Pulmonary Medicine | Fellowships | Policies and Procedures

1) Pulmonary Fellowship Policy on Evaluation of Pulmonology Fellows

a) Faculty Evaluation of Fellows
Pulmonary fellows will be evaluated on the six core competencies with each educational experience using multiple assessment tools.
   i) New Innovation tools will be used to evaluate each fellow on all six competencies.
   ii) we have tailored several assessment forms for specific rotations.
   iii) Evaluation Tools to Assess Fellows:
      (1) New Innovations Global Evaluation Tool- Faculty to complete within four weeks of the end of a rotation.
      (2) Mini-Cex- Performed every six months in the Pulmonary Clinic- core preceptor directly observes a history, physical examination, interpretation of data and assessment and plan of a pulmonary clinic patient by the fellow.
      (3) 360 Evaluation Tool- Each fellow gives this assessment form to a non-physician health-care worker (Working at the same site fellow is working at) of selected by the program director.
      (4) Patient Evaluation form- Form provided to a patient in either the inpatient or outpatient setting by the fellow.
      (5) Bronchoscopy Evaluation Form- Checklist to evaluate a fellow's competency in pre-bronch assessment, providing sedation and in bronchoscopy skills.
      (6) Physiology Evaluation Form- To be completed by the ambulatory service faculty, to assess the fellows ability to interpret PFTs and CPET studies.
      (7) Interpersonal and Professionalism Form- Completed by all faculty and nurse manager with nursing input to assess the fellow's professionalism and interpersonal skills.
      (8) Research Evaluation Tool- To be completed by research mentors.

b) Fellows Evaluation of Faculty and program:
   i) New Innovation assessment of faculty members- anonymous electronic feedback regarding supervising attending at the end of each rotation.
   ii) End of the Year Survey.
   iii) New Innovation Anonymous evaluation of each rotation
   iv) New Innovation Anonymous Semiannual evaluation of the program

v) These faculty evaluations are forwarded to the DIO, GME committee and departmental leadership.

c) Clinical Competency Committee: The new accreditation system (NAS) has set up a system whereby fellows need to meet certain milestones within the three years of training. These milestones correspond to the 6 competencies. A fellow's performance is evaluated by a Clinical Competency Committee Bi-Annually. The committee, consisting of the 3 key clinical faculty, will meet every six months to review each fellow's progress and then determine if there are any deficiencies in meeting milestones. If a fellow is found to be deficient in milestones, they will meet with the PD to discuss strategies on improvement.

d) The program director will meet the fellow quarterly and more if/as needed and will submit an annual summative evaluation of the fellow.

e) The competency assessment will be based on faculty judgement of fellows –
   i) Fund of knowledge concerning cell and molecular biology of the lung, pulmonary physiology and mechanics, lung pathophysiology, and clinical topics, and the application of that knowledge to patient care and diagnostic testing.
   ii) Clinical and technical skills, including expertise in procedures including fiberoptic bronchoscopy, bronchoalveolar lavage, transbronchial biopsy, EBUS, Central venous catheter placement, Endotracheal intubation, tube thoracostomy.
   iii) Clinical and scientific judgment.
   iv) Personal character traits displayed; interpersonal skills.
   v) Teaching skills.
   vi) Ability to assume increased responsibility for patient care.

f) An evaluation file shall be maintained by the program director for each clinical fellow and treated as confidential. The file may be reviewed by the fellow and by divisional or departmental faculty and staff with legitimate educational and administrative purposes. The Graduate Medical Education (GME) Committee will review the evaluation plan of a program at the time of the Internal Review. The reviewer who meets with program faculty may ask to review a representative set of trainee files.

2) Pulmonary Fellowship Policy on Fellows' procedure Competency and Supervision

a) Fellows will perform a minimum of Ten (10) faculty supervised Simulation Central Line Placement, Endotracheal Intubation, Thoracentesis and Bronchoscopies before starting procedures patients. A Simulation Training Evaluation form will be used to evaluate fellows' simulation training.
b) Attending Faculty will be personally present to supervise fellow taking consent, explaining procedure to patient and the family, prepare the patient, perform the procedure and do post procedure assessment during first twenty Bronchoscopies and will be personally present during the key procedure portion of all procures thereafter.
c) Specific evaluation forms will be used for all procedures including Central venous Catheterization, Endotracheal Intubation, Thoracentesis and Bronchoscopies.
d) Bronchoscopy Evaluation Form will have Checklist to evaluate a fellow's competency in pre-bronch assessment, providing sedation, bronchoscopy skills and post procedure

3) **Pulmonary Fellowship Policy on fellows promotion**

a) Promotion of clinical pulmonology fellows to the next level of the program or graduation of the fellow will depend upon the fellow's performance and qualifications. The fellow should achieve at least average(5 or higher in our new innovation score system) overall scores in their clinical evaluations. Decisions about promotion or reappointment of fellows by the program director are communicated to the trainee as soon as reasonably practicable under the circumstances.

4) Pulmonary Fellowship Policy on Disciplinary Action, Suspension, or Termination

a) Informal Procedures

i) The program director will use informal efforts to resolve minor instances of poor performance or misconduct. In any case in which a pattern of deficient performance has emerged, informal efforts by the Program Director shall include notifying the fellow verbally in face to face meetings, then in writing of the nature of the pattern of deficient performance and remediation steps, if appropriate, to be taken by the fellow to address it. If these informal efforts are unsuccessful or where performance or misconduct is of a serious nature, the fellowship program director may impose formal disciplinary action.

b) Formal Disciplinary Action

(1) Disciplinary action may be taken for due cause, including but not limited to any of the following:

(a) Failure to satisfy the academic or clinical requirements of the training program.

(b) Professional incompetence, misconduct, or conduct that might be inconsistent with or harmful to patient care or safety.

(c) Conduct that is detrimental to the professional reputation of the Hospital or the organization

(d) Conduct that calls into question the professional qualifications, ethics, or judgment of the clinical fellow, or that could prove detrimental to the Hospital's patients, staff, employees, volunteers, or operations.

(e) Violation of the bylaws, rules, regulations, policies, or procedures of Orlando Health GME office, including violation of the code of conduct set forth by the program director

(f) Inability to assume increased responsibility for patient care.

(g) Scientific misconduct.

(2) Formal disciplinary action includes:

(i) Suspension, termination, or non-reappointment.

(ii) Reduction, limitation, or restriction of the resident's clinical responsibilities.

(iii) Extension of the pulmonology fellowship or denial of academic credit that has the effect of increasing the number of clinical service months or extending the fellowship.

(iv) Denial of certification of satisfactory completion of the fellowship program.

(3) The division chief or the fellowship training program director shall notify the clinical fellow in writing of the action taken and the specific reasons. The

fellow will be notified in writing of any disciplinary action that would require extension of training or delays in promotion no later than four months before the end of the fellow's current contract. The notification should advise the fellow of his or her right to request a review of the action in accordance with the grievance procedure set forth below.

(4) In the case of a suspension, written notification will precede the effective date of the suspension unless the program director determines in good faith that continued appointment of the clinical fellow places safety or well-being of patients or personnel in jeopardy, or immediate suspension is required by law or necessary in order to prevent imminent or further disruption of activities at Orlando Health facilities in which case the notice will be provided at the time of suspension.

5) Pulmonary fellowship Policy on Duty Hours

a) Graduate medical education in many specialties requires a commitment to continuity of patient care. At the same time as such continuity of care must take precedence (without regard to time of day, hours already worked, predefined call schedules etc.), patients have the right to expect their care is being delivered by alert, healthy, responsible and responsive physicians. The program respects that the necessary balance between patient care and education is delicate and keeping all the above in mind, has endorsed the following requirement.

   i) Pulmonary fellowship program will follow the recommendations of the ACGME, RRC and GME committee of Orlando Health, which states that excluding exceptional patient care needs, clinical fellows should have, on average, at least one day out of seven free from routine responsibilities.

ii) The consult service fellow will get at least one weekend day off during the week and at least one full weekend off during the month. During the weekend coverage, the consult service fellow will round in the morning with the attending physician and respond to all pulmonary pages for the rest of the day.

6) Pulmonary Fellowship Policy on Moonlighting

a) Moonlighting is not required by the program.
b) Moonlighting is permitted only during the elective months when total hours of clinical assignment/week including Moonlighting will not exceed 60 hours/week.
c) Only when and where consistent, quantifiable and direct supervision of the fellow is available.
d) Only with explicit notice and written permission of the program director.
e) The Moonlighting permission will be retained in fellow's file.
f) The hours of moonlighting will be logged by the program coordinator and reviewed by the program director.

7) Pulmonary Fellowship Coverage Backup Policy

a) Back-up support systems will be in place for situations when patient care responsibilities are unusually difficult or prolonged for the fellow, or if unexpected circumstances create fellow fatigue sufficient to jeopardize patient care or effective learning.
b) The Fellow will be taken off all clinical service or nonclinical activities immediately.
c) The attending himself will assume full responsibility of caring for the patients being cared for by the fellow.
d) Depending on the length and intensity of heavy patient care load, at the discretion of the program director and Section chief, either a midlevel provider will be re-assigned to the service or a fellow from the elective services may be re-assigned to be the second fellow in patient care services (Consult/Critical Care services in our case) ensuring that the reassigned fellow does not cross 80 hours limit and gets her/his required days off during the week.

8) Pulmonary Fellowship Home Call Policy

a) The fellow would be taking home calls only during their consult rotation. The number of phone calls the fellow received per night will be reported by the fellow and be monitored by the program coordinator. Traditionally off hour call/pages are 2 or less a night and it is very rare a fellow would have to come to hospital during after-hours. In a fellow has to spend a significant portion of the after hour tending to patients on service, she/he will be allowed to take the following full or half day off.

b) Calls from outpatient services will also go to the consult service fellow. Outpatient call coverage begins at 4:30 PM and runs through 8:00 AM. The average page census at present time in 2 pages per night.

c) All outpatient calls handled by a fellow are documented in EMR(AllScripts) and reviewed in the morning by specific faculty and clinic staff

d) If the fellow ever faces a very unlikely scenario of reaching 80 hours' time limit, she/he will be taken off call service by the program director.

e) The fellow schedule will ensure that during their Critical Care Rotations, the fellow will get at least 24 hours off after six 12 hours shifts when they are working during the day. If they are working 12 hours night shifts, they will get at least 2 full 24 hours off during the week.

f) The fellow schedule will be made to ensure that during their elective weeks, except for one weekend, the fellows will be off both the days of rest of the weekends. If / when they cover the consult services during the weekend, they will be off services for at least 24 hours during the work week.

9) Pulmonary Fellowship Policy to minimize the number of transitions in patient care

a) During pulmonary consult rotation, the fellow will be on the service for the whole month, thus minimizing frequent needs of patient care transition.

b) During the weekends when the fellow is off, the on call attending, who has been on service for the previous week, will be on service - this obviating the need of any hand off

10) **Pulmonary Fellowship Policy on faculty (physician and non-physician) mandate to supervise and teach residents**

a) The faculty will be obligated to round on each patient the fellow will see during clinical service. The faculties will spend at least 50% of day rounding with the fellow and resident or doing bedside teaching.

b) During the rotation with the fellow and resident - the faculty will not be assigned to other major clinical or administrative responsibility which will make the faculty unavailable >10% of the rotation time.

c) The faculty will be mandated to be personally present and directly supervise all the procedures the fellow will perform.
d) Faculty presence in >80% of the educational activities will be mandatory to core/ key faculty and the faculty on service with the fellow.

11) Pulmonary Fellowship Policy on notifying Fellows of goals and Objectives of each Rotation

a) The fellows will receive both a hardcopy folder as well as an electronic copy containing the curriculum of a spcific rotation. The curriculum will contain, in addition to the academic and procedural requirements, the fellow year specific goals and objectives pertaining to all six ACGME core competency categories.
b) During the beginning of each rotation, the faculty will discuss the goals and objectives pertaining to all six core competency categories of ACGME

12) Fellowship Policy on how to handle complaints or concerns of the fellows about the faculty or the program director

a) There will be a multi-tier process to deal with fellows' complaints, concerns and conflict resolution. Depending on the type on concern/ complain/conflict the fellow may take the following steps-
    i) Contact the program Director - ideally the first line of contact
    ii) Reach out to the Designated Institutional Officer - if the complaint is about the program director or the program director is unavailable or the Program Director has not resolved an issue.
    iii) The above two steps fail to solve a complain/ concern, the fellow will be instructed to contact the Human resources department by email or contact the medical staff section of the hospital in which the fellow is working
    iv) There is a corporate Compliance Hotline which is a confidential, risk-free method for reporting fellows concern. This this web portal, Fellows will have the option to go online to report their grievances and concerns. The Hotline is managed and operated by an independent communications firm to ensure the integrity and objectivity of compliance reporting and is available 24 hours a day, seven days a week.

13) Pulmonary Fellowship Policy on Faculty Mandate on Timely Evaluation of the Fellows

a) The Faculty are mandated to fill out the evaluation of the fellows On the last day of the rotation of the fellow.

b) There will be daily automated New innovation email to faculty reminding the faculty of pending evaluation
c) There will be reminder emails from the program coordinator if an evaluation remains delinquent for 15 days
d) There will be telephone calls from the program Director to the specific faculty if an evaluation remain delinquent beyond a month
e) The program Director and the DIO can remove a physician from the role of faculty if the physician consistently remains delinquent in fellow evaluation

14) Pulmonary Fellowship Policy on monitoring fellows' stress, including mental or emotional conditions inhibiting performance or learning and drug-or alcohol-related dysfunction

a) Private one to one session with the attending faculty at least once during each rotation to discuss and assess fellows coping with the training and his mental, emotional wellbeing. The faculty will be trained annually for such assessments.
b) Quarterly one to one session with the program director when the fellow will answer a series of questions including questions regarding emotional well-being, learning difficulties, level of stress, stress factors, drug and alcohol use
c) Through Human resources services, specialized professional service will be employed if the fellow or any faculty and the program director deem the fellow require such professional assessment

15) Pulmonary Fellowship Policy on reviewing program goals and objectives, and the effectiveness with which they are achieved

a) At the beginning of each rotation, the fellow will be given a copy of the goals and objectives of that rotation and again at the end of the rotation, the fellow will be assessed by the attending physician to check whether the goals and objectives of that specific rotations has been achieved or not.
b) The New Accreditation System Milestones will be assessed for each fellow by the Clinical Competency Committee every six months. Each fellow will be assessed for any deficiency in meeting Milestone requirement in each of six ACGME core competencies.
c) During the quarterly one to one meeting with the fellows, the Program Director will review the rotation specific goals and objectives and accomplishments of the goals. In his annual summative evaluation, the program director will explicitly specify whether and how effectively the goals and objectives of each rotation have been met for each fellow.
d) Rotation Specific goals and objective is being attached as an addendum to this document.

16) Pulmonary Fellowship Policy on Medical record entry of the fellows

a) The Fellows are mandated to complete all the documentation before the end of the day or end of the shift
b) The fellows Are mandated to make all their documents incomplete for review by the attending physician
c) The electronic medical record system will send automated electronic notification to the fellow informing her/him of any incomplete chart.
d) If the chart is not completed within seven days, personnel of medical record department will directly contact the fellow degrading delinquent charts via telephone or email.
e) If any chart remains delinquent for two weeks – the program coordinator will be notified who will in turn notify the Program Director and directly contact the fellow in question.
f) If the fellow is on extended off or on vacation over one week, the program coordinator will notify the medical records department.
g) Feedback regarding fellows' medical record proficiency and timeliness will be part of fellows 360 evaluation, milestone evaluation and annual Program Director's summative evaluation. The fellow will be notified of these feedback and evaluations verbally and in paper.
h) A consistent pattern of failure to complete medical records in a timely manner may be a reason the Program Director may take punitive measures against the fellow that will include failing rotation, declining promotion to senior year or termination

17) Pulmonary Fellowship Policy on Professional behavior

a) The Fellows and the Faculty will be obligated to the Orlando Health Graduate Medical Education Code of Conduct
b) Using the ACGME core competency tools and 360 evaluation tools, there will be a constant surveillance for lack of professionalism
c) There will be faculty training and awareness to be role models of professionalism for the trainees.
d) There will be constant surveillance for unprofessional behavior among the fellow or the faculty by use of the ACGME core competency evaluations and fellows 360 evaluations
e) Every single unprofessional behavior will be noted and informally addressed with.
f) A pattern of unprofessional acts will be dealt with awareness intervention(Using, showing aggregate data) by the program Director or DIO
g) If he pattern persists, the next step will be authority intervention where a timed improvement and evaluation plans with ongoing accountability will be established by the DIO and Human resources department. Continued unprofessional behavior beyond this step will warrant disciplinary actions like probation, suspension etc.

18) Pulmonary Fellowship Policy on detection, prevention and mitigation of Fellow Fatigue

a) There will be an Annual Mandatory Grand round on Work Place Fatigue and Burn Out issues with special focus on Graduate Medical Trainees
b) Brochures with Symptoms and Signs of resident/Fellow Fatigue will be made and given to Faculty, Fellows/ Residents/ Nursing and other ancillary staff.
c) The Faculty and the Fellows will attend the American Academy of Sleep Medicine's Video session titled SAFER, or Sleep, Alertness and Fatigue Education in Residency. This session will be an introduction to the science of sleep and the effects of sleep deprivation with focus on the demands and stresses of medical residency. The presentation provides practical suggestions for residents to manage fatigue and sleepiness including:
d) The will be annual Educational sessions on Sleep deprivation, The influence of circadian and homeostatic processes, When and how long to sleep, What fatigue countermeasures to use etc.
e) The Faculty and fellows will be trained that when a fellow/ resident has trouble in 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 – the fellow might be experiencing Fatigue and should immediately be off duty.
f) The Faculty and Fellows will also be trained to notice and act on the common signs of fatigue like Involuntary nodding off, Waves of sleepiness, Problems focusing, Lethargy, Irritability, Mood lability, Poor coordination, Difficulty with short-term recall or Tardiness or absences at work.
g) Awareness will be created among the trainees about the environments/ times of the day with high risk of fatigue. The high risk times include shifts between Midnight to 6:00 AM, Early hours

19) Pulmonary Fellowship Policy on Vacation, Sick Leave, maternity/paternity leave, extended leave of absence, Holidays will follow Orlando Health GME and human Resources policy on the same issues

20) If there is a policy conflict or discrepancy between Pulmonary Fellowship Policy and Orlando health GME policy, Orlando health GME policy will supersede Pulmonary fellowship policy