research projects
   ii. Communication and networking opportunities
   iii. Access to national professional development programs
   iv. Opportunities to present scholarly work (local, regional, national)
3. **Current Programs**

The Institute has developed a number of programs that promote outstanding teaching and educational scholarship for our medical educators.

a. **Teaching Skills Development**

i. The Resident Teaching Development Program, the first major program developed by the IME in 2001, was for residents, given that they are the primary educators of our students. This 7-hour teaching course is now part of every core clinical specialty residency curriculum.

ii. The Teach the Teacher course is the faculty development program held once a year to train faculty to teach and implement the resident teaching curriculum in their own departments. 31 faculty in 7 specialties from 11 different institutions have participated.

iii. The Teaching Skills Faculty Development Series is open to all Mount Sinai faculty. Topics include small group teaching skills, bedside teaching, teaching on rounds, giving effective lectures, creating exam questions, writing goals and objectives, developing scholarship, leadership skills, and other topics by request.

iv. Becoming a Medical Teacher is a fourth-year medical student elective. We believe that doctors are lifelong teachers of patients and that formal teaching skills instruction should begin in medical school.

b. **Professional Development**

i. The Educational Leadership Conference is an annual faculty development retreat for all course directors, clerkship directors, deans, and other educational leaders at Mount Sinai School of Medicine (MSSM) and its affiliate institutions.

ii. Medical Education Grand Rounds is a bimonthly conference that serves as a forum for educators to exchange ideas about curricular innovations, new teaching theories, research in education, use of technology, or mentorship of teachers.

iii. The Harvard Macy Program for Physician Educators is a 2½-week program designed to enhance the educational scholarship of physician educators. Thus far, the IME has sponsored approximately 23 faculty with key roles in education to attend this internationally recognized
program. They have returned to make substantial educational contributions at MSSM for students, residents, and faculty at MSSM.

c. Reward and Recognition

i. Teacher Appreciation Day: Excellence in Teaching awards are presented to those faculty nominated by students and colleagues as their best teachers and mentors.

ii. Education Research Day provides a forum for faculty to present their innovative educational projects and research. The Blue Ribbon recipients are sponsored to present their work at the AAMC (Association of American Medical Colleges) Annual Meeting.

More detailed descriptions of programs can be found on the IME website.

D. PROGRAM DIRECTORS TRAVEL FUND

The Program Directors Travel Fund was established to promote the involvement of Mount Sinai School of Medicine Residency Program Directors in national associations related to residency training. Such involvement boosts the reputation of both the specific program and the School of Medicine. The completed funding request form (Appendix 13) should be sent via email to paul.f.johnson@mssm.edu.

E. VISITING ELECTIVES PROGRAM FOR STUDENTS UNDERREPRESENTED IN MEDICINE

A competitive electives program has been designed to increase the diversity of House Staff, and consequently that of faculty, at Mount Sinai School of Medicine and its affiliate institutions, by making subsidized electives available to third- and fourth-year underrepresented minority students.

These four-week electives are offered on a space-available basis to selected third- and fourth-year medical students in good standing at accredited U.S. medical schools. The electives are offered to third-year students between March and June, and to fourth-year students between July and February. Interested students should consult our Electives Manual for specific application instructions.

Reimbursement is provided for travel, and attempts are made to provide housing at the host institution for successful applicants. For the duration of the elective, students have access to seminars and other facilities at the School of Medicine and the affiliated hospital. Faculty advisors meet with the students on a regular basis.
Applicants may find information and application materials online. The student should rank his/her first three choices of electives and institutions on the application form. Virtually all institutions offer General Medicine and Pediatrics senior electives. The Family Practice elective is offered only at Jamaica Hospital. In addition to the application, the following must be included:

a. Curriculum Vitae

b. Official medical school transcript

c. United States Medical Licensing Examination (USMLE) Step 1 score (Score Card)

d. Letter of recommendation from the Dean

e. Letter of recommendation from a faculty member at the student’s school in the department to which the student is applying

The above material must be mailed with the completed application from the GME office. Please contact Monique Sylvester at (212)241-6694 or monique.sylvester@mssm.edu for additional information.

F. ACADEMIC PROGRAM IN THE MEDICAL SPECIALTIES FOR VISITING PHYSICIANS

The purpose of this program is to allow residents or attending physicians from countries other than the United States and Canada to pursue specialized clinical training at the Mount Sinai Consortium for Graduate Medical Education for periods of up to six months (Certificate Program). Eligibility requirements include 1) a license to practice medicine in the home country, 2) at least two years of prior residency training, and 3) a demonstrated command of the English language. Participants in this program will be sponsored by the Mount Sinai School of Medicine for F-1 visas.

In addition to the above requirements, clinical training beyond the six-month period (Diploma Program) will require that physicians have 1) ECFMG certification and 2) a limited permit to practice medicine in New York State.

Departments interested in participating must develop an organized, educational curriculum for the visiting physicians, including clinical and didactic components. This must include goals and objectives as well as a description of specific clinical and didactic experiences, including an outline of the hours per week devoted to each experience. A minimum of 10 hours of didactic sessions per week is required for all programs. The K-30 curriculum can be used toward this end. An evaluation system for participants should also
be specified. Visiting physicians may be able to participate as auditors in courses sponsored by the Clinical Research Training Program, by the Master of Science in Community and Preventive Medicine Program, and, where appropriate, by the Graduate School. All educational curricula must be approved in advance by the Dean for Graduate Medical Education. Physicians will not be paid for their participation, and tuition will be charged based upon the length of the program. However, tuition may be waived, as deemed appropriate. At the conclusion of the academic program, depending upon its length, a certificate or a diploma will be issued.

1. Certificate Program

This is either a three-month or a six-month program that will include clinical experiences with direct patient contact under careful faculty supervision, formal seminars, and grand rounds. The schedule of activities will vary by specialty but will be approved in advance by the Dean for Graduate Medical Education. All students will be matriculated on a full-time basis.

2. Diploma Program

This program will be either 12 months or 24 months in duration and will include clinical experiences with direct patient contact under careful faculty supervision, formal seminars, and grand rounds. For those physicians participating in the two-year program, supervised research on projects approved by the Institutional Review Board will also be undertaken. The exact curriculum will vary by specialty but must be approved in advance by the Dean for Graduate Medical Education. All students will be matriculated on a full-time basis.

3. Tuition

The tuition for the program is as follows:

   a. Three-month Certificate Program $6,000
   b. Six-month Certificate Program $12,000
   c. One-year Diploma Program $24,000
   d. Two-year Diploma Program $48,000
4. **Application Process**

Interested applicants should complete the application form and return it with the required credentials directly to the department. Applications and required documentation should then be forwarded to the Office for Graduate Medical Education (Box 1076).

**G. Fifth Pathway Program**

The Fifth Pathway Program was established to provide an alternative pathway to residency training and licensure for United States citizens who have completed medical school in a country, most notably Mexico, that requires an additional two years of internship and social service before granting the medical school degree. By completing a Fifth Pathway year, the student “saves” a year. In order to be eligible for the Mount Sinai Fifth Pathway Program, the student must be a United States citizen or permanent resident, must have completed pre-medical work in the United States, and must have completed four years of medical school in Mexico. In addition, the student must have taken the MCAT and must have passed Step I of USMLE.

MSSM sponsored a Fifth Pathway Program from 1973 until 1995 and has reopened the program as of July 2007.

The 48-week program consists of six required rotations (Internal Medicine, Surgery, Psychiatry, Pediatrics, Obstetrics/Gynecology, and either Emergency Medicine or Family Practice) and two to three electives. Program participants are considered medical students and are privileged as such. They are most like sub-interns. Currently, two hospitals are participating in the Fifth Pathway Program: Queens Health Network (Elmhurst and Queens hospital centers) and St. Joseph’s Regional Medical Center in Paterson, New Jersey. There are a total of 36 slots in the program.

Further information may be obtained from the Fifth Pathway Program website.

**H. The GME Website**

The GME website briefly describes the Consortium and provides links to all participating institutions. All Program Directors should access this website to make certain that both their institutions and their programs are described accurately. Web updates should be submitted to Paul Johnson at paul.f.johnson@mssm.edu.
I. JOBSITE

The Mount Sinai School of Medicine Consortium for GME Jobsite has been developed to assist residents who are completing their training in their search for career opportunities. Physicians and organizations may post available positions by following the simple instructions on the site. To view the Jobsite, go to http://fusion.mssm.edu/gme/view/.

It must be emphasized that, although specific information has been requested concerning the identity of physicians or organizations posting positions, their accuracy cannot be verified. It is therefore incumbent upon each resident to evaluate the posted job descriptions.