Welcome to Graduate Medical Education (GME)

The mission of the MMC GME program is to be a high-performance, quality GME system helping Maine become the healthiest state in the nation.

MMC has a long, proud tradition of medical teaching, extending back to the founding of the hospital. Medical education at the Medical Center began in 1874, when Drs. Erastus E. Holt and George W. Libby became the first ‘house pupils’. The internship remained the only postgraduate medical program through 1949, and trained 254 physicians. Residencies in surgery and medicine were developed in the late 1940’s, anesthesiology and radiology residencies in the early 1950’s, pediatrics in the early 1960’s, psychiatry in 1969, OG/GYN in 1975, and emergency medicine in 1996. The family practice program evolved from the former general practice program in response to the need for primary care physicians in Maine and the GME program has continued to expand its residencies and fellowships. Recent additions include Vascular Surgery Residency, Integrative Medicine and Preventative Medicine.

Today we have 22 accredited residency and fellowship programs, 3 non-accredited programs and a robust Dentistry program, with a partnership with Tufts University Dental School. Each program is administratively managed by a Program Director and a Program Manager, fully complying with the Accreditation Council for Graduate Medical Education (ACGME) requirements.

Oversight of all graduate medical education programs is done by the GME Committee and subcommittees, on which there is resident representation. The GME committee is chaired by the Designated Institutional Official (DIO), Kalli Varaklis MD, MSEd. GME oversight summary:
Maine Medical Center is dedicated to maintaining and improving the health of the communities it serves by working together so our communities are the healthiest in America.
The primary objective of this manual is to serve as a resource for information for residents and fellows at Maine Medical Center. It serves as an ongoing readily available source of information relating to operational policies and procedures, which affect your day-to-day activities, both from the professional and personal standpoints.

**Who to contact with additional questions?**

For general GME questions, your best first resource is either your Program Manager or Program Director. For additional questions/information you may contact:

Sarah Rusch  
GME Administrator  
662-7068  
SRusch@mmc.org

Kalli Varaklis  
Designated Institutional Official (DIO)  
varakk@mmc.org

For any Benefits questions – it is always best to call Human Resources for the most up-to-date, accurate and knowledgeable information.  
Any questions regarding short term disability should be directed to UNUM, the company who manages this for MMC and has the best and most accurate information to help inform your benefits.

Unum  
877-352-8818

HR Solutions  
661-4000

Please retain this manual for reference during your training period at Maine Medical Center. A current copy is always available on the Department of Medical Education intranet web site at http://my.mmc.org/C12/MEDED
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RESPONSIBILITY FOR THE PATIENT

Postgraduate medical training is a program of supervised, graduated patient responsibility to provide the highest standards of patient-centered care. The degree to which responsibility is assigned to you in each patient's care is a reflection of your own competence and your level of training, as determined by the attending physician. The ultimate responsibility for each patient's care is that of the attending physician. When a problem arises with a patient, the attending physician covering your service or whose private patients you are caring for must be called and the problem discussed with him/her for the purpose of reaching a resolution. That resolution may, in fact, be yours and may require relatively little input by the attending physician. However, the attending physician must always be aware of what is happening with the patients assigned to him/her. These house officer-attending contacts are not only necessary to assure continued quality of patient care, but also are an integral part of your professional education and growth. This relationship and its maintenance is the heart of postgraduate medical education.
The House Staff Association (HSA) of Maine Medical Center is the designated organization that represents all residents and fellows of Maine Medical Center. The HSA is a non-profit organization whose mission is to represent the Maine Medical Center residents/fellows. It is not a union, but has been established to guarantee representation of house staff interests at a programmatic and institutional level during the training period.

The HSA is headed by the five members who are peer elected annually to the House Staff Executive Committee (HSEC). The HSEC meets monthly and reports to the Designated Institutional Official (DIO). The President is responsible for contact with the Department of Medical Education (DME) as well as to oversee meetings and coordinate the executive HSA committee. The Vice-President acts to assist the President and to oversee meetings when the President is unable to attend. The Secretary keeps minutes, the Treasurer is responsible for the budget, and the Web-Master, with support from the DME, designs and manages the HSA website. HSA elected officials serve on the Graduate Medical Education Committee and sub-committees. The officers for 2018-2019 academic year are:

**President**
Katherine "Katie" Rizzolo PGY3 - Internal Medicine

**Vice President**
Adam O'Brien PGY4 - Anesthesiology

**Treasurer**
Russell Kizor PGY2 - Anesthesiology

**Secretary**
Jarrod Tembreull PGY3 - Internal Medicine/Pediatrics

**Communications Manager**
Adam Ludvigson PGY5 – Urology

The President is a voting member of the Graduate Medical Education Committee (GMEC) -Executive Committee meeting. This meeting is comprised of program directors, directors of medical education and other MMC administrative staff. GMEC responsibilities include establishing and implementing policies and procedures regarding the quality of education and the work environment for the residents in all programs. There are five GMEC sub-committees, on which peer-selected house officers are voting members. The President of the HSA will assign housestaff to sub-committees as requested.

The HSA financially supports house staff recreational initiatives through house staff annual dues. These dues total $100/year and are deducted in the amount of $50 first pay check and $2 per paycheck thereafter. Wellness improvements include complementary gym memberships, intramural team events, and regular interdepartmental social events.

The HSA is a safe and confidential place for residents to bring concerns about work, duty hours and safety. Residents with concerns should not hesitate to contact any member of the committee.
RESIDENT STIPENDS

Under Section 117 of the Internal Revenue Code, funds received through scholarships or fellowships in amounts not exceeding $3,600 per year for three years are excludable from a taxpayer’s gross income. In determining what monies qualify as a scholarship or fellowship under this section, courts look to the Treasury Regulations for guidance. According to the Treasury Regulations, payments received by an individual will be considered a scholarship or fellowship grant if the primary purpose of the grantee’s studies or research is to further the education and training of the recipient in his individual capacity and the amount provided by the grantor for such purpose does not represent compensation or payment for services.

One of the most frequently litigated issues under Section 117 is whether medical residents may exclude their stipends on the theory that the work they perform for hospitals is educational, not occupational, and that stipends are, therefore, not compensation for services rendered. Due to the unique nature of medical education, residents develop their skills through the treatment of patients which necessarily involves the performance of a service. The IRS, however, recognizes no distinction between medical residents and other on-the-job trainees who receive compensation for services. Compensation for services falls within the purview of Section 61 which defines gross income, and the IRS, therefore, views stipends as gross income and thus fully taxable.

The vast majority of judicial opinions on this issue have gone against medical residents; the courts holding that payments received by interns or residents performing services at a hospital in order to complete or receive specialized training involve a substantial quid pro quo and, therefore, represent compensation for services. Residents have prevailed in their quest to escape taxation in only a minority of cases. For example, stipends have been held to qualify for exclusion under Section 117 in situations where a resident spent only 20-25% of his time performing clinical duties and was not required to take call or maintain regular hours at the hospital, or where such payments were not conditioned upon job performance, residents' work was duplicated by attending staff physicians and not required for the operation of the hospital.

In sum, the struggle of medical residents to qualify for the exclusion under Section 117 is perhaps best summed up by an opinion of the United States Tax Court:

(o)nly rarely have the taxpayer-doctors been able to convince the courts that they qualify for the exclusion; but hope seems to spring eternal and the doctors continue to come to court with the argument that the facts and circumstances involved in their cases are sufficiently distinguishable from the prior cases to justify the exclusion.

Thomas W. Phillips, 35 T.C.M. 293, 294-95 (1976)
RESIDENT STIPEND POLICY

Maine Medical Center is committed to providing adequate financial support of residents/fellows so that they are able to fulfill the responsibilities of their educational programs. Resident/fellows’ stipend will correspond to the level of training the trainee is assigned to, such that a resident is paid for the PGY job they are doing.

All residents/fellows will receive either a full or partial stipend from MMC. All residents/fellows will be provided with a written contract outlining the terms and conditions of their appointment to the MMC residency program. This written contract will not require the trainee to sign any agreement not to compete with MMC after leaving its residency program.

Resident applicants will be informed in writing of the benefits for residents. The cost of benefits will follow MMC employee guidelines for full vs. part time employees, regardless of schedule.

Consistent with the MMC Leave of Absence Policy for Residents, if a resident takes an approved leave of absence prior to their last year of postgraduate training, advancement to the next postgraduate level, and the subsequent commensurate increase in pay level, will occur when the resident satisfactorily completes the postgraduate level during which the leave of absence occurred.

Changes in the yearly GME budget [i.e., FTE positions] should be budget-neutral, while acknowledging the need for flexibility due to special or unusual circumstances. No resident interdepartmental transfer requests will be allowed unless the “donating” department is willing to give up that resident slot going forward, or the “accepting” department has an open slot; if the accepting department is at full complement, it must decrease one slot the subsequent year. Any increase in resident complement which is not budget-neutral can be waived if other institutional or external funding can be secured for the GME budget for the total number of additional resident years.

Maine Medical Center will commit salary support for any resident or fellow who needs to extend their residency or fellowship program to meet board accreditation requirements.


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Administrative Chief Resident Stipend Policy

Guiding Principle: Administrative Chief Residents who are in their final year of residency and are taking on administrative responsibilities for their program in above and beyond their senior year requirements will be compensated for this work.

- Responsibilities:
  - Must include: Scheduling (Call schedules, holiday, vacation time away coordination, off-service resident call schedules while on service),
  - May include: Conference, Didactic Schedules, Block scheduling, Counseling junior residents, Teaching and Scholarly Activities and other professional development activities

- Program Eligibility:
  - Eligible
    - Programs with five (5) or more full time trainees
  - Not Eligible
    - Programs with a Super Chief*
      - exception: the position is not filled and senior chief residents are needed to assume the responsibilities
    - Programs with four (4) or fewer full time trainees
    - Non-ACGME accredited programs
    - Programs one year or less

- Compensation:
  - $2,700 per program budgeted at program level
  - If a program has more than one Administrative Chief Resident, the amount shall be allocated at the discretion of the Program Director to all Admin Chief Residents
  - Paid via SPV on a quarterly basis, based on the AY (Sept, Dec, March, June)

*Chief Resident who has already completed their residency program.

Approved by GMEC Exec: January 2018
PAYCHECKS

All new hires are required to sign up for direct deposit and have 60 days to sign up. Your bi-weekly paycheck will be usually be deposited into bank accounts on every other Friday, although occasionally as early as Thursday, depending on how quickly your financial institution clears the deposits and holidays. Remember, we are always one week in arrears when receiving paychecks.

Forms relating to withholding of taxes, payroll deductions of various types, including benefit elections will be discussed and distributed for completion at the time of orientation. Information about benefits can be obtained directly from “HR Self Service” on the Maine Medical center home page.

Last updated 6/2010

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Lifelong Learning Funds

Guiding Principle:
Promoting a culture of ownership and professionalism in the context of lifelong learning among our residents and fellows is critical to their success as a physician. Educational needs vary widely and it’s important to allow residents to have some autonomy in choosing what educational resources can best support their education.

- Each resident will be allocated a budget on a yearly basis at the beginning of the academic year and it will be based on his or her level of training as determined by the Department of Medical Education.
  
  PGY 1: $400  
  PGY 2: $800  
  PGY 3 and above: $1000

- This money is to go towards supporting and enhancing the lifelong learning of the residents.

- Unspent budgeted amounts each year will carry over and remain available to the resident until the resident graduates. If the training period for a resident/fellow is extended due to training reasons, such as remediation vs absence, the money is allocated on a monthly prorated basis.

- Unspent allocations at the end of any residency will go into a general “pool” of funds for the program. This general “pool” must also go towards supporting and enhancing the lifelong educational needs of the residents. The use of the “pooled” funds will be mutually agreed upon by the Program Director and Department Chief.

- Tracking of the money is managed by the Medical Education Program Administrator for the respective residents’ program. Any item not included in the list of examples, must be approved by the Program Director and Chief. All expenses must be approved by Program Director.

- Electronic devices/hardware are excluded from allowable purchases; software is included.

- Medical equipment is not considered educational and excluded from allowable purchases.

- A financial report of this Special Purpose account and all spending will be provided annually to an academic leadership group.

Examples of supported purchases:

- Conference travel (other than for presentation)  
- Scholarly activity  
- Subscriptions

- Board prep  
- Dues

Approved by GMEC: May 17, 2017
CONFERENCE ATTENDANCE POLICY

Attendance at national or regional conferences and meetings can be an important component of graduate medical education. MMC residents/fellows are strongly encouraged to present their scholarly work at such conferences. Attending conferences when scholarly work is not being presented should not be excessive and the educational focus should be consistent with the residents’ personal learning goals. To facilitate this latter requirement, residents should review their plans to attend conferences with their Program Director. In general, MMC residents/fellows are allowed to attend approved conferences for up to 5 days each year, which do not count against the resident’s vacation time.

- Each program will have a ‘time away’ or ‘conference’ policy, such that resident/fellow conference requests comply with programmatic restrictions, such as type of rotation, total number of days off within a rotation, educational content, residents under a remediation or probationary term, and other restrictions as defined by each program.

- Each program will have final authority for approving or denying a conference request, based on their programmatic policy.

- Residents and fellows are encouraged, as requested by their individual programs, to prepare a presentation of new educational content obtained at the conference for their peers and faculty such that the benefit of conference attendance is shared locally.

Support for travel to conferences (to which they are not presenting) is through the resident’s educational funds and/or other departmental resources.

Approved by GME Committee, 9-1-99
Updated by GMEC, 6/24/2010, September 2017

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MOONLIGHTING POLICY

This category encompasses clinical work during the residency years that is not part of the MMC educational program, and is entered into for the primary purpose of augmenting resident's income. Residents are not required to engage in moonlighting.

**Necessary Prerequisites:**

1. Resident has completed appropriate clinical training in the specialty the clinical work encompasses.
2. Resident obtains prospective, written approval from the program director, who ascertains that moonlighting will not detract from residency program, and will not result in hours of work which exceed RRC guidelines. This written approval is made part of the resident's folder.
3. Resident permitted to moonlight externally must have a license for unsupervised medical practice in the state where the moonlighting occurs. (Resident's educational training license does not suffice.)
4. The residents' performance will be monitored for the effect of these activities upon performance. Adverse effects may lead to withdrawal of permission.

**Mechanism:**

1. Resident stays on MMC payroll, etc.
2. Additional reimbursement goes from employer directly to resident.
3. Resident obtains own malpractice insurance coverage or arranges it to be provided by employer.
4. An institution hiring the resident to moonlight must ensure that licensure is in place, adequate liability coverage is provided, and whether the resident has the appropriate training and skills to carry out assigned duties.
5. Any moonlighting, internal and external, must be counted toward the 80-hour weekly limit on duty hours.

*There may or may not be additional specialty specific RRC requirements that residents will need to follow in addition to this policy.

Adopted by GME Committee, 10/21/91
Revised by GME Committee, 5/19/97, 12/10/01, 4/14/03, 9/22/2010, 9/16/11
GME Policy for Away Electives

Rotations outside MMC facilities and its physician practices or practice sites with pre-existing clinical rotations are considered a part of a resident's training program, but occur "offsite" from MMC. These rotations should be offered when a similar experience cannot be obtained within MMC facilities and practices.

**Necessary Prerequisites:**

1. Resident/Fellow completes DME away rotation request form and obtains Program Director endorsement.
2. Request form is sent to DME for review and approval.
3. Hospital Legal Affairs Department and Financial Planning offices are informed by DME so malpractice coverage is confirmed and appropriate Medicare reimbursement is tracked. Malpractice coverage is not provided for rotations outside of the U.S.

**Payroll/Benefits:**

Resident/Fellow stays on payroll with full benefits during approved offsite rotations.

**International Electives**

1. Final approval must be completed by the Program Director, Dept. of Medical Education, and other pertinent individuals at least 3 months in advance of the elective.
2. A plan of training and supervision proposed by the training site for the individual while on the rotation must be acceptable to the residency program. A defined faculty preceptor, who is responsible for the resident, must be clearly identified. The Program Director is responsible for approving the faculty supervision.
3. Review is required of safety considerations relating to the specific rotation site and the region of its location, including U.S. State Department travel warning criteria.
4. Description is required of resident goals in ACGME-competency based language for review and approval.
5. Agreement by resident to present their experience to the department after returning is required.
6. Resident/Fellow is responsible for obtaining:
   - All appropriate vaccinations as designated by an international health clinic.
   - Formal medical clearance by the resident's physician for travel to the specific area.
7. The resident is strongly encouraged to obtain an evacuation insurance policy.

At the time the request is made, an elective rotation is prohibited if located in a country listed under Travel Warnings or Travel Alerts by the U.S. State Department,
Exceptions may be considered, such as when the resident will be accompanied by a MMC faculty member and an established relationship with the clinical site has already been developed by MMC faculty.

If the country of the rotation is on the U.S. State Department list, the resident may request approval by providing information to support the specific site and region as being safe. The Program Director and Designated Institutional Official will review these requests on a case by case basis, and may request additional input from local faculty who have knowledge of a particular location. The department of Medical Education reserves the right to decline authorization to any international rotation.

Between the time of the request for approval and the actual rotation, if a country then appears on the State Department lists noted above, the resident is required to notify his/her Program Director, and the rotation request must be re-evaluated by the Program Director and Department of Medical Education.

Revised and approved by the GME Committee, in consultation with Human Resources, and Legal Affairs 2/24/10.
MEAL TICKET POLICY

On-call meal tickets will be issued by the office of the department for which you are taking call defined as a 24 hour in-house shift. There is a $6.00 limit per meal per ticket. Expenditures above $6.00 will be paid by you out-of-pocket. Your department will credit the cafeteria account with an amount appropriate for the number of call nights to which you will be assigned. This account may be accessed by use of your MMC ID badge when exiting the check-out line in the cafeteria. On-call meal allotments should be used by the resident, and not by medical student or attending.

Arrangements can be made to have meals deducted directly from your paycheck by completing an authorization form in the Food Service Department Offices.
STUDENT LOAN DEFERMENTS

The Department of Medical Education will complete certification forms necessary for application for deferment of student loans. We are able to make certification only for the period covered by an executed contract.

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BENEFITS POLICY

Resident and fellows are entitled to benefits as employees of Maine Medical Center. Residents enroll during orientation, and then annually – per Human Resources policies and procedures.

Residents and fellows are STRONGLY encouraged to obtain individual benefit information directly from Human Resources and UNUM (the company that administers MMC’s benefits). This is especially important for issues of short term disability, leaves of absence, etc. Although your program director and program manager can be helpful resources – they are not benefits experts and trainees should contact HR directly.
COUNSELING SERVICES AND SUBSTANCE ABUSE POLICY

The physical and psychosocial demands placed on residents/fellows are unique. From time to time, a resident/fellow may desire or be encouraged by their Program Director to seek short-term counseling/psychotherapy services voluntarily or as part of a corrective disciplinary action. In either situation, the institution recognizes the financial burden on residents/fellows utilizing these services, the need to pursue typical coverage mechanisms, and the need to consider providing such support when possible.

Psychosocial and substance abuse issues should be brought to the attention of the Program Director or DIO. Faculty and staff should identify such issues as soon as possible. Program Directors may also raise concerns at the semi-annual evaluation sessions with individual residents/fellows. Residents/fellows also have the option of confidential self-referral to those services below.

The institution will make available and support the following services:

1) Psychiatric consultation and treatment as well as the services of a psychologist for any resident/fellow in need of these services. The Program Director will make certain that the resident/fellow has the time to follow up in counseling and treatment and that the resident/fellow is supported adequately in terms of continued function as a resident/fellow.

2) Appropriate sick and leave time for the resident/fellow who requires time off.

3) An Employee Assistance Program which provides confidential counseling, support and referral for all employees, including residents/fellows.

4) Medical Professionals Health Program (MPHP), a department of the Maine Medical Association [www.mainemphp.com](http://www.mainemphp.com). The MPHP works in close association with the Maine Board of Licensure to offer consultation and assistance to physicians struggling with substance abuse.

Maine Medical Center will comply with all State reporting obligations.

Concerns regarding a possible learning disability in a resident/fellow should be brought to the attention of the Department of Medical Education (DME) Director or DIO. If approved by the central DME office, the institution will provide an appropriate resource and financially support the testing. Resident/fellow may also seek services outside of DME approval at their own cost.

Adopted by the GME Committee August 19, 1992
Last revised by GME Committee, 11/29/07, March 2016

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Please see the institutional Leave of Absence/Protected Leave Policy (LOA Policy). 
https://my.mainehealth.org/mmc/Departments/HR/Documents/Time%20Away%20from%20Work/Protected%20Leaves%20Policy%2007012015_MH.pdf

It is very important that each resident/fellow contact UNUM and get specific benefit information directly from them. Be aware that restrictions for coverage do apply, and a LOA may not qualify for short term disability coverage, depending on when in training the absence occurs.

In addition to the LOA policy, Residents/Fellows must understand that the Residency Review Committee (RRC) of their specialty may impose strict limitations on time away from training – limitations that may require extension of training program. Each resident is encouraged to research their unique circumstances at www.acgme.com and discuss with their Program Director.

While program requirements do not in any way limit a Resident’s/Fellow’s right to take a protected leave, it is important that the Resident/Fellow understand how much, if any, of their time away may need to be made up before either advancing to the next postgraduate training level or graduating from the program.

Therefore, if a Resident/Fellow is planning or expects they will be taking a LOA, they must meet with their Program Director and Medical Education Administrator (MEA) to complete the DME Leave of Absence form, available on the DME website. The completed form must be returned to the central DME office.
Your Leave of Absence as a Resident/Fellow

Your Checklist:
As a Resident/Fellow at Maine Medical Center, you are a regular employee and all MMC policies regarding a Leave of Absence (LOA) apply to you. If you are planning to go out on a leave of absence (e.g. Maternity Leave) this checklist can help us guide you through that leave process:

☐ Call Unum at 877-352-8818. They will discuss your options and rights with you.
☐ Meet with your program director and let them know about your plans.
  ○ Bring this checklist to your meeting
  ○ It’s important that you understand your program requirements with respect to time away from the program. Every program’s requirements are different and you need to understand whether or not you’ll need to make up any of your time away.
☐ Complete the fields below with your program director and administrator and submit this checklist to the central DME office. (The central DME office is responsible for working closely with HR and payroll to ensure residents and fellows are paid correctly while on a LOA.)

Your sick/vacation time balances:
I currently have _____ sick days and ____ vacation days available to me. (You’ll get these numbers from your MEA)

Understanding Your Program and/or Specialty Board Requirements:
Based on my discussion with my program director, I understand the following about my program/specialty board requirements:

- If I am away from my program for more than ____ [circle one: days / weeks] I have to make that time up.

- I understand that, as a result of this time away from my program, either my program year advancement or graduation date could be postponed/extended until all program requirements have been met.

____________________________________  res_______________
Signature of Resident/Fellow  ________________ Date

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VACATION AND SICK TIME

Sick Time
When residents begin training at Maine Medical Center, they will have 10 days (80 hours) of paid sick time banked. At the start of the third postgraduate year and each year thereafter, residents will be banked an additional 5 days per year up to a maximum of 35 days. In the event of a catastrophic illness/injury during the first year of employment, an additional bank of 5 days would be available for use, with program director approval.

Vacation
Each resident physician may take up to 21 working days of vacation per year. These 21 days are banked at the start of a training year. All House Officers are strongly encouraged to use all of their vacation each year to maximize wellness in the context of rigorous post-graduate training. At the end of each academic year, house officers may roll over up to 3 days of unused vacation, starting the following academic year. Any additional unused days are forfeited. In the event the House Officer’s contract is extended for a period of more than 2 months in their final year of training, but less than 12, vacation time is prorated on a monthly basis.

Weekend days and Holidays which would ordinarily be days off and not scheduled as workdays for a particular house officer, are not counted as vacation days that fall within this allotment. Time away from the program for Board exams is not counted as vacation time. A house officer may take up to 5 days for post graduate interviews without using vacation time. Any time beyond that is counted as vacation time, unless approved by the program director. (Time away for conferences, please see Conference Attendance Policy.)

Adequate notification of the department through which the house officer is rotating and the house officer’s parent department for the purpose of having requested vacation time approved is mandatory so that adequate coverage arrangements can be made. Each department has the prerogative to schedule a resident’s vacation time. Approval of vacation time must be predicated on availability of adequate coverage and will be in accordance with departmental regulation. There is no annual personal day for house officers.

This Vacation and Sick Time policy for House Officers supersedes the PTO policy in the MMC HR Policy and Procedure manual.

Allowed days away from a program may vary depending on the RRC and programmatic restrictions.

Approved by GME Committee, 3/13/95
Revised by GME Committee, 3/17/97, 11/5/97, 1/14/02, 6/10/02, 3/25/2008, 6/24/2010, 12/1/10, 9/16/11

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Institutional Policy on Clinical Experience and Education

Principles:

1. The purpose of graduate medical education (GME) is to provide an organized educational program with appropriate guidance and supervision of the resident.

2. Maine Medical Center must ensure that each residency/fellowship program establishes formal policies governing resident clinical experience and education hours that foster resident/fellow education and facilitate the highest quality of care of patients.

3. The learning by residents must not be compromised by excessive reliance on residents/fellows to fulfill non-physician obligations.

4. Experiential learning is a major component of GME and being on-call provides such experiences, especially from a longitudinal perspective.

5. Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

In concurrence with the above principles, the following guidelines should be considered for each residency-specific policy on the clinical experience and education:

1. Establishment of a defined work week (e.g., hours/week) of no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home and moonlighting activities.

2. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
   a. Residents should have 8 hours off between scheduled clinical work and education periods. Although there may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than 8 hours of clinical experience and education, this must occur in the context of the 80-hour and the one-day-off-in-seven requirements.
   b. On average, residents must have one full day (24 hour period) out of seven free of any clinical work and education averaged over four weeks. At home call cannot be assigned on these free days.
   c. Clinical and educational work periods must not exceed 24 hours of continuous scheduled clinical assignments. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care and/or resident education.

In rare circumstances, residents may remain or return to the clinical site to continue to provide care to a single severely ill or unstable patient, humanistic attention to the needs of a patient or family or to attend unique educational events. These additional hours must be counted toward the 80 hour weekly limit.
Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. All programs must comply with any additional RRC-specific restrictions.

Residents must be scheduled for in-house, overnight call not to exceed every third night, averaged over four weeks. At home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement of one day in seven free of clinical work and education, when averaged over four weeks.

If permitted by the individual RRC program requirements, an individual program wishing to increase the weekly limit of 80 hours by up to 10 percent must present to the Graduate Medical Education Committee details regarding the following for approval:

d. how the resident’s education will be improved
e. what mechanisms will be used to monitor the additional hours
f. what mechanisms will be used to monitor resident fatigue, patient care and safety, and what corrective mechanisms will be used if undue fatigue, or patient care and safety issues are detected
g. whether the weekly limit applies to one or more rotations

If the GMEC approves an increase above 80 hours, the Program Director will review annually with the GMEC the hours worked by individual residents and the assessment of fatigue and patient care and safety as noted above.

Residents within the department, and those residents from other departments who are rotating on the service, must be clearly and consistently informed of the expected Clinical Experience and Education and responsibilities.

The Clinical Experience and Education Policy must be shared with all faculty and residents within the department on a yearly basis.

Compliance of the residency with this institutional policy and the residency-specific policy will be monitored by the GMEC sub-committee on Resident Affairs and to the GMEC Executive Committee.

- Quarterly, each program is required to submit a report of violations for review by the GMEC sub-committee on Resident Affairs.

Each program must have its own Clinical Experience and education policy, which can be more stringent than this MMC institutional policy.

Approved by GME Committee, 4/7/99; Revisions approved 10/7/02, 9/29/04, 1/27/10, 2/28/12, 4/2017
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MMC Staff:

All faculty involved in the MMC postgraduate physician training programs will be evaluated by the 
sponsoring department annually. These evaluations should focus on the faculty members' 
effectiveness and competence as a teacher or clinical role model and must include evidence of resident 
participation. Residents must have the opportunity, at least annually, to submit confidential, written 
evaluations of the faculty. These evaluations will provide the basis for annual appointment of the 
faculty member to the active teaching staff. Appointment of Maine Medical Center staff to the 
teaching faculty will be made by the department or Division Chief, and will be based on documentation 
of appropriate clinical background, experience, and teaching skills.

Non-MMC Staff:

Clinical faculty who are not on the Medical Staff at MMC may be recommended by the Department 
Chief to the Associate Vice President for Medical Education for appointment to the teaching faculty. 
These faculty members must be appointed on the basis of clinical and teaching skills, and must be 
evaluated prior to reappointment as are all other clinical faculty. Such clinical faculty shall not be 
authorized to participate in patient care at Maine Medical Center unless granted clinical privileges in 
accordance with Medical Staff Bylaws.

Re-approved by GME Committee, 5/19/97

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Institutional GME Policy on Resident/Fellow Selection

All postgraduate physician training programs will select their residents through the National Resident Matching Program (NRMP), if it is operative for their specialty. Recruitment practices will follow procedures outlined by the NRMP. Candidates for positions outside the match program must be reviewed and approved by the Designated Institutional Official or in his/her absence, by the Vice President of Medical Education. Unless there are extraordinary circumstances, applicants recruited outside the match must be interviewed at Maine Medical Center.

Applicants with one of the following qualifications are eligible for appointment to programs:

a) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
b) Graduates of colleges of osteopathic medicine in the United States 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:
   (1) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates prior to appointment, or,
   (2) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training or practicing
d) Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME accredited medical school.

Each residency program must have a written policy and procedure for selecting eligible applicants. Residents in each training program are selected from among eligible applicants on the basis of their, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. In addition, prior to being selected as a match applicant for Maine Medical Center, each candidate must be interviewed at Maine Medical Center in order to assess personal qualities such as motivation and integrity, and ability to communicate. Strong consideration will be given to those students who come from the Maine-Track program and/or have strong ties to Maine.

Programs will not discriminate with regard to gender, age, religion, ethnicity, national origin, disability, sexual orientation, veteran status, or any other applicable legally protected status.

Visa Support: The department of Medical Education will sponsor J-visas only. **H visas will no longer be sponsored for GME training.**
MMC Resident Supervision Policy

It is the policy of this institution that all residents and fellows will be actively supervised by a licensed independent practitioner who has been granted appropriate clinical privileges and that this supervision will be documented in the medical record. Program Directors from each training program will provide residents, fellows and supervising faculty with explicit written descriptions of the roles and responsibilities of residents/fellows, as per Section 3-5 of the MMC Medical Staff Rules and Regulations.

Supervision refers to the authority and responsibility that staff attendings exercise over the care delivered to patients by housestaff. Such control is exercised by observation, consultation and direction, and includes the imparting of knowledge, skills and attitudes by the practitioner to the resident. Supervision may be provided directly or indirectly, including consultation by use of the telephone, as long as there is a rapid and reliable system for communication.

Although both supervising faculty and resident/fellows have collective responsibility for the safety and welfare of patients, the attending practitioner is expected to direct the overall care of the patient and to provide the appropriate level of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care and the experience and judgment of the resident being supervised.

**Graduated Levels of Responsibility**

The residency and fellowship experience is a continuum of graduated experience and responsibility. Trainees progress to the next level of training after review of performance and evaluations. Residents and fellows will be given increasing responsibility as they are advanced to each successive postgraduate year, to be determined by the Clinical Competency Committee of each respective training program.

**Progressive Responsibility:**

With each year of training, the degree of responsibility afforded to a resident/fellow, both professional and administrative, must be increased progressively. This includes responsibility in such areas as patient care, performance of procedures, leadership, teaching, organization and administration. The responsibility or independence given to residents should depend on their knowledge, judgment, manual skill and experience and will be determined by the Clinical Competency Committee of each respective training program. There must be a mechanism in each department by which ancillary and supervising staff are made aware of which procedures a trainee is authorized to perform without attending supervision.

**Evaluation**

To attain their full potential, residents and fellows need both formative and summative evaluation, as required by the ACGME. Attending faculty have a unique perspective on trainee performance and have an opportunity to see individual development over time. With this, comes a responsibility to fairly and frequently evaluate the residents. Attending faculty are expected to complete
resident/fellow evaluations in a thoughtful and timely manner, providing written narrative comment whenever possible.

**Oversight**

Each training program must have a residency/fellowship program-specific ‘Supervision Policy’ that is reviewed annually by the trainees and supervising staff. The Program Director and Department Chief will be responsible for monitoring appropriate resident supervision within each program. Trainee perspectives on the appropriateness of supervision within their program will be assessed by the annual ACGME survey and will be reflected on the Annual Program Assessment by the Graduate Medical Education Committee.

The GMEC shall communicate with the Medical Staff Executive Committee about the safety and quality of patient care provided by and the related educational and supervisory needs of the participants in professional graduate education programs, as requested by the Medical Staff Executive Committee, at least annually. The Graduate Medical Education Committee shall also periodically communicate with the Board Education and Research Committee about the educational needs and performance of the participants in the program.

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RESIDENCY CLOSURE AND REDUCTION POLICY

In the event an ACGME-accredited residency program is closed or reduced in size, or Maine Medical Center intends to close, Maine Medical Center is committed to informing the GMEC, the DIO, and the residents in that program as soon as possible, and to providing adequate educational resources in order to ensure that residents currently in the program may complete their training to satisfy board-eligibility requirements in that specialty. If any residents are displaced by the closure of a program or a reduction in the number of residents, Maine Medical Center will make every effort to assist the residents in identifying a program in which they can continue their education.

Approved by GME Committee, 11/5/97.
Revised by GME Committee, 1/27/10.

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Institutional Policy on Resident Evaluation, Promotion, and Dismissal

The GME Policy on Evaluation of House Officers, Reappointment, Disciplinary Action and Review Procedure outlines general guidelines for the evaluation, promotion [i.e., reappointment], and dismissal of residents. This policy also describes Corrective and Disciplinary Measures and the due process procedure.

Each residency should have specific policies which outlines additional details not covered by the above institutional policy or other requirements per their specific RRC.

1. Definitions

“House Officer” is defined as: interns, residents, and clinical fellows.

“Remediation” is defined as: the period of time designated by the Department Chief or Department Program Director during which the House Officer must correct identified deficiencies in performance or behavior. This period shall not be less than 30 days. Remediation terms require an Individualized Learning Plan (ILP) and allow additional time/supervision/training to meet the unique learning needs of individual house officers. Remediation terms are not reported to the Maine Board of Medicine.

“Probation” is defined as: the period of critical evaluation designated by the Department Chief or Department Program Director during which substandard performance may be cause for immediate dismissal from the program. The period of Probation shall be specified and normally should not exceed six months; however, there may be instances where it is appropriate for the period to be as long as twelve months. There are limited circumstances where the period of Probation may be indefinite and could be imposed for the remainder of the program. These circumstances include, but are not limited to, substance abuse and ethical misconduct. Terms of Probation must be reported to the Maine Board of Medicine.

“Immediate Suspension” means removal from clinical service for an indefinite period of time without prior notice. During the period of Immediate Suspension, the Department Chief or Department Program Director must determine whether the House Officer should be reinstated to clinical service or terminated.

2. Evaluation

Meaningful evaluation of a House Officer’s progress and performance is necessary for a number of reasons. The Accreditation Council on Graduate Medical Education and the boards require that performance be evaluated in an ongoing manner to certify competence and qualify each candidate to sit for the board examinations. It is also required to certify competence, personal and ethical integrity for various licensing boards, and to provide documentation of clinical ability for the purpose of delineation of privileges for various hospitals. There is an obligation to the Hospital and its patients to monitor for personal problems that would interfere with the House Officer’s ability to responsibly discharge his or her medical responsibilities, for difficulties in interpersonal relationships that impact on the House Officer’s ability to relate effectively to patients, as well as for competence and responsibility as a physician.

The resident/fellow’s departmental office must have a summary evaluation for each year that will serve as the basis of letters to boards, hospitals and licensing bodies. This summary evaluation should be based on individual evaluations of House Officers' performance submitted by peers and attending
staff. The individual evaluations should be used by the Department Chief or Department Program Director for regularly scheduled discussions of performance with each House Officer. Each Department Chief or Department Program Director should discuss performance with each individual House Officer twice a year. During the first year, in those programs whose House Officers are spending most of their time rotating through other departments, the Department Chief or Department Program Director should discuss the evaluations from other services with each House Officer on a more frequent basis and document that the discussion has taken place, especially where there are problems.

The majority of House Officers will perform effectively and will not have significant difficulties. However, it is also important that, despite the lack of problems, performance be reviewed on a regular basis for the purpose of providing each House Officer positive input relating to performance, suggestions for improvement and guidance relating to the role of the House Officer in the training program. Moreover, it is very important that there be an equitable and satisfactory mechanism for an exchange of information between all parties potentially involved when actions may be contemplated that could result in the House Officer’s dismissal or significantly threaten his career development, or when a House Officer seeks to raise issues about the program or institution. If a House Officer’s evaluations reflect problems, it will be the responsibility of the Department Chief or the Department Program Director to investigate each of these evaluations with the evaluator and determine whether the problems related are real and recurrent or perhaps an exception and unusual. Unless the Department Chief or the Department Program Director conclude the problems identified are an exception and unusual, they should discuss the individual evaluations with the House Officer and solicit the House Officer’s input. The Department Chief or Department Program Director will then make a determination as to what action is to be taken, if any, and record the discussion with the House Officer in the House Officer’s file with a copy to the Associate Vice President for Medical Education (“AVPME”). If an individual negative evaluation of a House Officer, after investigation by the Department Chief or Department Program Director and discussion with the House Officer, appears to be unwarranted, this evaluation may be discarded and not considered in development of the House Officer’s summary evaluation. However, those negative evaluations against House Officers that, after investigation, appear to be warranted, should remain on file in the departmental office with a copy to the Office of Medical Education.

3. **Informal Grievance**

At any time, a House Officer may raise concerns about the training program or the Hospital by bringing those issues on an informal basis to the attention of the Department Chief, the Department Program Director, or the DIO. If the House Officer is not satisfied with the response he or she has received to any issues raised, the House Officer may present the issue or issues in writing to the Vice President for Medical Affairs (“VPMA”). A House Officer may pursue the formal review procedure pursuant to section VIII below only for those issues involving the House Officer’s suspension or termination from the program or the decision of the program not to renew the House Officer’s appointment.

4. **Reappointments**

Each year the Department Chief or Department Program Director will compile the evaluations into a composite report of House Officer’s performance, overseen by the Program Director and each program’s Clinical Competency Committee (CCC). The CCC’s final recommendation will then be forwarded to the Executive Committee of the Medical Staff and the DIO for decision. If the Executive Committee of the Medical Staff does not approve the House Officer’s reappointment, the House Officer should be notified immediately of this decision and the reasons for non-reappointment. The House Officer will be provided
with written notice of the Program’s intent not to renew a House Officer's contract no later than four (4) months prior to the end of the House Officer's current contract. Upon request of the House Officer, the decision not to reappoint may be reviewed in accordance with the procedures outlined in Part VIII below.

5. **Corrective and Disciplinary Measures**

If the performance of a resident or fellow is considered to be unsatisfactory for reasons including, but not limited to, clinical skill, medical knowledge, performance of duties or ethical conduct, the Department Chief or Department Program Director must notify the House Officer, in writing, of the specific deficiencies. A copy of this letter shall be sent to the DIO.

The Department Chief or Department Program Director may utilize Remediation requirements or impose Probation for unsatisfactory performance by a House Officer, including but not limited to performance issues or ethical misconduct. The Department Chief or Department Program Director may designate a period of Remediation during which the House Officer must either correct the identified deficiencies or be dismissed. Remediation may include any special educational or remedial activities designed to improve specific weaknesses in the House Officer’s professional skills. The Department Chief or Department Program Director may also place the House Officer on Probation for a specified period of time. When appropriate, Probation may be imposed without a Remediation period. Remediation and Probation periods should be concurrent, although the Probation period may be longer than the Remediation period. The Probation or Remediation period should not be less than 30 days in length and should not normally exceed six months but may last as long as 12 months if appropriate (such as in the case of academic probation for yearly board exams, etc.). The Department Chief of Department Program Director may assign a mentor for the House Officer, if appropriate, during the Remediation or Probation period. In appropriate case such as ethical misconduct or substance abuse, the Department Chief or Department Program Director may place a House Officer on Probation indefinitely which could include the remainder of the training program. The mentor, if any, and Department Program Director shall meet with the House Officer at least every three months during the Probation/Remediation Period to formally review the House Officer's progress (meetings may be more frequent if deemed necessary).

During the Probation/Remediation Period, all moonlighting privileges for the House Officer will be suspended.

At the end of the Probation/Remediation Period, the Department Chief or Department Program Director will review the House Officer’s progress and determine whether satisfactory improvement has been made based on feedback which may be solicited from faculty, staff and peers of the House Officer. If the Department Chief or Program Director concludes that the trainee has made satisfactory improvement but that an additional period of demonstrated improvement is warranted, they may continue the resident/fellow on Probation for a specific period of time not to exceed six months. If the House Officer's performance again becomes unsatisfactory during the Probation period, the trainee can be dismissed without an additional Probation/Remediation Period.

For House Staff who have been placed on Probation for substance abuse or ethical misconduct, if the House Officer's performance again becomes unsatisfactory for either substance abuse or ethical misconduct during the length of the residency/fellowship period, the House Officer can be dismissed without an additional Probation/Remediation Period. Any House Officer who is placed on Probation for a third time for any reason may be continued on Probation indefinitely, including the remainder of the
training program. Examples of ethical misconduct include but are not limited to: sexual harassment, patient abandonment, abuse of prescribing privileges, or unlawful discrimination.

6. **Immediate Suspension**

If a House Officer's behavior creates an imminent danger of injury to patients, staff members or persons on the Hospital premises, or fails to meet the level of requirements for professional licensure, s/he may be summarily suspended or assigned to non-clinical duties by the House Officer's sponsoring Department Chief (“Immediate Suspension”). Immediate Suspension may be reviewed in accordance with the procedures outlined in Part VIII below.

A Probation/Remediation Period is not a prerequisite for Immediate Suspension when, in the opinion of the Department Chief, Department Program Director, the DIO, a determination is made that a House Officer’s discharge of clinical responsibilities would expose patients to unnecessary medical risks and the Hospital to unnecessary liability. In this case, a trainee may be temporarily relieved of his/her clinical responsibilities, with pay, reassigned to other duties with pay or suspended with pay pending the outcome of an investigation by the Department Chief or Department Program Director. A House Officer who has been so relieved/reassigned with pay or suspended with pay pending the outcome of an investigation, shall receive, within a reasonable length of time, not to exceed ten (10) working days, a written statement from the Department Chief or Department Program Director or designee containing a description of the deficiencies in the performance of the House Officer that prompted the Immediate Suspension. If the Department Chief or Department Program Director determines the deficiencies warrant further disciplinary measures, the procedures detailed above concerning a Probation/Remediation Period shall apply. In cases in which the investigation reveals the House Officer was incorrectly suspended or charged with misconduct, all record of the incident should be removed from his/her file and back pay issued. In cases of misconduct of a serious nature the Department Chief or Department Program Director can recommend that the House Officer be subject to termination without application of a Probation/Remediation Period. The review procedures of Part VIII below shall then apply. A House Officer may be suspended or terminated from the program for unprofessional, unethical or illegal conduct, unsatisfactory or substandard performance, or conduct disruptive to the operation of the Hospital or the training program. In rare circumstances, the DME reserved the right to refer serious infractions to the appropriate law enforcement agencies. All terminations will be reported to the Maine Board of Medicine.

7. **Dismissal**

If the resident/fellow’s deficiencies are not satisfactorily corrected at the end of the Probation/Remediation Period, the Department Chief or Department Program Director will notify the DIO of their intent to dismiss the trainee from the residency training program. The DIO will review the Department's intended action prior to any notification being sent to the House Staff. After review by the DIO, the Program Director must notify the House Staff in writing (if mailed, certified mail is required) of their decision to dismiss them, with a copy of the notification to the DIO. The letter must identify the deficiencies that have not been adequately corrected. All terminations will be reported to the Maine Board of Medicine.

If the House Officer believes the dismissal is unwarranted, the House Officer may file a request for review following the procedures of Section VIII, below.

8. **Review Procedure**
This Review Procedure is limited to challenges by a House Officer to suspension, termination during the training year or non-renewal of the annual House Staff Appointment agreement or a decision to require the House Officer to repeat a program year, or part thereof.

The decision to suspend, terminate, not to renew the appointment of, or the required repetition of a program year by a House Officer is an academic responsibility of the Hospital. The Review Procedure is intended to protect the rights of the House Officer and the training program and to insure fair treatment for both parties.

All "written notification" associated with the Review Procedure shall be by certified mail.

a. Notification of intent to appeal:

After receiving the written notification of suspension, termination, non-renewal or the required repetition of a program year, the House Officer will have 10 calendar days to file, in writing, a request for review with the DIO.

b. Assembly of Review Committee:

Upon receipt of a written request for review, the DIO will convene an ad hoc committee to review the House Officer's case (the “Review Committee”). The Review Committee shall seek advice from Hospital Counsel who shall be present for the hearing to advise the Committee. The Review Committee may also seek advice from outside experts in the field of the House Officer's specialty if deemed necessary.

The Review Committee will consist of four physicians, two of whom shall be attending members of the Medical Staff, one senior House Officer and one House Officer at the same educational level as the House Officer under review. None of the members of the Review Committee shall be from the same department as the House Officer under review or have any direct involvement with any matter upon which the suspension, termination or non-renewal of appointment or repetition of a program year is based. The DIO will chair the Review Committee. If the DIO is from the same department as the House Officer or has direct involvement with any matter upon which the suspension, termination or non-renewal of appointment or repetition of a program year is based, then the DIO shall designate an attending member of the Medical Staff member to serve in his/her place. The House Officer may object to a member of the Review Committee for cause. The DIO has sole discretion to replace a member if deemed warranted.

c. Hearing:

The Review Committee will assess the merits of the case and hear evidence and arguments by; the House Officer and the Department Chief or Department Program Director. The House Officer may be represented by an attorney in an advisory capacity, but the attorney may not function as a spokesperson for the House Officer during this review process or take an active role in the hearing process. The Department Chief or Department Program Director is obligated to present to the Committee the reasons for, and substantiating evidence for, the House Officer's suspension, termination, non-renewal or required repetition of program year or part thereof. The House Officer may question witnesses who testify on behalf of the Department Chief or Department Program Director. The House Officer may present documents, letters of support and call the testimony of witnesses. These witnesses may be questioned by the Department
Chief or Department Program Director. Formal rules of evidence shall not apply. The House Officer shall have the burden of persuading the Review Committee that the charges or grounds involved lack any factual basis or that such basis or any action based thereon is arbitrary, unreasonable or capricious.

The Committee shall tape record the hearing proceedings, but not its deliberations. Either party may, at its own expense, have a verbatim transcript made of the proceedings by a court reporter. Both parties may request a copy of the tape recording made by the Committee.

d. Committee Determination:

The Review Committee will make its determination within 30 days from the close of the hearing. The Committee will notify the House Officer, Department Chief Department Program Director in writing of their decision. The Committee shall decide whether to uphold the suspension, termination, non-renewal or required repetition of a program year or to reinstate the House Officer. Should the House Officer be reinstated, the Committee may impose an additional period of Probation and/or Remediation as a condition of continuation.

e. Right of Further Review:

If the House Officer is not satisfied with the decision of the Review Committee, s/he may appeal the decision within ten calendar days by filing a written statement with any supporting information or documentation with the VPMA. Upon receipt of the request for further review, the VPMA shall review the information and within ten (10) business days notify the House Officer of his/her decision, which shall be final. The only grounds for review by the VPMA shall be: the failure to comply substantively with this section VIII, that the recommendation or decision of the Review Committee was arbitrary or capricious, or that the recommendation or decision of the Review Committee lacked any factual basis.

f. Record-Keeping/Reporting:

A final adverse decision as to reappointment, suspension, termination or required repetition of a program year, or any disciplinary action shall become a permanent part of the House Officer’s record. Information concerning any Probation/Remediation period shall be kept in the House Officer’s record until the House Officer is eligible for reappointment, but shall be kept for at least one year. A final decision to reject a prior adverse decision will be kept permanently in the House Officer's file. Final adverse decisions shall be reported to the appropriate body as required by governing state or federal law and regulations.

Reviewed and approved by the GME Committee, May 13, 2002.
The majority of medical malpractice claims can be avoided by establishing a sound physician-patient relationship. Lawsuits are frequently the result of patient surprise and anger, or of the failure of hospital personnel to communicate effectively among themselves and with the patient and their family. A physician's best defense is to act medically, not legally. In general, a physician who acts as another medical practitioner similarly situated would have acted will be able to defend a malpractice action successfully.

Documentation of the adequacy of care a patient has received during his/her hospitalization has a significant impact on whether the care rendered is defensible. A meticulous and objective record can offer substantial proof that a physician has acted in accordance with standards of accepted medical practice. Use of the medical record progress notes to suggest another physician was somehow at fault, is always inappropriate. The ideal record is one which can be used in the treatment of a patient by any physician who becomes involved in his care without compromising the patient's health by failing to provide sufficient information. The medical record also should indicate whether the patient's informed consent for treatment was obtained. If informed consent is lacking, the patient's chart should include an explanation of any medical or other reasons for this omission. Effective communication among all medical personnel involved in a patient's care is an integral part of providing quality health care. Information to ensure continuous safe treatment and to prevent decisions or actions that can be harmful to the patient should be transmitted among the attending physicians, residents and nurses. There is also a need to identify a physician to be responsible for a patient who may have several medical problems and is being treated by more than one department in order to prevent the patient from "falling through the cracks." Furthermore, open communication between the physician and the patient minimizes the possibility of surprise or anger occurring as the result of the manner in which a patient's particular treatment was handled.

Since legal responsibility for a patient's care rests with the attending physician, a resident should act pursuant to that physician's instructions and maintain close contact with the attending in the management of the patient's case. The Medical Staff By-Laws state that the purpose of the Maine Medical Center is "to ensure that all patients treated at the Hospital receive the best possible medical care." The aforementioned concerns facilitate this objective and, thus, should be implemented accordingly.
WHAT TO DO AFTER AN ADVERSE EVENT

DO: Contact your attending supervisor immediately. This person can help you make sure the patient is receiving appropriate patient care, talk with the patient and family and mobilize appropriate resources.

DO: Report the incident to your Program Director and Division Director/Chair

DO: Report the incident in RL Solutions. If there is a very serious outcome (death, serious injury, dangerous situation) call Risk Management immediately so they can offer patients resources and secure appropriate follow up (security, referral to Employee Health, etc)

DO: Remember that providers need support after adverse events. Encourage your team to de-brief, multiple times if necessary. Talk to your supervisor about the many resources that exist to help providers deal with the emotions that are normal after involvement in an adverse event. Employee Assistance is always a resource for all employees. The department of Psychiatry offers residents and fellows unique, confidential access to residents and fellows.

DO: Make every effort to participate in Root Cause Analysis (RCA) meetings coordinated by Risk Management. Involve your senior residents and/or Program Directors to free you from clinical duties to attend these meetings. Do prepare to present cases at your departmental M&M meetings.

DON’T Contact the hospital’s insurance carrier directly. The Office of Risk Management will contact the hospital and your malpractice and liability carriers immediately after notification of an adverse event.

DON’T Talk to any lawyer who may call you on the phone for information. Any contact with lawyers (yours, the hospital’s or a claimant’s) will be coordinated and supervised by the legal department. If you get a call – refer them to the Legal Office 662-2129.

DON’T Give patients hard copies of their medical records. The Office of Information Management (formerly Medical Records Department) is the appropriate place for patients to get access to their medical records.

DON’T Have unsupervised discussions with patient and family regarding adverse events. It is imperative that we uphold the principle of transparency with respect to medical errors, however an attending supervisor should be present to precept the conversation as well as to role model and teach around these sensitive communication challenges.

Approved by GME Committee, March 2016

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These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct and his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1
The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2
Physicians should strive continually to improve medical knowledge and skill, should make available to their patients and colleagues the benefits of their professional attainments.

Section 3
A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4
The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession, and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5
A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged, he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6
A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7
In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient’s ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8
A physician should seek consultation upon request in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9
A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10
The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well being of the individual and the community.
TEMPORARY LICENSES/DEA NUMBERS

Temporary licenses to practice medicine at Maine Medical Center will be obtained through the Department of Medical Education.

DEA numbers (to be added to the institutional number as a suffix identifying the house officer writing the prescription for controlled substances) will be listed under the house officer’s account in the New Innovations software. Each House Officer will receive a notice informing with their individual DEA suffix number. If you obtain a Federal DEA number you should use that number instead of the MMC assigned number and notify the Department of Medical Education.
RESPONSIBILITIES

Each house officer is responsible administratively to the Designated Institutional Official (DIO) and clinically and professionally to the Chief of the department and Program Director. The department Chief is responsible for defining how the house officer will function within the framework of his residency training program through identification of proper goals and objectives at each level of training. Assignments and delineation of privileges are the responsibility of the chief of service. The individual departments offer administrative support to each Program Director coordinates rotations and the educational program, and assures evaluation of each house officer's professional competence.

Night and weekend coverage will be assigned to House Officers in accordance to departmental policy. Night schedules are available through AMION and through the hospital Switchboard. Any change in coverage schedules should be reported immediately to the departmental office and updated on AMION. Absences because of illness should also be reported to the department to assure adequate patient coverage is arranged. Vacation times must be cleared with the chief of the department to which the house officer is assigned. If this be a rotation in an area other than in the parent department, the chief of the department to which the house officer is assigned as well as the chief of the parent department must each approve the vacation.
SEXUAL HARRASSMENT POLICY

Every employee is entitled to a working environment free of verbal, physical, visual, or other harassment because of race, color, religion, sex, age, national origin, handicap, veteran status, or citizenship status.

Harassment includes, but is not limited to, verbal abuse such as offensive racial, ethnic, or sexual threats or comments, physical overtures, rude gestures, or any type of pressure to engage in sexual activity.

Sexual harassment is specifically prohibited by state and federal law. It consists of any unwelcome sexual advance, touch, comment, request, or other type of conduct which:

a. Is made, explicitly or implicitly, a term or condition of employment;
b. Is used as a basis for employment, compensation, advancement, or work assignment; or
c. Has the purpose or effect of unreasonably interfering with work performance or creating a threatening or hostile work environment.

Any incident of harassment or gender discrimination should be reported to the Program Director or Associate Vice President for Medical Education. MMC will investigate immediately and, when justified, will take prompt and appropriate corrective action.

Employees who file a complaint about harassment are protected from retaliation.
Maine Medical Center Professional Appearance Policy

PURPOSE

MMC requires all employees to present a professional image to our patients and the public while assuring everyone’s safety. Accordingly, each employee is required to wear appropriate attire while at work, internal or external meetings or other MMC paid functions. MMC expects all employees, including volunteers, allied/adjunct staff physicians, contractors, vendors, visiting scholars, students, interns, residents, job shadow candidates, and any other individual who provides patient services on behalf of MMC to meet these standards. Leadership with supervising responsibilities is accountable for educating and enforcing dress and appearance standards in their areas of responsibility. This includes coaching and counseling employees whose appearance is inappropriate. If appearance does not meet standard as defined herein; or is distracting, the employee may be sent home to correct the problem.

PERSONAL APPEARANCE

- All employees must wear their ID badge at all times while working and displayed where it can be easily read, either around the neck with a lanyard or clipped to a lapel or shirt collar. It should not be worn at waist level.
- Picture ID’s are not to be defaced by stickers or pins.
- Employees are asked to use good judgment in choice of work attire and they are to present themselves at all times in a manner that best represents MMC. In all cases, the hospital reserves the right to determine the appropriateness of an employee’s attire.

DRESS

The reference to appropriate attire may encompass many different looks. For the purpose of this policy, appropriate attire means clothing that allows employees to perform work duties safely and effectively, while continually promoting a positive professional public image of MMC. At minimum, all clothing should be neat and clean. If an employee is unsure as to the appropriateness of any item of clothing they should check with their supervisor before wearing it to work. The following are a few examples of clothing considered inappropriate and unacceptable at work, including but not limited to:

- All articles of clothing including pants, skirts, overalls, or tops made of denim/dungaree material of any color (including camouflage). An exception to denim-wear will be based on job responsibilities and will be determined by the department manager.
- Ripped, torn, wrinkled or faded clothing
- Slogan T-shirts or casual T-shirts. Exceptions: MMC Approved Logo or Unit logo
- Pants: Gym, yoga, flannel or pajama style, wind pants, sweatpants or bib overalls
- Top or Shirts: Gym or yoga tops, sweatshirts and hoodies.
- Athletic type clothing such as spandex, tank tops, and halters, cut-offs, jogging suits, or shorts (including Bermuda shorts), mini-skirts, skorts.
- Revealing or distracting outfits. Examples: Tight, clingy, or excessively baggy fitting. Low-riding pants, any backless, strapless, or a top that reveals midriff or cleavage. Skirt/dress lengths should be at a professional length, no more than 4” above the knee. In general, it is wise to dress in a manner that will make your patients comfortable, some of whom have differing cultural backgrounds.

FOOTWEAR

- Safety, comfort, appearance and noise are the main considerations for acceptable footwear.
- Employees in direct patient care or clinical areas must wear closed-toe shoes and shoes without holes (i.e. Crocs). Staff that enter patient rooms or work in areas where they may be in contact
with blood and/or body fluids must wear shoes that have solid uppers to be resistive to exposure from blood and/or body fluids.

- In patient care areas, selection of shoes and clothing with consideration for safety and exposure risk associated with tasks being performed. All tasks requiring specialized safety personal protective clothing or shoes shall be governed by the Personal Protective Equipment Policy.
- Styles of footwear vary considerably. Sandals, open toe, open heel, open sided and high spiked-heeled shoes are examples of footwear not to be worn by employees providing direct care to patients.
- No flip flops of any kind, including thong style flip flops, yoga flip flops are to be worn by any employee.

GROOMING

- In areas that involve direct patient contact, hair that is shoulder length or longer must be drawn back and secured. All beards and mustaches should be shaped and neatly trimmed. Extreme trends in hairstyles should be avoided. Non-natural hair colors such as pink, blue, green, etc are not considered professional. Employees should not wear hats, handkerchiefs, or bandanas to restrain their hair, unless approved and due to special circumstances.
- The determining factor as to the appropriateness of hair, including facial hair, will be safety precautions respective of the department one is assigned.
- Employees are encouraged to limit the use of jewelry or other ornamentation and to assure that adornments are not considered a hazard, safety risk or distraction.
- During work hours, pierced earrings may be worn in moderation in the earlobe and other piercing adornments should be removed or covered while at work. Tattoos that are visible should be covered while at work as well.
- Artificial nails of any kind (acrylic, gel, overlays) are not permitted for any employee who has direct patient care, food preparation or cleaning responsibilities.

FRAGRANCES

Maine Medical Center is a Fragrance-Free environment (perfumes, colognes, lotions or any similar, scented product) of any kind are not permitted. In addition, tobacco products on clothing should not be noticeable by others.

EXCEPTIONS

MMC will make reasonable accommodations for appearance and grooming directly related to an employee’s religion, ethnicity, or disability. Leadership will use these guidelines to determine the appropriateness of an employee’s attire and personal grooming and will have the ultimate discretion as to the appropriateness of attire in the work setting.
Institutional Policy on Surgical Attire

Policy Summary: It is the policy of Maine Medical Center (MMC) that street apparel is prohibited in all restricted and semi-restricted surgical areas. Temporary exceptions may occur when jumpsuits/cover gowns must be worn to cover street apparel. Scrub suits, pant suits, warm-up jackets, disposable head coverings, disposable shoe covers and protective eyewear are supplied by the department.

Policy:
1. Green/teal scrubs are to be worn in the restricted areas of the Bramhall and Scarborough OR’s and in the Labor and Delivery OR’s. Scrubs of other colors are not permitted.

2. Operating Room Scrubs are never to be worn outside of the walls of the hospital. (They are not to be worn in the courtyards).

3. All MMC provided scrub apparel worn in a surgical area is to be laundered by the hospital.

4. Scrubs are to be changed at least daily and whenever soiled. Scrubs worn during dirty or contaminated cases should be changed prior to subsequent cases.

5. Scrub dresses are not allowed except for religious or cultural sensitivity. In this setting scrub pants are worn under the scrub dress.

6. When wearing a scrub shirt and pants, the top of the scrub suit must be secured at the waist, tucked into the pants or fit close to the body.

7. For scrubbed personnel, under garments should not exceed beyond scrub apparel except at the V at the neck of the scrub top.

8. Non-scrubbed personnel should wear long-sleeved cover jackets buttoned or snapped at the bottom when they are in the OR. Long sleeved attire is advocated to prevent shedding from bare arms. Buttoning the cover jacket keeps it from flapping and potentially hitting sterile areas.

9. The acceptable head covers are the disposable bouffant caps or disposable skull caps. They would ideally cover all hair though a small amount of hair exposure in sideburns or the nape of the neck is acceptable. OR staff may wear cloth head covers but when entering the restricted areas in the OR, all cloth caps will be covered with a bouffant cap.

10. Disposable shoe covers are optional unless gross contamination is anticipated. Shoe covers are to be changed daily and when torn, wet, or soiled.

11. Surgical attire is to be changed daily or whenever it becomes visibly soiled or wet by blood, body fluid, sweat or food.

12. All beards and moustaches must be covered by appropriate head cover and mask.
13. Masks must be worn when open sterile items and equipment are present. Masks must cover both mouth and nose. Masks are not to be worn or left dangling from the neck outside of the perioperative area.
14. Bracelets, rings and watches will not be worn by scrubbed personnel. Earrings must be confined under the scrub hat or removed. Necklaces and chains must be confined inside scrub attire.

15. **Artificial nails**¹ shall not be worn on duty. Freshly applied nail polish may be worn. Nail polish that is chipped or older than 4 days should be removed. Nails for physicians, scrubs and circulating nurses must be short, healthy and well-trimmed.

16. Facial makeup is to be minimal. Heavy eye makeup is unacceptable due to flaking and contamination.

17. Stockings or socks are required.

18. Shoes that provide protection should be worn within the surgical environment. Cloth shoes do not offer protection against spilled liquids or sharp items that may be dropped. Shoes should have enclosed heels and toes. No sandals are allowed.

19. Approved eye protection must be worn in the operating rooms by scrubbed personnel. Examples are goggles or face shields.

20. Lanyards are not permitted in the Perioperative areas as they may swing and contaminate sterile areas.

**Definitions:**

1. **Artificial Nails**: Substances or devices applied or added to the natural nail to augment or enhance the wearer’s own nails. They include, but are not limited to acrylic, gels, shellac, bonding, tips, wrappings or tapes.

**Reference**: Guidelines: Surgical Attire - AORN and Statement on Operating Room Attire - American College of Surgeons

**Dates**: Revised and approved by the Infection Control Committee December 2016.

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[more text]
SMOKING POLICY

Maine Medical Center is a smoke free institution in compliance with state law. As such, smoking and the use of tobacco products is prohibited in Maine Medical Center buildings and vehicles, on all Medical Center property and grounds, and within 50 feet of any entrance or commonly used passageway. Employee tobacco cessation efforts will be supported through the Employee Assistance and Insurance Programs.
MEDICATIONS FROM THE PHARMACY

Employees may purchase medications from the MMC pharmacy at relatively low cost on presentation of the proper identification. Prescription medications for your personal use should be prescribed for you by your health care team. Please do not ask fellow house officers or attending staff, who are not your part of your primary health care team, for prescriptions. It is never appropriate to write a prescription for yourself or other house staff – unless you are an official part of their health care team. Please do not ask for or take medications/supplies from the floor for personal use.

The MMC pharmacy is open 24 hours a day, 365 days a year and offers employees a discount on prescriptions.

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GYM MEMBERSHIPS

Department of Medical Education provides a group membership to World Gym, 265 Marginal Way, Portland, for use by our residents. Maine Medical Center has committed space and resources to build an MMC-specific gym within several blocks of the main hospital – to be completed in 2020.

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PARKING

Parking for house officers is available in the multi-level parking facility (Gilman Street Garage) located at the back of the hospital (facing onto Congress St.). Overflow parking, with shuttle service to and from Maine Medical Center, is available at the parking lot behind Union Station (First Atlantic building) on Saint John Street. There is also limited parking during normal office hours off Forest Street at the Congress Medical Office Building. An employee parking sticker and MMC ID is required for access. The cost for parking is $3.00 per week and is available through payroll deduction. Maine Medical Center’s parking facilities are quite overcrowded. We would thus appreciate your compliance with parking restrictions in and around hospital property. Parking facilities are to be utilized only when on duty at the hospital. Parking vehicles in the garage when not at work is not permitted (ie: leaving your car in the parking lot during snow storms when you are not at work, etc)

***As part of the major MMC renovations, there will be significant disruptions to parking for all employees and re-location of parking facilities – to be determined.

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IDENTIFICATION

All house officers should wear proper MMC identification at all times. A photo ID will be taken during your orientation period. Identification in an institution as large as ours is necessary for security reasons and to assure that only authorized personnel have access to our patients and their records. Access to the institution during the night and early morning will require a photo ID.

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MMC GME Policy on Resident Fatigue

In residency training, impaired performance due to resident fatigue means missed opportunities for learning and, at worst, hazards to patients.

a. Fatigued residents typically have difficulty with:
   - Appreciating a complex situation while avoiding distraction
   - Keeping track of the current situation and updating strategies
   - Thinking laterally and being innovative
   - Assessing risk and/or anticipating consequences
   - Maintaining interest in outcome
   - Controlling mood and avoiding inappropriate behavior

b. Signs of fatigue include:
   - Involuntary nodding off or waves of sleepiness
   - Problem of focusing
   - Lethargy
   - Irritability or mood liability
   - Poor coordination
   - Difficulty with short-term recall
   - Tardiness or absences at work

c. High risk times for fatigue-related symptoms are:
   - Midnight to 6:00 AM
   - Early hours of day shifts
   - First night shift or call night after a break
   - Change of service
   - First two to three hours of a shift or end of shift
   - Beginning of residency or new to night call
d. Methods to limit and address fatigue-related problems could include:

- Following the RRC-specific limit of the total number of hours worked.
- Establishing a workload that allows for as little variation in work schedules as is feasible. Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.
- Encouraging residents to consult their primary care physicians if daytime fatigue seems out of proportion to the workload. Sleep studies may be warranted.
- Obtaining diagnosis and treatment to determine if fatigue is depression or other psychiatric syndrome.
- The continuous monitoring of resident behavior by the chief residents and program director.
- It is the responsibility of every house officer to report excessive fatigue to the senior residents and Program Director – who will arrange for immediate staffing changes and/or changes in scheduling.

Approved by the GME Committee 6/28/06.

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