

UNIVERSITY OF UTAH DEPARTMENT OF INTERNAL MEDICINE
Internal Medicine Residency Program – University of Utah Health
STANDARDS OF PERFORMANCE AND EVALUATION POLICY

REVISED: March 2014

I. EXPECTATIONS:

1. It is the intent of this three-year training program to develop physicians clinically competent in Internal Medicine. Physicians completing the program will be eligible for certification by the American Board of Internal Medicine with an ultimate goal of a 100% pass rate on this examination.
2. Clinical Competence Requires:
 - a. A solid fund of basic and clinical knowledge.
 - b. The ability to perform an adequate history and physical examination.
 - c. The ability to appropriately order and interpret diagnostic tests.
 - d. Adequate technical skills to carry out selected diagnostic procedures
 - e. Clinical judgment to critically apply the above data to individual patients.
 - f. Practice-based learning and improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvement in patient care.
 - g. Attitudes conducive to the practice of Internal Medicine, including appropriate interpersonal interactions with patients, professional colleagues and supervisory faculty, and all paramedical personnel. Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practices, an understanding and sensitivity to diversity and a responsible attitude toward patients, their profession and society. These humanistic aspects of medicine are of critical importance.
 - h. Personal integrity, which includes strict avoidance of substance abuse, theft, and unexcused absences.
 - i. Regular, timely attendance at educational activities of the Department of Medicine.
 - j. 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.

II. ASSESSMENT AND EVALUATION OF CLINICAL COMPETENCE

1. Fund of Basic and Clinical Knowledge
 - a. During the PGY1 year this will be assessed monthly both by supervisory faculty and by supervising PGY2 and PGY3 residents based on direct observation at the bedside as well as on performance during work rounds and teaching rounds. During the PGY2-3 years, this will be assessed on an ongoing basis by the senior resident, Chief Medical Resident (CMR) and/or attending, as applicable
 - b. This information is recorded on the American Board of Internal Medicine (ABIM) Evaluation Forms and maintained in the resident's file.
2. Ability to Perform an Adequate History and Physical Examination
 - a. During the PGY1 year this is assessed on a monthly basis both by supervising faculty and PGY2 and PGY3 residents and recorded on the ABIM Evaluation Form. Additionally, at least twice during the year, the ABIM Clinical Evaluation Exercise (CEX) is performed under the supervision of a faculty member in an OSCE setting, discussed with the PGY1 resident, and incorporated into the resident's file. This exercise involves the directly observed evaluation, workup, and analysis of a

- standardized patient. In addition, the PGY1 resident also receives comprehensive didactic instructions while on the ambulatory care rotation and again tested on a standardized patient at the end of this rotation.
- b. At the end of the PGY3 year, the resident is again tested under the supervision of a faculty member in an OSCE setting on a standardized patient.
 - c. Throughout the year, mini-CEX (clinical exams) will be evaluated in the out- and in-patient settings. These evaluations will be incorporated into the resident's file.
 - d. During the core conference lecture series each organ system is covered for review of complete physical diagnosis requirements. In addition, cardiac auscultation skills and history taking skills are covered.
3. Ability to Appropriately Order and Interpret Diagnostic Procedures
 - a. This is assessed monthly by the supervising faculty, CMR, and/or PGY2-3 residents and recorded on the ABIM Resident Evaluation Form.
 - b. Chart reviews will be performed regularly by the attending physician.
 4. Adequate Technical Skills to Carry Out Selected Diagnostic Procedures
 - a. All PGY1 residents must be both BLS and ACLS (Advanced Cardiac Life Support) certified prior to beginning the training program. All residents must maintain active certification for both BLS and ACLS throughout the duration of the training program.
 - b. When performing procedures, PGY1 residents are directly monitored by supervising faculty, CMR and for certain procedures by qualified PGY2 and PGY3 residents.
 - c. PGY2-3 residents are directly monitored by supervising faculty, CMR and/or PGY2-3 residents.
 - d. Refer to the Program Procedures (Clinical) Policy for additional information.
 5. Clinical Judgment
 - a. Clinical judgment is defined as the ability to synthesize data collected from history, physical examination, and lab studies and critically apply it to individual patients is of importance to the effective clinician.
 - b. The clinical judgment skills of the resident are assessed monthly by the faculty supervisor based on direct observation at bedside work rounds, attending rounds, and teaching conferences. This assessment should be verbally communicated to the resident and recorded on the monthly ABIM Evaluation Form.
 6. Attitudes and Behavior Conducive to the Practice of Internal Medicine
 - a. The humanistic aspects of medicine, including appropriate interpersonal interactions with patients, peer colleagues, supervising faculty, nursing, and paramedical personnel are important to the effective internist.
 - b. Houseofficers are assessed monthly on interpersonal and communication skills and professionalism aspects of medicine by faculty supervisors and peer colleagues via the ABIM Evaluation Forms.
 - c. Input may also be obtained periodically from nursing staff and other paramedical personnel.
 7. Personal Integrity and Accountability
 - a. Substance abuse, theft, deceitful medical practices, and unexcused absences or lack of availability when on call, cannot and will not be tolerated in physicians at this institution.
 - b. Since professionalism cannot be evaluated solely on written or oral examination, we use the following descriptors to identify behavior which are unacceptable for meeting the standards of professionalism inherent in being a physician (Academic Medicine. 1999: 74:980-90).
 - i. Unmet professional responsibility
 1. Needing continual reminders to fulfill responsibilities to patients and

- to other health care professionals.
 - 2. Unreliability to complete tasks.
 - 3. Misrepresentation or falsification of information.
- ii. Lack of effort toward Self-improvement and Adaptability
 - 1. Resistance or defensiveness in accepting criticism.
 - 2. Remaining unaware of own inadequacies.
 - 3. Resists considering or making changes.
 - 4. Not accepting responsibility for errors or failure.
 - 5. Is overly critical/verbally abusive during times of stress.
 - 6. Demonstrates arrogance.
- iii. Regular, Timely Attendance at Educational Activities of the Department of Medicine
 - 1. All residents are expected to regularly attend educational activities. See the Program Conference Attendance Policy for more information.
 - 2. Recurrent tardiness without adequate excuse will be grounds for disciplinary action.

III. METHODS OF RESIDENT EVALUATION - The following methods of evaluation are utilized in resident assessment:

1. Objective Structure of Clinical Examination (OSCE) (as discussed above) / Mini-CEX
2. ABIM Evaluation Forms (as discussed above) completed each rotational block by the faculty supervisor(s) assigned to ward teams, ICUs, and subspecialty rotations via the E*Value online resource.
 - a. It is our expectation that these evaluations are discussed in person with the teaching attending PRIOR to the completion of a rotation.
 - b. Residents can immediately access faculty evaluations completed about themselves via E-value.
 - c. Residents will discuss their evaluation summaries at the semi-annual review.
3. General Medicine Continuity Clinic Evaluations
 - a. Residents are evaluated every 6 months by their general medicine clinic attendings using the ABIM Evaluation Forms.
 - b. Residents must discuss any unsatisfactory evaluations personally with both the clinic attending and the Housestaff Program Director or designee.
4. Systems-based practice, professionalism, and interpersonal and communication skills will be evaluated.
 - a. Evaluations of residents by nursing and social service staff in the ICU, MICU, STICU, Continuity Clinic and Huntsman Inpatient rotations will be collected.
 - b. Unsatisfactory evaluations will be discussed at the next Clinical Competency Committee meeting.
5. Personal observations by the Housestaff Program Director related to direct patient care activities, performance/attendance/punctuality at morning report and other teaching conferences, are also considered in the overall evaluation of residents. Concerns of the Program Director related to unsatisfactory performance will be immediately communicated to the resident verbally and in writing.
6. Written Examination
 - a. All categorical residents will take the in-training examination sponsored by the American College of Physicians each year. These results are reviewed by the program director with the resident to assess any deficits that may be present and to prepare a formal board exam study schedule.
 - b. Categorical residents will complete and pass medical knowledge modules, assignments, and quizzes as required by the program Ambulatory Care

Curriculum and Medical Knowledge NEJM+ Quiz policies.

7. Record Review
 - a. Written records are routinely reviewed by faculty preceptors (outpatient setting) and attendings (wards).
 - b. Record reviews provide evidence about clinical decision making, follow-through in patient management and preventive health services, and appropriate use of clinical facilities and resources. Feedback is provided to the resident directly by the faculty member.
8. Resident Portfolios: Each resident has a portfolio which includes:
 - a. Procedure logs
 - b. Evidence of literature reviews related to specific patient care issues
 - c. Evidence of teaching experiences (teaching rounds, morning report, lunch-time conference)
 - d. Journal club presentations relating to specific topics of interest
 - e. Any ethical dilemmas faced and how they were handled
 - f. Summaries of scholarly projects and evidence of any outcomes achieved (regional or national posters, presentations or published reports)
 - g. Rotation evaluations
 - h. Preceptor Reviews
 - i. Mini-CEX

IV. FEEDBACK PROCESS:

1. Attending of resident evaluations can be viewed by the resident immediately after completion and are always accessible online.
2. Residents will receive aggregated and anonymous semi-annual summaries of evaluations from nursing staff and peers
3. Evaluations of attendings by residents are anonymous
4. Semi-annual reviews
5. Attendings are encouraged to meet personally with their residents at the end of each rotation to discuss their performance.
6. For evaluation purposes, the Program Promotion Policy provides a standard or measuring stick by which ALL evaluators must follow.

V. Academic Action and Dispute Resolution

1. See the Program Academic Action, Dispute Resolution, and Hearing Procedures Policy for the rights and procedures to be followed by all parties.