Last Edited on: 8/13/2020

BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL

Diagnostic Radiology Residency Program

Policies & Procedures Manual

Program Director
Glenn C. Gaviola, MD

Associate Program Directors
Jeffrey Guenette, MD
Shanna Matalon, MD
Jennifer Uyeda, MD

Chief Residents
Borna Dabiri, MD (DR)
Ariadne DeSimone, MD (DR)
Peter Schaefer, MD (IR/DR)

Program Coordinators
Kathleen Garney
Sandra Palma

Contents

Academic Enrichment Funds

Due to the ongoing Covid-19 pandemic and current institutional financial landscape, the current status of the academic enrichment / fringe accounts is under review and subject to change, as of July 2020. The residents will be notified of updates/changes and policy below amended.

Each resident is provided academic enrichment funds to supplement the costs of their education experience. The amount funded for each incoming class may change depending on the availability of sources of funding.

Reimbursement is processed by the Radiology Finance Department via PeopleSoft. To be reimbursed for any purchase, the online form must be submitted within 180 days of purchase with scanned receipts. Textbooks may be ordered by the resident and reimbursed through the academic enrichment/fringe account. If you purchase a textbook through a bookstore or other means, you may present a Tax-Exempt Form, which is available from the Program Coordinators or Finance Department. You will not be reimbursed for taxes on purchases.

ABR fees will be reimbursed using these funds.

Computer Ordering: When ordering a computer or computer equipment for home use (i.e., signing reports, research, etc.), you must contact the Radiology Finance Department with computer specifications and complete the appropriate forms for processing. Only a single computer purchase (laptop) is allowed over the duration of the residency. Tablet devices, such as an iPad, may be purchased through the enrichment account at the discretion of the Radiology Finance Department. Reimbursement is not available for telephones, or computer and tablet accessories. Computer and iPads cannot be purchased in the last year of training.

The following items are NOT reimbursable through the academic enrichment/fringe account:

- Furniture
- Utility bills
- Internet connection(s) (i.e., Comcast, Verizon, etc.)
- Computer accessories: mouse, adapters, keyboard, etc.

Beginning with the graduating Class of 2023,

1) All DR and IR/DR residents will have $700 per year for discretionary fringe expenses
   a) The $700 will be paid as additional salary at the start of each academic year
2) Other items provided to residents by the Radiology department through Radiology finance, in addition to discretionary fringe funds described in number 1 above as follows:
   a) Purchase of a Laptop in Year 1 – Each first-year Radiology resident (PGY2) will be paid $1,500 as additional salary at the start of the academic year to purchase a computer laptop.
   b) ABR Dues – The department will reimburse each resident for their ABR Dues each year ($640/year)
   c) Massachusetts Full Medical License and Renewal – Radiology residents beginning in their second year of residency, are able to apply for a full Massachusetts Medical license thereby becoming eligible to

perform moonlighting coverage if needed. The cost of the full license will be reimbursed in the second year of residency, and the renewal of the full license will be reimbursed in the fourth year of residency.

d) AIRP Expenses – In the third year of residency AIRP expenses will be reimbursed upon satisfactory completion of the course and receipt of a completion certificate, subject to the following
   i) Residents can submit for expenses up to $2500, in the following categories: travel to AIRP at the start of the program and return home at the end of the program; lodging and meals while at AIRP; local travel (subject to limitations below) while at AIRP.
   ii) To minimize workload for our accounting staff, residents should keep the number of itemized expenses to the smallest number that reaches the $2500 limit. Expenses for taxi/Uber travel during the time at AIRP should only be submitted if the total of all other expenses are less than $2500; if taxi/Uber expenses are submitted, they must clearly indicate why that travel was required as part of the AIRP course.

e) Core Exam Travel and Fees – Radiology residents in their third year will be reimbursed up to $2,000 for the Core Exam registration fee and any travel and lodging expenses incurred when traveling to take the exam in Chicago or Tucson.

Angiography/Interventional Radiology (Angio/IR) Call

During each Angio/IR rotation, on-call residents stay to finish late cases, and then cover the Angio/IR pager from home after the daily cases are completed. The on-call schedule typically results in 2 calls over a 2-week Angio/IR rotation and 4-6 calls over a 4-week rotation. The Angio/Interventional Radiology Section determines the call schedule. The resident answers pages, triages requests with the help of the on-call Angio Interventional attending faculty member over the phone and assists with the procedure if the study is approved.
(Please see the additional details in the Supervision Policy below.)

Attendance at National Meetings and Travel Stipend

Due to the ongoing Covid-19 pandemic and current institutional travel restrictions, the current status of the travel stipends for attendance at national meetings is on hold and subject to change, as of July 2020. The residents will be notified of updates/changes and policy below amended.

Eligibility for attendance and abstract support at national/international meetings

- Resident must be performing at a satisfactory level on clinical rotations, as determined by their current evaluations and recommendations by the Clinical Competency Committee.
- Prior presentations should have resulted in submissions for publication (if applicable).
- The resident's time away must not exceed program and/or ABR guidelines. (*e.g. 1 week per year and 2 weeks per residency is the maximum absence from any rotation except breast imaging/mammography and nuclear medicine when all required days must be made up*).
- The same research may not be presented at more than one meeting.
- First-year residents are encouraged not to take meeting time that occurs concurrently with clinical time.
- The mentor/co-author for the accepted abstract submission must be a BWH or affiliate staff member and must approve of the request for resident attendance at the meeting.

- Final approval for meeting attendance may be withheld, if the above is not met.
- International meetings require approval by the Program Director *prior to abstract submission*.

Number & Types of Abstracts Supported for the Department Travel Stipend

- A Department Travel Stipend not to exceed $1500 is available to support residents to attend national meetings for accepted abstract submissions. Reimbursement will be in accordance with the Partners Finance Travel Policy. The funds will come from the Department and not from the Resident's academic fringe account.
- All funded abstracts require acceptance notice from the meeting organizer, and that the resident be the 1st author, with attestation from the resident's mentor on the abstract:
    - Eligible accepted abstracts include: oral presentation, poster or e-poster presentation, or teaching faculty for a course (e.g. Hands-on demo, RSNA Refresher Course).
    - A maximum of 1 poster/e-poster presentation will be supported over the course of the residency, unless the meeting requires that the resident specifically be present at the meeting for the poster presentation for a question & answer session (such as when CME credits are available)
    - If applicable, prior presentations should have resulted in submissions for publication prior to additional funding with a Departmental Travel Stipend.
- Eligible meetings for support include RSNA, ARRS, AUR, and subspecialty society meetings in the continental US or Canada.
- Meetings out of the continental US or Canada or other meetings are approved on a case-by-case basis by the Program Director in conjunction with the Residency Program Leadership.
    - Requests for international meetings require approval by the Program Director before submission of the abstract, including documentation of support by the sponsoring faculty member.
- Meeting time granted will be for the day of presentation, the day before, and the day after.
- Successful submission of a Request for Departmental Travel Stipend & Time Away (as detailed below in Directions for Applying for a National Meeting & Departmental Travel Stipend) and approval by the Program Director prior to the meeting are required.

Other Meetings

Post-Graduate /CME courses/Local Meetings: Post-graduate/CME courses are not eligible for a travel stipend or Departmental sponsorship. However, half-day conference time may be approved by residency leadership or residents may use vacation time to attend. The resident's individual academic fringe account (as applicable) will be used to fund local meetings/courses. Permission of the Program Director is required prior to registration.

Senior Meeting Benefit

- Fourth-year residents may be eligible for Senior Meeting benefit of time and funding (up to $1500) outside their academic fringe account.
- One meeting (maximum 5 days) is granted in the fourth year to attend the RSNA, AUR, ACR, ARRS or a subspecialty society national meeting.
- Must be approved by the Program Director, at least 90 days prior to the meeting.
- Total reimbursement will be in accordance with the Partners Finance Travel Policy.

MGH/BWH Radiology Review or New England Roentgen Ray Review Course

- Available to third-year BWH radiology residents in preparation for the ABR Core Exam.
- Funds are sponsored by the Department, not the resident academic fund, at a reduced fee.

National Committee Meetings/ Meetings representing the Department *(e.g. ITAR)/ACR annual meeting, SCR RLI Leadership Summit)*

- Up to 2 meetings of this kind are permitted for the entire residency period.
- The resident must be an active committee member.
- Travel is limited to 3 days for Committee Meetings (to include the day of the meeting and travel before and after) or 5 days for Scholarship Meeting (such as ITAR/ACR).
- Funds come from the sponsoring organization or if no funds are provided by the sponsoring organization, the resident may be eligible for a Department Travel Stipend at the discretion of the Program Director. Funding limit from the department may not exceed $1500.

In-house/Partners' CME Courses

Residents will be given the opportunity to attend "in-house" enrichment CME courses as a special privilege within the following guidelines:

- The resident must be performing satisfactorily academically and professionally, as determined by the Clinical Competency Committee.
- Funds must come from the Resident's academic fringe account (as applicable) or his/her own funds and are not eligible for a Departmental Travel Stipend. Total reimbursement will be in accordance with the Partners Finance Travel Policy and not to exceed $1500.
- The resident may not take time off from the first rotation of core subjects in Year 1. Residents must adhere to the maximum time away from a section policies and procedures.
- Up to 3 courses in years 1-4 may be used for these courses. Additional course attendance in the fourth-year is at the discretion of the Program Director.
- A paragraph indicating why you are interested in a specific course should be submitted to the Program Director for approval.

American Institute of Radiologic Pathology (AIRP) Course

Residents (except those in the CSRP pathway) will receive time off and funding for travel to attend the AIRP course in R3 year. The timing of the course for each resident will be determined by the Chief Residents and incorporated into the schedule. The residents will be eligible for funding up to $2,500 separate from the academic fringe account (as applicable) for lodging, travel, and food. Additional expenses cannot be reimbursed from the academic fringe account. Reimbursement will be in accordance with the Partners Finance Travel Policy and departmental policy on AIRP funding. Funding is contingent upon successful completion of the AIRP course and receipt of a completion certificate.

Reimbursement Guidelines

- For the AIRP meeting, the maximum reimbursable amount is $2500. Expenses beyond $2500 will be the personal responsibility of the resident.
- If the travel benefit is not used, it is not convertible into cash or other professional benefits.
- Reimbursement is subject to Partners Travel Guidelines and methods of submission http://is.partners.org/finance/travelcentral.html
- Approval by the Program Director is necessary prior to conference attendance for reimbursement for departmental sponsorship in the form of the Departmental Travel Stipend.

Directions for Applying for a National Meeting & Departmental Travel Stipend

1) Before applying to go to a meeting, review the Resident Attendance at National Meetings and Departmental Travel Stipend Policy to determine if you are eligible.
2) If there is any question about your eligibility to attend the meeting, email the Program Director before submitting your abstract.
3) If the guidelines are met or if approved by the Program Director (based on academic performance, publications related to prior presentations, mentor support, etc.), submit abstract or application to the meeting.
4) To be eligible for a Department Travel Stipend, please submit to the Program Director in a single email for review and approval by the Program Director the following:
   a) Statement that you have reviewed the Resident Attendance at National Meetings and Departmental Travel Stipend Policy, and an attestation of your eligibility;
   b) Copy of the 1st-author accepted abstract;
   c) Letter of acceptance of the abstract from the meeting organizers, identifying the accepted format of the abstract (i.e. oral presentation, poster or e-poster, or faculty leader);
   d) Attestation statement from your submitted abstract mentor confirming support of the project and requesting your attendance to attend the conference as a 1st-author presenter.
5) Once approved by the PD, forward the approval email to Chief residents.
   a) If > 90 days: Chief Residents notify the section resident liaison.
   b) If < 90 days, Chief Residents review coverage. If coverage is not adequate, permission may be denied by the Division Chief and/or Resident Liaison.

Away Rotations

Due to the ongoing Covid-19 pandemic and current institutional travel restrictions, some away rotations are on hold and subject to change, as of July 2020. The residents will be notified of updates/changes and policy below amended.

Generally, rotations at another ACGME-approved residency program must be pre-approved by Program Director in writing with objectives for the rotation clearly stated. In addition, the following documents must be provided by the Residency Program Office to the program the resident is visiting:

- Copy of Massachusetts medical license
- Copy of malpractice insurance (CRICO) face sheet
- Evaluation Form to be completed on last day of rotation

Rotations at non-ACGME programs (e.g., in another country) may require review by the American Board of Radiology prior to arrangements being finalized. Once the ABR has approved the rotation, approval by Program Director(s) must be given. An Evaluation Form will need to be provided to non-ACGME programs.

The following Required Away Rotations are considered part of the BWH curriculum:

- Children's Hospital Boston (Pediatric Radiology):
- Mass Eye & Ear Infirmary (Head & Neck Radiology):

The following rotations are not considered "Away":

- DFCI

- 850 Boylston Street
- Faulkner Hospital
- American Institute for Radiologic Pathology (AIRP)
- Massachusetts General Hospital

Vacation is highly discouraged during away rotations, (except with prior approval in accordance with the policies of outside rotations, including Children's Hospital and approval by Children's Hospital Residency Program Director).

If a resident is ill on an away rotation, the Program Coordinator and Chief Resident(s) must be notified and the same procedure as in *Sick Leave Policy* shall be followed.

Chief Resident Overview

Term of Office:

- Term begins after completion of the ABR Core Exam approximately June 15- June 14 the following year. The period of June 15- July 1 can be used as a transition period.

Number of Chiefs:

- Two DR and one IR/DR chiefs will be selected for the term, from the third-year class.

Selection Process:

- The selection process will take place in the Spring. A list of candidates will be administered to all clinical radiology residents and faculty and results are tabulated by members of the radiology education leadership team and Program Director who will select the final candidates
- Final appointment of Chief Residents must be approved by Residency Program Director

Responsibilities:

- A separate Chief Handoff document will be drafted from the outgoing Chief residents and submitted to the incoming Chief residents
- Attend Meetings: Monthly Education Committee meetings, monthly meetings with the Chair or Vice Chair of Education, and weekly Chiefs' Meeting with Residency Program Leadership including the Program Directors and Program Coordinators; additional subcommittees, as necessary.
- Facilitate cross-institutional (MGH/BWH/BI) social functions (including AUR dinner) – coordinate with respective cross-institutional Chief Residents
- Provide orientation for new and first-year residents
- Answer emails from residents and staff pertaining to resident schedule, rotations, and functions. Refer to the Residency Program Leadership, as necessary.
- Maintain the clinical residency schedule– done by Chief Residents with guidelines from the Residency Program Leadership and former Chief Residents, as necessary. Also, keeps amion.com scheduling system current/updated.
- Assist with Recruitment & Interview Season/ NRMP Match Process – introductory remarks each interview day and participate in applicant dinners as available.

- Facilitate recording of daily resident attendance on clinical rotations – use the system in place for notification of section for sick leave or other excused absences.
- Coordinate extracurricular activities within the residency, as needed, and in accordance with Residency Wellness Committee.

REWARDS:

- Stipend ($5000)
- 3 days off to make schedule
- 2 additional days of vacation during the year
- AUR Meeting attendance (During spring before beginning of the Chief year and spring of Chief year)
- ACR Meeting attendance (During spring of Chief year)

EVALUATION:

- Evaluation of the performance of Chief Residents will be done by the Residency Program Director.
- Evaluation of the job will be done by Chief Residents at the end of their term

Children's Hospital Call

- Please refer to the Children's Hospital Radiology Residency manual for additional and current up-to-date changes.
- In-house call is arranged in blocks of night float, late shift and single weekend/holiday days, with average number of calls depending on the number of residents. The scheduling of CHB call is done by the Children's Hospital Program Director and the BWH Chief Residents are not able to make any changes to the CHB call schedule.
- While at Children's Hospital, residents should not responsible for call at BWH radiology.
- While at Children's Hospital, one week of vacation or meeting time is permitted if adequate notice is given to Children's Hospital Program Director in accordance with CHB policy. Additional time off may be granted at the discretion of the CHB program director.
- Residents should not attend meetings or conferences at BWH during their Children's Hospital rotation.

Evenings/Consult Rotation (On-Call)

BWH Radiology Evenings/Consult rotation is based on a weekly on-call system that is covered by second-, third- and fourth-year residents. The average distribution of Consult Shift is approximately as follows:

Second Years: 2 weeks

Third Years: 2 weeks

Fourth Years: 1 week.

Effective July 2020, the week-long rotation consists of six shifts beginning on Sunday evening and ending on the following Saturday morning. All shifts will be 7:00PM to 2:00AM. The Saturday evening Consult shift will be covered on a rotating basis and will also run from 7:00PM to 2:00AM. Consult shifts that fall on holidays will be covered by the same resident assigned to Consult for that week. The Consult resident is not expected to attend resident morning or noon conference

Consult Responsibilities:

- Refer to the *First Actionable Communication Transparency (FACTs): Details for Residents* document for the most up-to-date responsibilities of the Consult and NF resident as the duties may change over the course of the academic year.
- Effective July 2020, after-hours residents (both Consult and Night Float resident) will sit in Shapiro L2 CV reading room to cover the COVID-19 Shapiro scanner
- The Consult resident will be responsible for covering the on-call radiology pager (#11883) until the end of their shift (2:00 AM), at which time it will be transferred to the Night Float resident. At that time, the resident communicates with the Night Float resident to discuss unresolved issues, urgent pending studies, and confirm pager hand-off.
- During the overlapping period between 10:30 PM and 2:00 AM, when both the Consult and Night Float residents are on-site, inpatient cases and ED cases can be distributed at their discretion and in conjunction with the ED attending. However, the Consult resident's primary responsibility is for inpatient examinations as per the FACTs initiative.
- The Consult resident is responsible for providing a preliminary interpretation via Alert Notification for Critical Results (ANCR) for:
    - Any unread STAT inpatient CT, MRI, abdominal US, and MSK US, and STAT/"patient waiting" outpatient CT,MRI, and radiographs that appears on the "BH Consult After Hours" Primordial worklist.
    - Any non-STAT CT, MRI, or radiograph about which the resident is called.
    - The Consult resident is strongly encouraged to look at and issue a first communication on as many of the non-STAT inpatient CT and MRI exams (prioritizing "within 6 hour" and then routine studies) as possible during the shift, as time allows.
    - Additionally, as mentioned above, when feasible the Consult resident can help read ED cases between 10:30 PM and 2:00 AM if all inpatient cases that meet the above criteria have been reviewed and the results have been communicated to the responding clinicians.
- Communication of results should be documented using the ANCR system. Refer to *First Actionable Communication Transparency (FACTs): Details for Residents* document for further details.
- The resident will also generate a "sticky note" within Visage saying "ANCR" with a short summary if possible, to ensure that the radiologists reviewing the study are aware that communication already took place on this case.
- If the Consult resident does not feel comfortable issuing an actionable report on an exam (e.g., CTA or MRI) or is unable to do so within a reasonable time frame due to time constraints, he/she should request that the case be reviewed by the fellow-on-call for the respective division via purple ANCR page using the "Consult" category. Make sure the page option is checked as the fellows are not expected to check their emails after hours.
- After-hours inpatient ultrasound preliminary interpretation will be performed by the in-house sonographer, though subject review by the on-call resident.
- All nuclear medicine studies (including V/Q, GI bleeding scans, gallium scans, etc.) are covered by the on-call Joint Program in Nuclear Medicine (JPNM) Resident/Fellow.
- The radiologist officially interpreting studies that have been preliminarily reported by the overnight resident are responsible for notifying the requesting physician of any major discrepancies between the preliminary read and the final report. In this case, a new ANCR should be submitted by the resident/attending faculty

member who officially interprets the study. Additionally, the “Worth Another Look - Purple ANCR” system is used in the morning to notify the on-call resident of any major discrepancies or missed findings.

- The Consult resident covers inpatient and ED fluoroscopy studies, coordinating the study with the Lead technologist on call who is stationed in the Fluoroscopy area (ext. 33880 or 33882). The resident provides the technologist with the patient’s name, MRN, exams to be performed and patient location. If the lead technologist is not available, page directly the "Tower Portable XR Technologist" at 11870 or the "Shapiro Portable XR Technologist" at 12915. If performance of the study would cause the Consult resident to be pulled from their duties outlined above for too great a time to hinder appropriate patient care, the on-call Abdominal Imaging fellow may be called for backup.

Daily Morning/Noon Conferences: 7:45-8:15 AM and 12:15-1:15 PM

Resident morning/noon conference attendance is mandatory for all residents rotating during standard working hours at Brigham & Women's Hospital and DFCI. Residents who are on an ‘off-site’ (e.g. AIRP, Children’s Hospital), ‘*off-hours*’ rotation (e.g. Consult shift or NF rotation, AM conference for ED days rotation), on a fourth-year focused mini-fellowship experience (as required by patient care responsibilities, such as a procedure, or to attend an alternative conference) or excused time away (e.g. vacation, leave of absence) are excused from attending conference. Residents who are required to maintain continuity of patient care, such as an interventional or procedural rotation, may be excused from attending conference at the discretion of their supervising faculty member. Residents should be excused from section at 12:00 PM to have time to get lunch and arrive promptly at lecture by 12:15 PM. Morning conference should end promptly at 8:15 AM and residents should be back to their sections by 8:20-8:25 AM. Noon conference should end promptly at 1:15 PM and residents should be back to their sections by 1:20-1:25 PM. Of note, on days of Grand Rounds or conferences that are scheduled from 12-2pm, the AM conference will be canceled in lieu of the longer noon-time conference. This is the same as well for days of the New England Roentgen Ray Society (NERRS) conferences on Friday afternoons-there will be no AM conference and residents are excused prior to meeting start time at approximately 3:00 PM to allow for travel. On these days when there is no scheduled AM conference, residents should report to their assigned section at 7:45 AM. Conferences are considered an integral part of the residency program and our faculty work hard to provide these educational experiences.

Attendance will be recorded at conference as required by the ACGME and used as a metric for Professionalism as mandated by the ACGME Milestones criteria. Residents are expected to record conference attendance through New Innovations on a daily basis. Attendance of each resident will be reviewed routinely. Attendance at fewer than 75% of conferences (allowing for the exceptions listed above) is considered unacceptable. Suboptimal attendance will result in a meeting with the Program Director, and as needed, will be reviewed by the Clinical Competency Committee for further corrective action. Poor or suboptimal attendance will be considered by the Clinical Competency Committee in the resident’s annual evaluation for promotion.

The following conferences are provided on a regular basis:

- Radiology/Pathology Correlation Conference (RadPath)
- Missed/Difficult Case Conference
- Radiology Grand Rounds
- New England Roentgen Ray Society (NERRS)
- Section-specific conferences (including Journal Club and Difficult Cases/QA conference)
- Senior Resident Teaching Conference

In addition, to prepare residents for the ABR Board examinations, the Department provides the following courses.

- Physics Review Courses
- Departmental Longitudinal Radiological Physics Courses
- MGH/BWH Review Course or NERRS Review Course

The designated core faculty Resident Liaison for each assigned division must provide speakers for these conferences. The Program Coordinators will send a reminder to the speakers in the week prior to the scheduled conference. In case of personal emergencies, inadequate staffing, or situations that might compromise providing excellent patient care, the division's staff or administrative assistant must recruit another speaker.

Disciplinary Actions

Standards of academic performance and personal professional development are the responsibility of the Program Director, the Clinical Competency Committee, and as needed, the Vice Chair for Education and Department Chair. A resident experiencing difficulty with academic performance, impairment or professional misconduct may undergo disciplinary action as per the Partners GME educational policies: https://www.partners.org/Graduate-Medical-Education/Policies-Resources/Policies.aspx

Dress Code

Radiology residents should dress in a professional manner. Professional dress and appropriate hygiene and grooming are required as a measure of the ACGME Professionalism Milestones Requirement, including the use of professional white coat on certain rotations. Hospital protocol should be followed, including the use of perfumes and colognes. Clean scrubs are considered professional attire for all rotations.

Excused Absences From Clinical Work

- Morning and Noon conference. This does not apply to procedural rotations (including Mammo procedures). Residents should be excused as close to 12:00 PM as possible for Noon conference.
- ACLS training – 5-hour half-day session, once every 2 years per resident.
- Resident Wellness Retreat – full day event on a weekend day in the Fall.
- GME-mandated training sessions (Intern Retreat, professionalism courses, Chief Residents Retreat, etc.) – typically half- to full-day activities, once per year per resident.
- HMS tutorials (assigned and documented well ahead of time in Amion) – average three 60-minute afternoon sessions per month, split equitably amongst R1 and R2 residents.
- Autopsy conference – Monday/Wednesday/Friday conference in the hospital morgue with the pathology and clinical teams, typically 60 minutes in length beginning at 8:00 or 9:15 AM. One R1 or R2 resident is assigned each week, typically 3-4 weeks during the R1 year and 1-2 weeks during the R2 year.
- Med conference – Tuesday/Thursday conference with the internal medicine teams from 10:30 AM – 12:00 PM. One R2-R4 resident assigned each week, typically 2-3 weeks/year.
- NERRS meetings – meeting held once/month for 6-7 months of the year, beginning at 3:45 PM. Residents are excused from service at 3:30 PM on meeting days and are expected to attend the entire meeting.
- ACR in-service examination – once/year in January for R1-R3, typically a half-day commitment

  - Note: Chief Residents will try to minimize situations where multiple residents on the same rotation take the exam at the same time
- Bi-annual program director meetings – twice-yearly meetings to review resident progress, typically for 30 minutes during the workday.
- Senior residents needing to finish various clinical requirements for graduation. This principally applies to observing the required six I-131 treatments during the R4 year, which are not currently built into the Nucs training in the first 3 years. These are brief, infrequent absences (usually 1-2 hours on a particular morning).
- Residents in good standing who are approved by the Program Director for national conference attendance – averages less than one conference/resident/year
- I-131 observations: Senior residents with fellowship or job interviews that cannot be moved. Residents are given up to 5 days for interviews (see below). If a resident has a distant interview and requires travel days, these days will come from the 5 granted interview days.
- Mandated civic duties, such as Jury Duty

In accordance with the recent July 1, 2017 updates of the ACGME Common Program Requirements (Section VI.C.1.d), residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. For healthcare appointments that are needed on an intermittent and/or recurring basis, the trainee will be provided with clinical coverage for these periods of brief absence. This can be arranged by the trainee or by the Chief Residents, if the trainee wishes to keep this absence confidential.

Additionally, every effort should be made to accommodate residents in good standing who express interest in the various department-sanctioned HMS teaching sessions. These sessions are infrequent (2-4 sessions/year) and are dependent on voluntary resident/faculty participation for success.

Except in very unusual circumstances, there will be no resident schedule switches to address staffing issues when one of the aforementioned issues is at play.

Graduate Trainee Leave

General

The Partners GME office provides guidance on determination of Graduate Trainee Leave (https://www.partners.org/Assets/Documents/Graduate-Medical-Education/Policies/GME-Trainee-Vacation-and-Leave-Policy.pdf). Since each graduate trainee must meet certain educational and competency requirements as defined by the program, ACGME, and the American Board of Radiology, the graduate trainee may be required by his/her Chair and/or training Program Director to make up missed time upon returning from any leave prior to advancing to the next level of training and/or prior to completion of the training program. In such cases, restoration of the graduate trainee's previous position beyond the term of the original appointment and provision of salary during the "make up" period are at the discretion of the Department Chair and Program Director; the Hospital is not required to extend the period of training to accommodate this.

Whenever the need for leave is foreseeable, the graduate trainee will make a reasonable effort to schedule the leave so as not to unduly burden the program and give notice no fewer than thirty (30) days before the leave is to begin. If the reason for the leave requires that the leave begin in fewer than thirty days, the graduate trainee will give notice as soon as is practicable. A graduate trainee should give the training Program Director notice as

far in advance as possible regarding planned Parental Leave or Family Medical leave; six months (confidential) notice is requested for planned leave after the birth of a child, to facilitate appropriate scheduling.

The ABR has mandated that leaves of absence and vacation may be granted to residents at the discretion of the Program Director in accordance with local institutional rules. There is no specific minimum amount of training time required for graduation; decisions regarding advancement and graduation will be determined by each trainee's ability to meet certain educational and competency requirements as defined by the program, including assessment by the Program Director and Clinical Competency Committee (CCC).

- SICK LEAVE/TIME. A graduate trainee is entitled to twelve (12) paid sick days annually upon matriculation, to be used solely for illness significant enough to interfere with the performance of duty. Unused sick days may accrue to a maximum (60) days, but they may not be "cashed in". When trainees must be absent because of health issues or for health care appointments, the Program Director may not query the trainee regarding the health issue. If a Program Director requests verification of the need for time off for absence due to illness (or for health-related appointments), the request should be made to Occupational Health to ensure confidentiality with respect to the Trainee's health information.
- MEDICAL AND FAMILY LEAVE. A graduate trainee may request up to twelve (12) weeks of leave in a 12-month rolling period for any of the following reasons:
    - Family Medical Leave: taken to care for a spouse, child or parent with a serious health condition. (*A "serious health condition" is an illness, injury, impairment or physical or mental condition that involves either inpatient care or continuing treatment by a health care provider*.)
    - Personal Medical Leave: taken because of a serious health condition that makes the individual unable to perform the functions of his/her position.
    - Parental Leave: taken in the event of childbirth, or for parenting a newborn child, or placement of a child for adoption or foster care within one year of birth or placement.
- ADDITIONAL PROVISIONS RELATING TO MEDICAL AND FAMILY LEAVE:
    - Job security: Upon return from an approved family or medical leave of absence, the graduate trainee will be restored to the position left.
    - Insurance: If enrolled at the time of commencement of an approved family leave, the graduate trainee's health and other insurance coverage during the period of leave shall remain intact at the same levels and cost to the individual as if the trainee were not on leave.
    - Timing of leave: Parental leave must be taken within one year of the birth or adoption, unless an individual plan for part-time or intermittent leave has been approved by the Program Director.
    - Structure of leave: If an intermittent or partial leave (i.e., a reduced work schedule) is requested, the Department Chair/Chief and/or training Program Director may alter the graduate trainee's work schedule to accommodate the leave as deemed possible and appropriate within the context of the educational program and the clinical service.
    - Coverage of program-related responsibilities: It is the responsibility of the Program Director or his/her delegate – not of the Graduate Trainee taking a leave - to make arrangements for coverage of the Graduate Trainee's clinical responsibilities in the case of family, medical or bereavement leave.
    - Make-up requirements: The Graduate Trainee should seek clarity from the Program Director about make-up time as required by American Board of Radiology and/or the Program, and how the need to demonstrate achievement of competency prior to graduation may impact the need for make-up time. In addition, it is the responsibility of the Program Director to determine what specific

experiences or activities that may be missed during a leave need to be made up, even if the time spent on leave does not need to be made up.

Personal Leave

The Department Chair and/or training Program Director may on occasion, in accordance with the bylaws of the Professional Staff, grant an unpaid leave of absence to a graduate trainee for any form of extended illness or disability or for other compelling reasons (i.e., personal leave of absence). Such leave must be requested in writing with maximal advanced notice prior to the requested leave date. Timing and duration of the leave, and questions regarding return to the position, requirement for make-up time, etc, should be discussed by the Graduate Trainee and Program Director in advance, and documented after consultation with the Chair, the GME Office and Human Resources.

Bereavement Leave

Graduate Trainees may take up to ten (10) work days of bereavement leave following the death of an immediate family member (defined here as a parent or step-parent, sibling or step-sibling, child or step-child, and spouse or domestic partner), with salary continuance. Longer leave, or leave for the loss of other connected individuals, is at the discretion of the Program Director.

Sick Leave

If a resident is ill and/or unable to perform their expected duties, a Sick Leave day must be utilized. As above, a graduate trainee is entitled to twelve (12) paid sick days annually; unused sick days may accrue to a maximum (60) days, but they may not be "cashed in". The resident must inform the Chief Residents and their assigned rotation/division reading room or core faculty Resident Liaison by 7:45 AM (if on Angio/IR, then the Interventional Radiology Resident/Fellow on-call by 7 AM). The resident must email the Chief Residents and Program Coordinators indicating the person(s) who was/were contacted.

Absences are considered unexcused unless this communication is documented. The Chief Residents must be notified even if the resident arrives at work and is sent home by the section due to illness.

- Days used for Sick Leave during call responsibilities must be made up by additional days, at the discretion of the Program Director; if sick leave results in another resident covering a consult or night float shift, the shift is generally courteously returned to the covering resident later in the year.
- If a resident is scheduled on an "Away Rotation", Sick Leave must be reported in the same manner as above, in addition to that institution's policies.

Salary Continuance

Salary continuance is provided as below. In general, paid vacation can also be used to functionally extend the period of salary continuance during a leave, if/when it is feasible, and with Program Director approval.

Salary will be continued as follows:

- Family Medical Leave: Graduate trainees may use vacation time, but *not* accrued sick time, for family medical leave. Salary will be continued only in *exceptional* circumstances, at the discretion of the Department Chair/Chief.
- Personal Medical Leave: The graduate trainee must use any accrued sick time while on personal medical leave. At the discretion of the Department Chair/Chief, the graduate trainee may use vacation time while on personal medical leave to provide salary continuance. An additional period of salary continuance may be

given at the discretion of the Department Chair/Chief up to a maximum of ninety (90) days. (Long-term disability insurance may apply after that period.)

- Parental Leave: Graduate trainees who are the parent of a new child by birth, adoption, or placement in foster care are eligible for salary continuance for a period of eight weeks following birth, adoption or foster care placement. Accrued sick time cannot be used to extend salary continuance for parental leave. Vacation time may be used to provide or extend a period of paid leave up to a maximum of twelve weeks. Requests for Parental Leave should be submitted to the Partners Leave of Absence Administrative Office at the Human Resources and Benefits Office after discussion with the Program Director. However, if a trainee requires a personal medical leave related to pregnancy or childbirth, and this leave is handled according to the personal medical leave parameters set forth above, the medical leave is separate and in addition to paid parental leave.
- Personal Leave of Absence: Graduate trainees may use vacation time, but not accrued sick time, for personal leave. Salary will be continued only in exceptional circumstances, at the discretion of the Department Chair.

Hand-Off Processes and Critical Results Reporting

Critical Results Reporting

Generally, communication in the Department of Radiology is via the radiology report. Critical results or results of STAT exams are communicated per a standard policy of using the Alert Notification of Critical Results (ANCR via https://ancr.partners.org) system using Red, Orange and Yellow ANCR alerts using the established Departmental online system. Trainees are instructed in these policies during the summer Welcome Orientation and during their clinical services. Monitoring is done by periodic sample report review by the Section/Division Directors. Details about Critical Results Reporting are available at: (http://quality.partners.org/).

Hand-Off Process in Angio/IR and CSIR Rotations

Training: Trainees are instructed in hand-over policies and procedures by the staff radiologist faculty member when they begin rotation on the Angio/IR and CSIR services. These policies are available in a written policy given to all residents at the beginning of their CSIR and Angio/IR rotations.

Hand-Off Process:

ANGIO/IR: The Angio/IR service has a formal sign out process. The IR inpatient service list (includes patients admitted to Angio/IR service directly and patients on the Angio/IR consultation service) is maintained on the Partners Epic Patient List interface. In-patients are followed by an individual trainee with attending supervision until discharged from the hospital or signed off from the consultation service. All trainees sign out their inpatients to the trainee and/or attending faculty member on-call prior to leaving the hospital. The sign-out is a person-to-person discussion of each patient. If a trainee is leaving the service permanently or for an extended period (vacation week), his/her patient load is divided and transferred formally to the trainees remaining on service. If a trainee goes off-service post call for duty hours' compliance, the new patients/consults are formally discussed and transferred to the on-call trainee prior to departure. Attendance at morning rounds to present the new patients is required prior to departure post-call.

CSIR:

- *See also the CSIR written fellow's policy for additional details.*
- Specific instructions are delineated in the manual regarding direct person-to-person sign-out for trainees each evening to the on-call fellow.

- The CSIR fellow or resident on service during routine daytime hours, reviews any late add-on cases, pending emergency consults, and in-patients with the fellow on-call for the evening or weekend.
- The CSIR Physician Assistant (during regular work hours) or fellow on-call carries the on-call pager and the pager number is posted on the hospital paging portal. The resident does not carry the CSIR pager.
- Specific instructions are delineated in the manual regarding direct person-to-person sign-out each morning to the fellow or resident on the daytime CSIR service, by the post-call fellow. The post-call fellow reports any procedures performed during call and any new consults or pending consults received during the on-call shift to the daytime CSIR team.

Structured Hand-off Processes utilized in CSIR

- Systems used to support hand-offs include worklists in Visage and Epic. Epic provides a tool for monitoring all CSIR patients for all CSIR management issues. Verbal physician-to-physician and nurse-to-nurse hand-offs are documented in the Powerscribe procedure dictation immediately following every CSIR in-patient procedure.
- The CSIR pager is transferred to the CSIR Fellow on-call each evening and weekend. The pager is transferred to the CSIR daytime service each routine weekday morning after call.
- All CSIR procedures are recorded in the REDCap CSIR QA Database.

Monitoring effectiveness of hand offs

All patients on the inpatient service lists in both Angio/IR and CSIR rotations are discussed in formal rounds each morning. Formal rounds serve as a platform for continued re-assessment of patient's clinical condition and treatment plan. During rounds, the attending faculty members on service continually assess the treatment plan, and in so doing, assure that there is continual effective hand-off of clinical information. The attending radiologist faculty member supervises hand-offs at the end of each routine CSIR shift.

Communicating and documenting results in Emergency Radiology: *(summary, see ED radiology rotation manual for details)*

- In Emergency Radiology (ER), all critical and discrepant results are communicated in-person or by phone and documented in ANCR per Departmental procedure. Email MUST NOT be used anywhere in the department for Orange or Red alerts as loop closure cannot be guaranteed within the required time frame. In the ER, Yellow paging alerts are communicated in-person or by phone to the ER requesting physicians or accepting in-patient teams (due to our immediate access to the referring physicians and the revolving shift nature of these care teams). Email may be used for communication to patient's Primary Care Physician, only if the patient and care team are no longer present, and the finding is a Yellow alert allowing for a longer time frame. This should be documented in ANCR.
- In the uncommon circumstance that the patient has been discharged home and the ER care team is no longer on-shift, a critical result should be communicated to the Emergency Department Alpha-pod attending, who will review the patient's records and determine appropriate follow-up.
- Discrepancies need to be clearly documented. The radiology report should describe the sequence of communications.
- The resident should actively seek out the attending faculty member when needed, and particularly if an imminent management decision requires clarity of the imaging result.

Informal Corrective Measures

Remediation, Probation, and Written Letter of Warning and Dismissal

A comprehensive evaluation and remediation program is an essential component of any residency program. The Clinical Competency Committee (CCC) acts as a standing committee within the residency program, addressing resident issues, and evaluating resident progress within the program and as such is responsible for evaluating promotion to PGY levels, meting graduation requirements, and issuing recommendations to the Program Director for residents requiring informal corrective measures, formal remediation, probation, written letter of warning or concern and dismissal, as necessary.

Non-disciplinary responses to substandard performance may include but are not limited to: informal corrective measures (*not reportable to accrediting or credentialing authorities*), formal remediation, probation status, or a written letter of warning or concern. The decision to act based on poor performance is within the discretion of the Program Director after the recommendations by the CCC have been reviewed.

The CCC evaluation system is designed to identify problems accurately and early to allow residents with problems to be assigned to an informal corrective measures program or formal remediation program that effectively deals with them, with mentorship and supervision. Elements of our proactive remediation program include a process for outlining deficiencies, providing resources for improvement, communicating clear goals for acceptable performance, and reevaluating performance against these goals.

Informal corrective measures will typically be considered the initial step prior to placing a trainee on formal remediation status, depending on the circumstances. It is important to distinguish between informal corrective measures and placing a trainee on a formal remediation plan due to external reporting consequences: *see Partners GME Guidelines Regarding Trainee Non-Disciplinary Remedial Actions on Reporting and Review for further information*:

https://www.partners.org/Assets/Documents/Graduate-Medical-Education/Policies/Remediation-Probation-House-Staff-080317.pdf

Formal Remediation is undertaken before Probation is considered. However, in some circumstances the deficiencies may be so acute and significant as to warrant more definitive action, including Probation, when first noted. Particularly when misconduct is involved and depending on the severity as decided by the CCC and Program Director, a single event may be the trigger for action, without warning or a history of negative feedback.

Non-disciplinary actions will be considered by the CCC for a trainee who is not meeting the program's performance or behavioral standards relating to one or more of the ACGME Core Competencies (listed below) or to other aspects of performance or behavior, including misconduct.

1. Patient Care
2. Medical Knowledge
3. Practice-based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-based Practice

Objective and subjective evaluation methods including milestones data to be reviewed three times per year by the Radiology Residency Clinical Competency Committee:

1. Electronic Resident Rotation Evaluations: Online ACGME competency-based evaluation forms (New Innovations) incorporating many of the required ACGME radiology milestones is completed by individual faculty members or the educational faculty liaison for each section following discussion with the other section members after each rotation.
2. ACGME Milestones requirements: Includes first year OSCE scores, ACR In-service scores or equivalent examination scores, board scores, conference attendance, peer review surveys, record of successful attainment of specified technical skills, scholarly activities, semi-annual evaluation completion, and 360-evaluations in select rotations.
3. Documentation of verbal, written or email communication regarding a resident related to the ACGME Core Competencies including cognitive and or behavioral processes from other sources such as the Education Committee, other faculty, residents, staff or Program Director.
4. Questions or Comments raised by the Education Committee Members or other faculty regarding a resident competence will be directed to the CCC for review.

When confronted with a resident performance issue, a fair and comprehensive assessment and investigation will be performed in a timely manner by the CCC to fully describe the nature and severity of the problem and identify any secondary problems leading to suboptimal performance. This includes the following steps:

1) Meet with the assigned Faculty Mentor to review any issues or have mentor meet with resident
2) Discuss with the resident
3) Address relevant investigative questions to determine the true nature of the problem and its effects on other residents, staff, patients and/or faculty members.
4) The CCC may need external physician evaluation. Secondary issues need to be addressed before any corrective action or remediation.
5) Occasionally the CCC may require legal counsel before any action in which there is doubt about correct course.
6) If corrective measures are required:
    a) Decide whether resident remains on usual duty or not
    b) All efforts are made to maintain confidentiality and respect the resident's privacy. The Program Director will update the resident schedule with the assistance of the Residency Program Leadership and Chief Residents per this mandate.

Once a problem is detected and the CCC identifies that a problem exists with that resident, the resident must be:

1. Notified in writing and in person by a member of the Clinical Competency Committee and/or Education Liaison and the Program Director of the nature of the problem and its potential impact on his/her career.
2. Given the opportunity to review the concerns and respond to those concerns. A meeting with the Faculty Mentor and/or CCC member will satisfy this requirement.

Based upon this analysis, a decision will be made as to whether an intervention is necessary and what kind of intervention is required.

To establish the optimal plan, it is necessary to correctly diagnose or categorize the problem into one (or potentially both) of the following categories so the plan can target the unique issues limiting the resident's success:

- **Primarily cognitive** (related primarily to one's knowledge base and cognitive skills) in nature
- **Primarily non-cognitive or behavioral** (related primarily to difficulties with professionalism and interpersonal communication) in nature

Although cognitive problems are typically amenable to traditional instructional methods, non-cognitive or behavioral issues are more likely to respond to other methods, such as close monitoring/feedback of attitudinal and interpersonal behaviors for ''mild'' problems and referral to the Employee Assistance Program and/or a mental health profession such as psychologist or psychiatrist for residents with serious psychological symptoms.

Educational Corrective Action Plan (ECAP)

If an intervention is deemed appropriate, the CCC is responsible for developing a time-limited individualized Educational Corrective Action Plan (ECAP) which can be an informal corrective measure plan, remediation plan or probation, following the policies and procedures of the CCC. There are 2 types of ECAP:

- **Informal Corrective Measures or Formal Remediation** - program of intensive tutoring designed to help the resident improve knowledge and skills. (Primarily for Cognitive issues)
- **Probation** – wherein the primary intervention is to clearly warn a resident that behavior is wrong and must be stopped. (*Primarily for Non-cognitive or Behavioral Issues - see Probation discussion below*)

Informal Corrective Measures or Remediation Plan

For any resident issue requiring initial Informal Corrective Measures or Formal Remediation, an individualized time-limited and faculty mentored Educational Corrective Action Plan (ECAP) with specific goals and objectives will be developed by the supervising faculty member, with input from the resident as well as a resident advocate (usually the resident's faculty mentor or other faculty member) for final review by the PD. The resident will be notified in writing as well as in person of this process.

The faculty supervisors, PD and resident need to adhere to the specifics of the plan and be consistent. The faculty mentor will assist the resident via a tutor meeting regularly with the resident. A written contract documenting the reasons for corrective measures, the steps to be taken within the individualized learning plan, the desired outcomes and the consequences of failure of plan, outcomes and consequences will be reviewed and signed by all involved: the resident, CCC chair, Core Faculty Resident Liaison, Faculty Mentor and PD. This will serve as the "contract'' that lays out the rationale for informal corrective measures or remediation, the specific details of the plan, and the expectations of each party. All involved will also be required to formally sign-off on any other investigations, changes in remediation plans, or updates. A copy of the ECAP learning plan and contract will be given to the resident, and another copy placed in the resident's file.

NOTE: If the Section Faculty Education Supervisor is a member of the CCC, that individual cannot vote on the outcome of the resident's case at the CCC review.

Documented Components of the Informal Corrective Measures or Remediation Plan

1. Core competency being addressed
2. Detailed description of the events⁄behaviors that led to corrective measure
3. Time frame for remediation

4. Objective measures being used to assess compliance and success
5. Approximate schedule for meetings with the program director or designee
6. Individualized learning strategy and plan
7. Consequences of failure to successfully remediate
    a. May include additional sanctions, more intense interventions, and/or the potential for probation or dismissal or termination.
8. What information will/may be communicated to others and to future employers. Need to review verbiage and provide accurate proposed written and communicated information for future use with licensing or with future employers with the resident.
9. Dated signatures of all relevant personnel

Personnel Involved in the Educational Corrective Action Plan

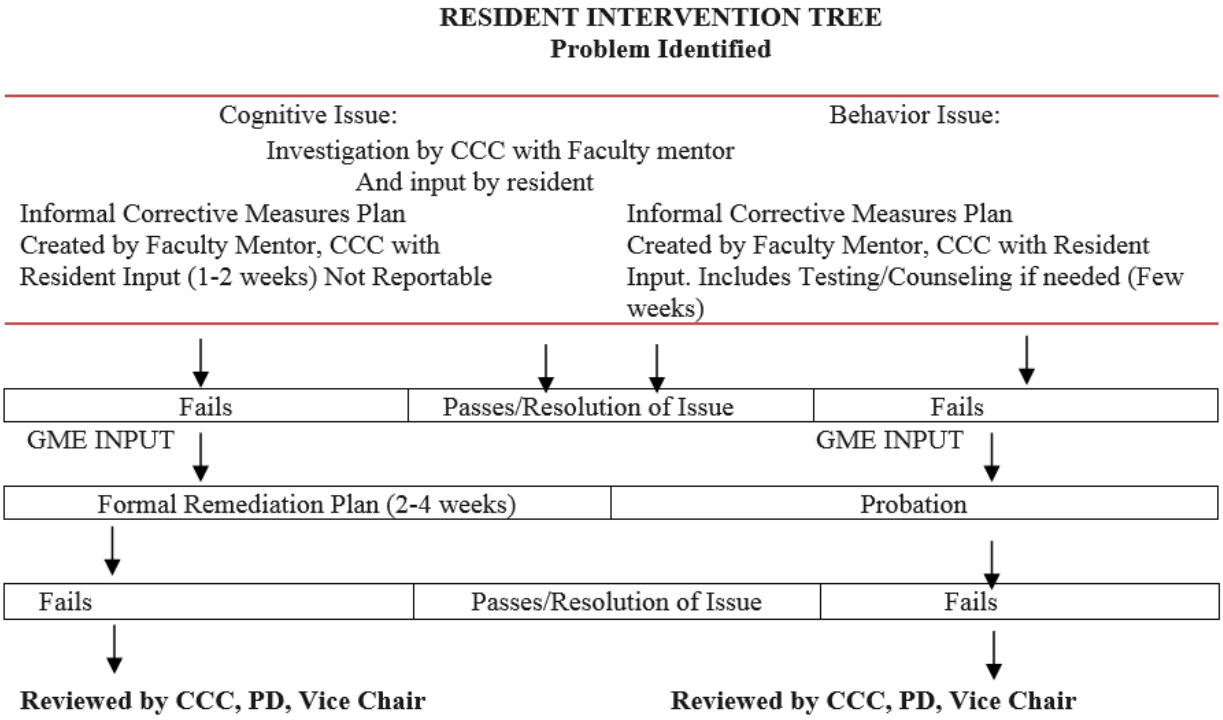
Residents are encouraged to choose an advocate for interventional plan discussions who can be their faculty mentor or other individual. Alternatively, an impartial intra- or extra-departmental faculty member or advisor can be assigned to assist. They may be present during the explanation of the problem and proposal of remediation as well as throughout the process. A faculty mentor may be chosen to help facilitate the discussion and plan and monitoring of the plan with the resident and CCC. During remediation, the same individual should maintain the supervisory role throughout the process, typically someone from the section in question. Prompt responses should follow any deviations from the plan.

Monitoring

The specific methods of monitoring a remediating resident will be based on the deficiency in performance and will be objective, measurable, appropriate, feasible and realistic. At pre-specified intervals, the resident's progress and adherence to the plan will be evaluated. At least quarterly reassessments of progress are required by the ACGME.

Consequences

The CCC, Faculty Supervisor and Program Director will adhere to and implement pre-specified consequences for unmet expectations that will be provided to the resident prior to the implementation of the plan. The typical plan as devised by the BWH CCC is outlined in the Resident Intervention Tree provided below.



Resolution of intervention

After the specified corrective period, the Program Director will meet with the CCC chair to determine whether the informal corrective measure or remediation was successful. The ideal plan will have objective means by which to assess performance and outcomes. The resident may be formally re-evaluated after the time period, or re-evaluation can be ongoing. Informal corrective measures/Remediation ends when the resident either successfully incorporates new information that puts the resident at or above the minimal acceptable standards for the program, or fails to adhere or successfully achieve the terms of remediation.

Successful outcome

1. Resident can resume their positions within the training program
2. May necessitate extension in the time period for residency training.
3. Both Informal Corrective Measures and Remediation are to be documented in the resident's file, however only Remediation is reportable for future information.
4. Periodic reassessment is often warranted to ensure that the resident continues to maintain the behaviors that were remediated.

Resident not meeting Informal Corrective Action Plan requirements

If it becomes apparent that a resident is not meeting the goals of Informal Corrective Actions Plan, the resident will be reviewed and if failure occurs the resident will be put on formal Remediation with construction of a formal timed plan and contract as noted above.

Resident not meeting Formal Remediation Plan requirements

If it becomes apparent that a resident is not meeting the goals of the Formal Remediation Plan:

1. The early involvement of the Partners GME and/or Partners Office of General Counsel is essential.

2. Excellent documentation, adherence to due process, and fair and equitable treatment are essential.
3. The resident will be given written notice of the assessments and will be provided access to the relevant policies pertaining to resident probation, termination, and disciplinary action. (*See Partners GME Documents in Appendix*)
4. The resident should be counseled about his or her options. It is strongly recommended that these discussions occur with an unbiased third-party present.

Probation

In this scenario, non-cognitive or behavioral issues are paramount (e.g. referral for anger management therapy). This may be more open-ended for surveillance purposes and surveillance may continue after the probationary period. In rare cases, if the resident issue is severe enough, Probation may be selected as the first intervention rather than Informal Corrective Measures or Formal Remediation. If Probation requirements not met, dismissal is the next option. See the Partners GME Document available online: Adverse Actions: BWH Radiology Department adheres to the Partners GME Graduate Trainee Adverse Actions Policy

http://www.partners.org/Assets/Documents/Graduate-Medical-Education/Policies/RemediationProbation-Guidelines-121414.pdf

Summary:

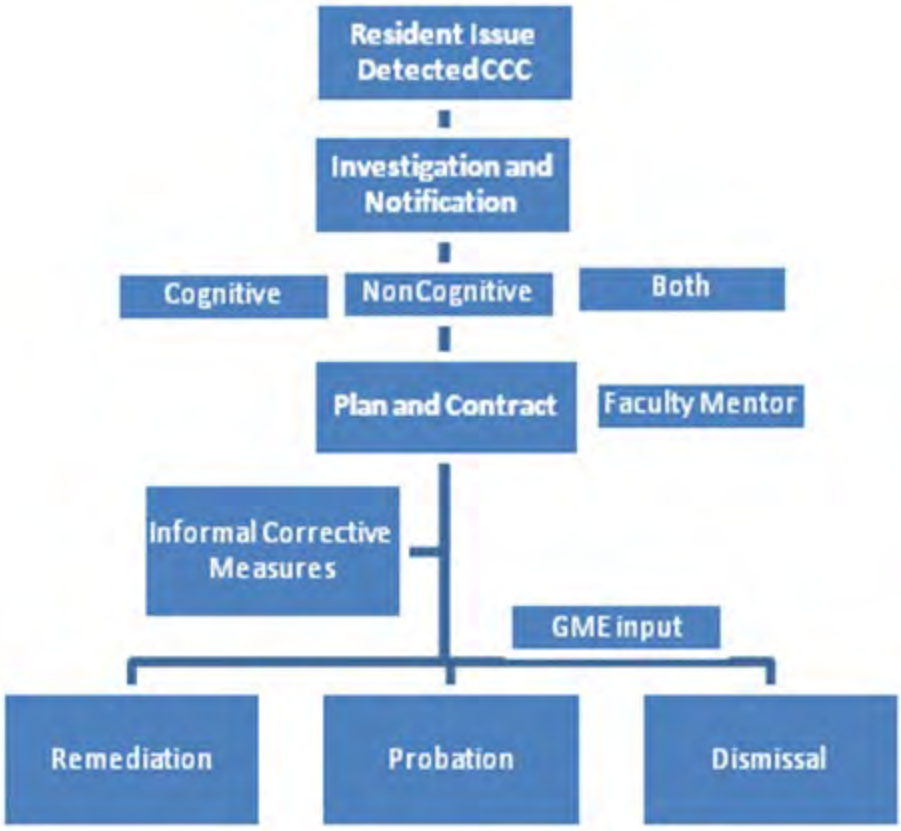
CCC Plan and Responsibilities for Issues with Residents:

1. Investigate issue at hand.
2. List objective problems and decide whether primarily a cognitive or non-cognitive issue or both exist. Begin with initial Informal Corrective Measures and further evaluate need for Formal Remediation. After which will determine whether severe enough for potential Probation or dismissal using directives as outlined by Partners GME documents.
3. Plan to intervene with corrective measures using Resident Intervention Tree.
4. Faculty supervisor involved from section in question, with inclusion of Faculty Mentor or advocate by association with resident or other for investigation and review with resident

Resident Responsibilities if issues arise:

1. Meet with CCC representative/Section Supervisor/Resident Liaison, Faculty Mentor and/or PD to discuss issue and have input
2. Acknowledge problem or provide other information which may impact current issue and eventual plan implementation
3. Work with Faculty Mentor and Faculty Supervisor on Informal Corrective Measures Plan or Formal Remediation Plan with goals, deadline and consequences if goals not met. Sign contract for plan.
4. If failure of corrective measures, CCC develops Formal Remediation Plan with resident and faculty mentor and supervisor with oversight by PD for measurable goals and deadlines and consequences.

**If member of CCC is the Faculty mentor best suited for the role of working with the resident in question, they must present the outcomes material to the CCC but recues themselves from the final decision-making process regarding possible resolution versus incomplete resolution of the problem for that resident.*



GMEC Policies and Procedures online at BWH:

All Partners GME policies are provided on the website – see the link below.

http://www.partners.org/Graduate-Medical-Education/Policies-Resources/Policies.aspx

Adverse Action and Redress of Grievances including trainee contract attachments can be obtained through this link. In general, all issues pertaining to remediation, probation and dismissal should be discussed with the Program Director or Partners GME Director.

In-House On-Call Coverage: Saturday, Sunday, and Holiday Call

All Saturdays, Sundays, and hospital Holidays throughout the year are covered by the second, third- and fourth-year residents. For each Saturday, Sunday, and holiday call day worked, the resident will receive a "flexible" vacation day, in addition to the vacation days granted to all residents. This amounts to approximately 4-5 days per year. These "flexible" vacation days are subject to the same scheduling restrictions as described in the *Vacation Approval* section above.

- Shifts are from 10:00 AM to 7:00 PM.
- The resident covers the Radiology Resident On-Call Pager (#11883)
- This call is covered by
    - Second Years: (4-5) In-House shifts per year
    - Third Years: (4-5) In-House shifts per year
    - Fourth Years: (4-5) In-House shifts per year

In-House On-call Saturday, Sunday and Holiday Call Responsibilities

- Covers the On-Call pager (#11883) and refers any requests for reads to the appropriate sections
- 10:00 AM – 1:00 PM: the resident is stationed in the Neuroradiology reading room with the attending and covers all neuro CT, CTA, and MRIs, and ED neuro CTAs and MRIs.
- 1:00 PM – 2:00 PM: the resident ties up loose ends and eats lunch.
- 2:00 PM – 5:00 PM: the resident is stationed in the CV reading room but works remotely with the attending and covers all abdominal CT, MRIs, and radiographs, as well as fluoro studies as needed.
- 5:00 PM – 7:00 PM: the resident remains in the CV reading room and assumes the responsibilities of the Consult resident until 9 PM when the Consult resident assumes responsibility for the on-call pager.

Mentoring & Advising

First-Year Advising & Coaching: First year of residency poses unique challenges frequently encountered at the beginning of Radiology residency training and mentoring and advising first year residents are crucial to ensure a successful transition from internship to residency. We encourage all residents in the first-year class to solely focus their energy into learning the basics of clinical radiology. The first years are paired with a First-Year Advisor, one of the Associate Program Directors, who coordinates a bonding activity in the late summer, encourages class camaraderie and interaction, and conducts 1:1 meetings three times during the first year. The First-Year Advisor meets with the first-year residents individually semi-annually to review their evaluations and clinical performance. The residents complete a self-assessment form designed to initiate conversation about their long-term career goals. These conversations are designed to help the residents "see the forest through the trees" early in residency and enable the residency leadership to direct residents toward appropriate opportunities, courses, and staff, helping them to use the resources available at BWH to the fullest during their residency. In the spring, residents are encouraged to begin thinking about scholarly/research projects, select a faculty mentor and further help the residents hone goals and determine areas of extra-clinical specialization. The first-year resident advisor has an "open door policy" with the high accessibility, visibility, and availability.

Resident Mentoring after First Year: Rising second-year residents are assigned a Faculty Mentor and as part of the BWH Radiology Residency Mentoring Match Program. This provides a formal mentee/mentor match allowing for closer alignment of individual interests, career goals, etc. for the next three years of residency. The program includes a formal mentoring contract, access to mentoring and mentee toolkits and online literature, and quarterly Mentor/Mentee Meeting times provided during the work day (during the standard resident conference time) allowing for increased mentor accessibility and continuity of the program.

Moonlighting

Residents are permitted to moonlight in accordance with the Partners GME Policy (http://www.partners.org/Graduate-Medical-Education/Policies-Resources/Policies.aspx) regarding professional activities outside the scope of the educational program. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety. Time spent by the resident in internal and external moonlighting must be counted towards the 80-hour Maximum Weekly Duty Hour Limit.

All moonlighting occurrences must be documented and sent to the Residency Program Director for approval. The following residents are permitted to moonlight:

Second-Year Radiology Residents:	Non- interpretive radiologic services
Third-Year Radiology Residents:	Non- interpretive radiologic services
Fourth-Year Radiology Residents:	Full License - can moonlight at outside departments

Prior to accepting any moonlighting responsibilities, the resident must submit to the Department Chair and/or Program Director a letter in writing listing the institutions for the moonlighting activities, the scope of the proposed activities and the maximum number (per-week and per-month) of the proposed moonlighting hours.

The resident must receive from the Program Director or the Department Chair (1) a signed copy of the letter, indicating permission to proceed and (2) the malpractice (CRICO) form signed prior to beginning of the moonlighting. Blank copies of the forms are kept on the resident Radcommons website, or can be obtained from the Resident Moonlighting Coordinator, and a copy must be sent to the Program Coordinator.

For weekday evening moonlighting shifts at 850 Boylston St, residents must be dismissed by their section by 4:30PM, in time to board the 4:45PM BWH-850 shuttle to ensure arrival by 5:00PM. In addition, for the 850 weeknight moonlighting shifts, the resident must carry the emergency contact telephone. This can be retrieved the covering afternoon attending (usually stationed in the 5th floor Mammo/US reading room) or from the MR technologist if the departing attending has already dropped it off.

For weekday and weekend moonlighting shifts at Foxborough and West Bridgewater, travel expenses will be reimbursed. For weekday moonlighting shifts at 850 Boylston St, travel expenses to BWH or home at the end of the shift are reimbursed only if you must stay late past 8:00PM for an ongoing scan and miss the BWH-850 shuttle. Expenses can be submitted in the month following the month when expenses were accrued and must be submitted in a single expense report with each trip as a separate line item. The appropriate expense codes vary based on site and can be obtained from the Resident Moonlighting Coordinator. A copy of the credit card statement with name, and to/from address should also be included as an attachment. For weekday moonlighting shifts at Foxborough, residents will be compensated for an hour of travel time in each direction, at the same rate as the normal moonlighting rate.

At all outpatient moonlighting facilities, the resident must remain at the site for the entire time slot, even if no contrast studies remain on the schedule to accommodate potential add-on cases.

The Resident Moonlighting Coordinator administrates and coordinates internal moonlighting with the training program, in collaboration with the Chief Residents.

Moonlighting Coordinator details:

Job Description

The Resident Moonlighting Coordinator responsibilities are the following:

1) Arrange contrast coverage moonlighting for the various Brigham Health sites every quarter.
   a) Brigham Health Radiology administrative leadership will post moonlighting opportunities including sites and hours as soon as they are determined.
   b) A pool of residents and fellows who are interested in moonlighting will be created; these trainees must be designated as trainees “in good standing” and have the approval of their Program Director with completed documentation in order to participate.

   c) Resident availability to moonlight will be solicited from the trainees 1-2 months prior to each quarter.
   d) The Resident Moonlighting Coordinator will be responsible for making shift assignments while taking into consideration resident availability to ensure equitable distribution of shifts and minimize interruption to educational training and clinical responsibilities.
   e) The shift assignments will be made in the month prior to each quarter and published in the form of a google document accessible to all residents and on Amion.
   f) The Resident Moonlighting Coordinator will also manage any coverage change/swap/cancellation requests to ensure adequate coverage and update the Google doc and Amion schedule accordingly.
   g) If there is no available resident, the Coordinator will solicit fellows or others for moonlighting coverage.
2) Submission of moonlighting payrolls
   a) The Resident Moonlighting Coordinator will be responsible for submitting accurate monthly moonlighting payroll information to the department Finance leadership at the beginning of the following month.
3) Liaison with department leadership and administration
   a) The Resident Moonlighting Coordinator will serve as the liaison between the residents and the department leadership and the imaging sites' leadership on all moonlighting-related matters.
   b) This includes keeping track of changes in days and hours of moonlighting coverage at the various sites and updating the moonlighting schedule and informing the residents accordingly.
4) Provide resources and guidance to eligible trainees regarding moonlighting
   a) The Resident Moonlighting Coordinator will work with the resident web development committee to ensure that moonlighting related information on the resident website is up to date. This includes information on credentialing and site-specific information for first-time moonlighters.
   b) Address any questions from residents regarding moonlighting policy.

Timeline

The moonlighting coordinator role will be a 13-month position (running from February to February), with a 1-month overlap in the month of February between the outgoing and incoming moonlighting coordinator. The moonlighting coordinator will be granted a stipend of $2,500 for the 13-month term.

Selection Process

The Chief Residents will solicit applications for the Resident Moonlighting Coordinator position around December of each academic year and selected with the consultation of the Residency Program Director. The Resident Moonlighting Coordinator must remain "in good standing" for the duration of the appointment. Any R2 or R3 resident who has previously moonlighted will be eligible to apply. If there are no eligible R2 or R3 residents for this position, an R4 will be selected for this position for February-June, followed by selection of an R2-R4 for July-January.

<u>Template letter between resident requesting moonlighting privileges and the Program Director or Department Chair:</u>
Date:

Dear Dr. [Program Director or Department Chair]:

I hereby request permission to engage in professional activities outside the scope of my residency-training program (i.e. "moonlighting"). Specifically, I request permission to work at the following health care facilities: (note: include "home" institution/s if applicable)

1. _____

2. _____

3. _____

4. _____

I will limit the hours of moonlighting to within work hour requirements and will not allow my "duty hours" (i.e., the sum of time spent in the training program plus time moonlighting) to exceed limits set by the Program Director and by the ACGME and the Diagnostic Radiology Residency Review Committee (RRC). The ACGME duty hour requirements may be found at https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/420_DiagnosticRadiology_2019_TCC.pdf?ver=2019-03-28-091211-973 f and include the following:

Duty hours must be limited to no more than 80-hours per week, averaged over a four-week period including all moonlighting and in-house call. Time spent in internal and external moonlighting must be counted towards the 80-hour maximum weekly hour limit.

Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks).

Intermediate level residents (Years 1-3) should have 10 hours free of duty and must have 8 hours between scheduled duty periods.

I recognize that the residency program is my highest professional priority and I will not let additional professional activities interfere with this. I have read and understand the Partners Graduate Trainee Moonlighting Policy and will abide by it.

Sincerely, _____

Resident name

Approved _____

Program Director / Department Chair

New Innovations

New Innovations (NI) (http://www.new-innov.com/) is the residency management site that Partners GME uses to administer resident schedules, evaluations, procedure logs, conferences, and duty hours. The Radiology Residency uses this site to store all demographic information, licensures, certifications, curriculum vitae, and other pertinent documents.

Logging in: *Please note: login is case sensitive*

Institution login will always be: PARTNERS

Username:

Password:

After your login, the first time there is an option to change your password.

Evaluations

Evaluations are a crucial component of your residency. Not only are they an ACGME requirement, but they are also reviewed by the Program Director and Clinical Competency Committee to assess your performance and review comments from the faculty, peers, and 360 evaluators. All evaluations should be completed through the New Innovations site.

Residents will receive a notification email from New Innovations when an evaluation is required. The evaluation should be completed as soon as possible. Failure to complete the evaluation by the due date assigned will result in continued delinquent evaluation notifications until all evaluations are completed. Remember, evaluations are an ACGME requirement and considered a component of professionalism. It is important to complete all assigned evaluations in a timely fashion and failure to do so will be considered a metric for the Clinical Competency Committee. If the evaluation you are being asked to complete is not accurate, please notify the Program Coordinator.

After each rotation, a resident is required to complete an evaluation via New Innovations for each of the following:

- Rotation Evaluation
- Evaluation of Faculty/Attending Evaluation with whom a resident has worked

Annually, each resident will be required to complete the following evaluations:

- Annual Program Evaluation (in New Innovations)
- Annual Program Resident Survey (administered via the ACGME)

Clinical and Educational Work Hours (formerly Duty Hours)

The Brigham & Women's Hospital Radiology Residency Program is dedicated to ensuring that our residents receive an excellent education while ensuring patient safety and resident well-being. For the program to meet ACGME requirements, every resident must accurately record all clinical and educational work hours. All work hour surveys sent by the GME office must be completed. Proper and accurate documentation of clinical and educational work hours is required and will be utilized as a measure of Professionalism for the ACGME Milestones requirement.

- Clinical and educational work hours include clinical and academic activities related to the residency program, administrative duties, and time spent in-house during on-call activities
- The ACGME work hour requirements may be found at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf
- It is the mutual job of each resident and the Residency Program Leadership that Work Hours be limited to 80-hours per week, averaged over a four-week period including all moonlighting, in-house call and clinical work done from home.
- Each resident must have a minimum of one day free of all clinical duties (a continuous 24-hour period) every week (when averaged over 4 weeks). At-home call cannot be assigned on these free days.
- Each resident should be given adequate time for rest; residents should have eight hours off between scheduled clinical work/education periods.

- Clinical work periods must not exceed 24 hours of continuous scheduled clinical assignments. Additional patient care responsibilities must not be assigned to a resident after this time. Up to 4 hours of additional time may be used for activities related to patient safety.
- Residents must have at least 14-hours free of duty after 24 hours of in-house duty.
- Residents must not be assigned in-house call any more often than every third night, averaged over a four-week period. (*Note: This excludes on-call beeper coverage from home*).

Procedure Logs and Resident Learning Portfolio

- Case Logs required by the ACGME are recorded by the Department Quality Dashboard through Partners BWH Radiology Analytics (https://radiologyanaylytics.partners.org). A separate Case Log is provided by the Children's Hospital Radiology rotations in the evaluation.
- All your BWH procedures and dictated cases are saved in a database such as in Epic and/or RedCap QA Database, for which your name is **not** on the final report should be recorded by you, given to the Program Coordinator and placed in each resident's individual residency folder for documentation.
- As per the ACGME, each resident must maintain a Resident Learning Portfolio.

Conferences

Residents can view the schedule for morning and noon conferences in New Innovations. Conference attendance is mandatory and required as a measure of the ACGME Professionalism Milestones Requirement. Residents are required to log their conference attendance in NI on a daily basis.

Night Float Rotation (On-Call)

BWH Radiology Night Float (NF) rotation is based on a weekly call system that is covered by second, third- and fourth-year radiology residents. The average distribution of overnight call for each resident during the duration of residency is approximately as follows:

Second year:	2 weeks
Third year:	2 weeks
Fourth year:	1 weeks

The week-long Night Float rotation consists of six shifts beginning on Sunday evening and ending on the following Saturday morning. All shifts will be 10:30 PM to 7:30 AM. The Saturday Night Float shift will be covered on a rotating basis and will also run from 10:30 PM to 7:30 AM. The NF resident is not expected to attend resident morning or noon conference.

Night Float Responsibilities

- Refer to the *First Actionable Communication Transparency (FACTs): Details for Residents* document for the most up-to-date responsibilities of the NF resident as the duties may change over the course of the academic year.
- At the time of this writing, after-hours residents (both Consult and Night Float resident) will sit in Shapiro L2 CV reading room to cover the COVID-19 Shapiro scanner.
- During the overlapping period between 10:30 PM and 2:00 AM, when both the Consult and Night Float residents are on-site, inpatient cases and ED cases can be distributed at their discretion and in conjunction with the ED attending. However, the Consult resident will preferentially be responsible for inpatient

examinations (as discussed in the "Consult Rotation" section) while the NF resident is preferentially responsible for ED exams.

- The NF resident will then solely cover the Resident On-Call Pager (#11883) from 2:00 AM to 7:30 AM as the Consult resident will end their shift at 2:00 AM. At that time, the Consult and NF residents should communicate to discuss any unresolved issues, urgent pending studies, and to confirm pager hand-off.
- The NF resident will provide coverage of all ED studies, including radiographs, ultrasound, CT/CTA, MRI, and extremely rare fluoroscopy. Acute stroke and cord compression MRI/MRAs on ED patients performed during the NF shift are read by NF resident. (7 AM – 7 PM these are covered by the Neuroradiology division and the Neuro On-Call Fellow).
- ED neuro MRI studies other than acute stroke and cord compression protocols during the NF shift should be reviewed and dictated by the NF resident if the requesting physician is an Emergency Medicine physician and the patient's disposition hinges on the MRI result. All MRIs performed for tumor assessment, surgical planning, and multiple sclerosis evaluations and MRIs requested by Neurology/Neurosurgery (patient slated for admission regardless of MRI results) may be referred to the Neuro On-Call Fellow or preliminary reads placed with final read deferred to the neuroradiology division at the discretion of the ED attending faculty member.
- The NF resident also covers BWH and NWH ED studies. Refer to the Emergency Radiology resident manual for details of hours of coverage.
- Once the Consult resident has left at 2:00 AM, the NF resident should review and issue a preliminary read on STAT inpatient CTs, MRIs, abdominal US, and MSK US performed, as well as any inpatient CT, MRI, or radiograph for which they are called. Communication of results should be documented using the ANCR system. Refer to First Actionable Communication Transparency (FACTs): Details for Residents document for further details. The resident will also generate a "sticky note" within Visage saying "ANCR" with a short summary if possible, to ensure that the radiologists reviewing the study are aware that communication already took place on this case. If the NF resident does not feel comfortable issuing an actionable report on an exam (e.g., CTA or MRI) or is unable to do so within a reasonable time frame due to time constraints, he/she can first ask the ED attending for a second opinion. If not available, then should request that the case be reviewed by the fellow-on-call for the respective division via purple ANCR page using the "Consult" category. Make sure the page option is checked as the fellows are not expected to check their emails after hours.
- After-hours inpatient ultrasound preliminary interpretations will be performed by the in-house sonographer.
- Vascular ultrasounds will be performed by the Vascular US department until 5 PM during weekdays and until 3 PM on weekends. After these hours, lower extremity vascular US will be performed by the ED/inpatient US technologist and all ED vascular ultrasounds will be reviewed by the ED/NF resident and ED attending faculty member.
- For after-hours upper extremity vascular US, the NF resident should direct requests to the Vascular Lab.
- Performance of fluoroscopy overnight is generally not feasible due to the volume of ED cases and therefore fluoroscopy studies may be deferred to the next morning.
- All nuclear medicine studies (including V/Q, GI bleeding scans, gallium scans, etc.) are covered by the on-call Nuclear Medicine Fellow.
- The radiologist officially interpreting studies that have been preliminarily reported by the overnight resident are responsible for notifying the requesting physician of any major discrepancies between the preliminary read and the final report. In this case, a new ANCR should be submitted by the resident/attending faculty

member who officially interprets the study. Additionally, the "Worth Another Look - Purple ANCR" system is used in the morning to notify the on-call resident of any major discrepancies or missed findings.

Patient Safety, Quality Improvement Education and Project Requirement

Residents will receive training and experience in quality improvement processes, including an understanding of health care disparities. This is achieved via educational resources through the Partners GME office and through a dedicated residency curriculum in Quality and Patient Safety. Each resident is required to participate in at least 1 Quality Improvement Project prior to successful graduation and as part of the Milestones requirements. A summary of the project including mentor, title, statement of the problem, literature review and quality improvement plan with outcome is required for successful completion of the program. On a semi-annual basis, each resident's project will be reviewed, along with each resident's quality metrics and benchmarks related to their patient populations. Residents are given the opportunity to participate in interprofessional quality improvement activities through individual divisional participation in interdisciplinary conferences and via the resident-led monthly "Difficult Cases/QA" Conferences.

Through Hospital-wide and Departmental initiatives, residents can actively participate in patient safety systems and contribute to a culture of safety. The hospital provides formal educational activities that promote patient-safety related goals, tools and techniques, including the use of Safety Reporting (https://bwhcsafetyreporting.partners.org/RL6_Prod/Homecenter/Client/Home.aspx). Residents should participate as team members interprofessional clinical patient safety activities, such as root cause analysis, as well as formulation and implementation actions, through selected participation in hospital-wide patient safety and quality committees. Education is achieved through dedicated resident conferences in these topics including training and participation in the disclosure of patient safety events.

Professionalism

As per the ACGME, the residency program in partnership with the Partners GME office, provides a culture of professionalism that supports patient safety and personal responsibility. Residents must demonstrate an understanding of their personal role in the:

- provision of patient- and family-centered care;
- safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
- assurance of their fitness to work, including
    - management of their time before, during, and after clinical assignments; and,
    - recognition of impairment, including from illness, fatigue and substance abuse, in themselves, their peers and other members of the health care team.
- commitment to lifelong learning;
- monitoring of their patient care performance improvement indicators; and
- accurate reporting of clinical educational work hours, patient outcomes, and clinical experience data.

In addition, residents are required to adhere to the prompt and timely completion of required professional activities including on-time attendance at resident conference, completion of mandatory paperwork for credentialing and reporting agencies (e.g. Healthstream modules, Duty Hours reporting, Partners GME & ACGME

Surveys), and adherence to institution-wide policies. Delinquency in completion of these professional activities will be referred to the CCC for further action as needed.

All residents must demonstrate responsiveness to patient needs that supersedes self-interest. This includes recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified resident.

The residency program provides a professional, respectful, and civil environment that is free from mistreatment, abuse or coercion of students, residents, faculty and staff. Education regarding unprofessional behavior and a confidential process for reporting, investigating and addressing such concerns is provided in conjunction with the Partners GME office.

Promotion and Re-appointment Requirements

The Clinical Competency Committee (CCC) will be responsible for providing recommendations to the Program Director for Resident Promotions and Reappointment. The CCC is chaired by an Associate Program Director.

The CCC meets three times per year to review each resident's evaluations, the 6 ACGME Core Competencies and subcompetencies, including the Milestones and other evaluative data. The CCC provides recommendations to the Program Director regarding appropriate progression and promotion of each resident to the next year of training, as well as potential issues that may require intervention. Residents will progress through the Core Curriculum in the first 3-years of the 4-year residency with the fourth-year consisting of primarily electives within a focused interest or 'mini-fellowship' program which can include Core Rotations.

For each rotation, specific competency-based guidelines are in place detailing the goals and objectives, ACGME Milestones, and evaluation process for the rotation. Residents must meet the goals and objectives in each rotation and achieve Meets or Exceeds Expectations on their New Innovations evaluation to be advanced to the next level in that section. Other competency-based ACGME Milestones and evaluation methods (i.e.: 360-Evaluations, passing grades on first-year rotation specific OSCEs and specified attendance at residency conferences) are integrated into each year of the residency program and are outlined in the CCC Milestones document provided to all residents at the beginning of their training. The resident must successfully pass; achieve Meets or Exceeds Expectations in these Milestones/Competencies to advance, as these are additional methods used by the Clinical Competency Committee (CCC) to evaluate the resident.

a) While a resident can still graduate without having fulfilled all 5 levels of the milestones criteria, it is recommended that the resident attain at least their respective year level of the Milestones along with their peers.
b) NOTE: Occasionally there may be circumstances that delay completion of the requirements within the stated timeframe of each rotation (e.g. pregnancy, illness or lack of a particular study available to the resident during their rotation time). This must be discussed with the Division Chief/Resident Liaison and Residency Program Leadership and a plan put in place to achieve the Milestones competency at the next rotation or at another time to meet the requirements. This information should be entered into the resident's New Innovations Portfolio and provided to the Program Coordinator at the time of the rotation for the CCC review.

Residents must complete all hospital records in a timely fashion to maintain hospital privileges.

As per the Partners GME Guidelines, each resident must successfully complete all required clinical rotations, required OSCEs, evaluations, and required ACGME Milestones, show competence in all 6 ACGME Core Competencies, maintain the required attendance at Resident Conferences and complete year-specific knowledge goals, as noted below, for advancement to the next year accordingly:

Criteria for assessment of Promotion

TO 2ND YEAR- demonstrates sufficient skills and knowledge to take call. Successfully passed all first year OSCEs and first year rotations. Knows when to ask for back-up, utilizes resources such as textbooks and on-line information to improve skills and knowledge. Professional and responsible. Able to communicate via written reports and verbally to patients and health care team. Demonstrates satisfactory interpersonal skills with radiology team (including administrative staff, technologists and nurses), patients and referring physicians. Demonstrates sensitivity to cultural diversity in the workplace.

TO 3RD YEAR- As above and demonstrates sufficient knowledge of core subjects to progress to more complex modalities and subspecialty training. Plans and performs appropriate procedures and obtains consent. Has attained technical skills and Milestones for 3rd year trainee.

TO 4TH YEAR- As above and demonstrates increased ability to act as a consultant with greater ability to work independently. Demonstrates knowledge of complex radiologic techniques, procedures and interpretation. Aware of best radiological practices and makes an effort to minimize cost and radiation dose in accordance with them. Professional and ethical in all activities.

GRADUATION– Demonstrates sufficient competence to enter practice without direct supervision, completion of both the Scholarly Project and Quality Improvement (QI) project, completion of residency survey, completion of all ACGME Requirements including nuclear medicine, breast imaging, and Case Log requirements, professional and ethical in all aspects and completion of the Level 4 milestones at the mean level of other peers.

Conditional Promotions

1. A resident may be conditionally promoted to the next year having failed 1-2 rotations or having failed 1-2 competencies. They must attain a passing grade or achieve Meets/Exceeds Expectations as designated by the Informal Corrective Measure Action Plan/Remediation Action Plan Contract to remain in good standing for that year. A resident who fails the Informal Corrective Measures Action Plan proceeds to either repeat informal corrective measures or to a formal remediation (or potential probation depending on the situation as assessed by the CCC) with a formal contract in place. (*See section below on Evaluation and Corrective measures*)
2. If a resident fails 3 rotations or competencies in a specific year of training, the decision on promotion or restriction of promotion will be discussed by the CCC, Program Director (PD) and/or Vice Chair of Education. Depending on the situation, the CCC and PD may recommend repeating a portion or all an academic year, with the most extreme result being disciplinary actions such as potential probation or dismissal.

Research/Scholarly Activity Requirement

Residents are required to complete a research/scholarly activity project prior to successful graduation. This can be performed in, but is not limited to, clinical radiology, basic science, education, administration, information technology, or health care policy. Successful completion of a first author paper/manuscript, poster presentation/educational exhibit, or oral presentation at a national meeting satisfies this requirement and is utilized as a Milestones Requirement.

For qualified residents who are interested in a future academic research career, the Clinician Scientist Research Pathway is available for dedicated, protected research time and research mentorship in conjunction with the Vice Chair of Research. Otherwise, dedicated research time is available at the discretion of the Program Director to fourth-year residents. To request dedicated research time, a resident must submit a detailed research proposal signed by the research mentor that includes the hypothesis, project abstract, and proposed timeline for the project. When more than 4 weeks are requested, progress reports submitted to the Program Director are required monthly. Options for extended research time (greater than 4 weeks) are made at the discretion of the Program Director and Residency Program Leadership.

Resident Teaching

As a members and appointees of Harvard Medical School, residents are encouraged to participate in the mission of education of medical students, as lecturers and mentors in the Radiology Clerkship, Advanced Clerkship, and other teaching sessions. The Medical Student Education Program Coordinator coordinates these efforts with the help of dedicated members of the BWH Radiology Faculty and Residents. Residents may be assigned to mentor and/or teach HMS students. Assigned mentors work with the HMS student during the clerkship rotation and help with the student's required presentation. HMS Tutorial Lectures are given by the residents as part of the clerkship's didactics once a month and are mandatory, as assigned by the Chief Residents. If the resident is unable to attend, they must find an appropriate substitute. Awards are presented at the end of each year in recognition of outstanding efforts. Additional opportunities exist for residents to participate in the teaching of HMS Students, including the Fundamentals of Imaging Course and other courses as requested from the Director of Medical Student Education, training Program Director and/or Vice Chair of Education.

Senior residents are also expected to take an active role in teaching junior residents, during daily interactions while on rotation, assisting in preparation of conferences such as the Missed/Difficult Case Conferences, and during selected resident lectures. Each fourth-year resident will be required to provide one senior teaching conference to residents annually. Residents are expected to participate in interdisciplinary conferences including pathology and medical conferences.

Schedules

Individual resident rotation block schedules are inputted into the New Innovations system at the beginning of the academic year. For the 2020-2021 academic year, schedules may be updated on a month-to-month basis to account for missed rotations and varying degrees of competency due to the COVID-19 pandemic. Residents can view their upcoming and past rotations only in the block format. Each resident schedule can also be found in Amion. The official annual Residency clinical schedule including daily and on-call rotations, assigned conference schedules, vacations, and other calls is posted on Amnion (amion.com), with the password **bwhrad**.

Selective Rotation (R1)

Each first-year radiology resident will have 2-weeks of a dedicated selective rotation in their clinical schedule to provide flexibility and additional clinical exposure to supplement the first-year curriculum. Ideally, this should be scheduled in the latter half of the year. Each first-year resident is encouraged to discuss how they plan to use this time at their initial meetings with the First-Year advisor. This time is meant to provide additional exposure to clinical radiology and is not meant to support time for research or other scholarly activities. The selective rotation should be used to supplement time required for any informal corrective measures or other "make-up" clinical time for missed rotations, as required by the Clinical Competency Committee. Each first-year resident is

required to submit a brief written plan for how to utilize their selective time, which is to be approved by the First-year Advisor, the Clinical Competency Committee Chair, and/or Program Director at least 3 months prior to the scheduled selective time. Once approved, the Chief Residents and Program Coordinator will update the clinical schedule and details in New Innovations. Examples of selective time include time in CSIR, Angio/IR, Ablation Clinic, additional time in Core Rotations (eg. Abdomen, US, MSK, Nuc Med, etc), or BWH clinical medical or surgical specialties pending approval from the Partners/MGB GME office. Rotations outside of Partners/MGB or without a formal Program Letter of Agreement are discouraged.

Schedule Changes

Notification of any clinical schedule changes, whether personally arranged (e.g., ED Weekends, Med Conference, sick call) or arranged as part of a formal vacation request, must be sent to the Chief Residents such that appropriate changes can be made in the Amion master schedule. If changes affect a resident's block schedule or conference attendance, the Chief Resident will notify the Program Coordinator so that appropriate changes are made in New Innovations.

Fourth-year residents on a mini-fellowship must have time off or schedule change requests approved by the section's fellowship director; these changes should then be communicated to the Chief Residents to update Amion, and the Program Coordinator to update New Innovations. These changes follow the standard 90 day rule as detailed in this manual. Any significant changes to the R4 plan that affects the overall composition of rotations compared to the approved R4 proposal must be approved by the Program Director and the Clinical Competency Committee. If a resident chooses to add non-clinical time in place of already scheduled clinical time, the resident must have a faculty mentor approval, a short description of the research and goals, and fill out a form detailing these changes. The change in schedule will then be subject to approval by the PD and CCC. Fourth-year residents on a non-mini-fellowship rotation are subject to the same policy for schedule changes as any other resident.

For any planned absences, including approved leave of absences, non-urgent medical, mental health, and dental care appointments, that occur during an ED, Consult, or Night Float rotation, the resident is responsible for arranging a schedule swap or back-up coverage.

Semi-Annual Evaluations & Feedback

Each resident will have the opportunity twice yearly to meet with the Program Director(s), or in the case of the first-year residents, with the First-Year Advisor APD, to receive feedback, review their rotation evaluations, and receive a summary of their clinical performance from the Clinical Competency Committee. Evaluations include those from the teaching faculty, Peer Evaluations, and 360 Evaluations. During this time, the residents will also be required to perform a self-reflection exercise of their individual performance by completing a "Self-Assessment Form". This includes an individual review of their ACGME Case Logs and data of their Practice Habits to ensure prompt and timely completion of ACGME and ABR requirements for graduation. A review of their scholarly activities, quality improvement project, and their strategies for wellness and success in the residency are reviewed during this time. The resident also can give both written and verbal feedback about the program. Both the resident and Program Director(s) will provide their signatures for documentation of this meeting.

Feedback to resident takes multiple forms during the residency, both written and verbal. Daily feedback will be given to the resident during their daily work, at the workstation by review of their diagnostic reports and

interpretation skills, and during procedures. Written feedback for each resident will be provided by the Resident Liaison after each rotation and is to be entered into New Innovations, in a timely manner for review by the resident and the residency program leadership, including the Clinical Competency Committee.

Sick Call & Back-up Policy

As per the ACGME, there are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. Assuring that trainees understand program standards around accessing coverage when appropriate is important for well-being. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

Residents who have unplanned, urgent absences due to circumstances such as illness, family emergencies, such as attending funerals, should notify the Chief Residents, Program Coordinators, and/or the Program Director via e-mail or page, as soon as possible in order to provide back-up clinical coverage, as needed. Planned absences, including approved leave of absences, non-urgent medical, mental health, and dental care appointments, should be coordinated in advance and the Program Director in advance via e-mail, in order to provide adequate back-up clinical coverage, as needed. At a minimum, identifying coverage for urgent absences and for family or medical leave must be the responsibility of the program (first through the Chief Residents) and not the trainee that needs to be absent.

In the event of illness severe enough that a resident may be unable to attend work, a Sick Call policy allows for clinical back up for on-call services.

Sick Call is covered by the second, third- and fourth-year residents.

If a resident is unexpectedly absent from the ED day shift, Night Float shift, evening shift, or weekend/holiday in-house coverage shift, the resident assigned to Sick Call will be called in to cover for the absent resident. The Sick Call resident may also be called upon if a resident is unable to fulfill his/her duties due to fatigue or family emergencies. It is the responsibility of the resident assigned to Sick Call to be available and ready to provide this coverage. Therefore, the Sick Call resident must remain within the Boston area and be reachable by page throughout the course of their Sick Call assignment. If the Sick Call resident is her/himself sick, then s/he should email the Chief Residents immediately and work together to arrange a Sick Call swap.

Each Sick Call block will begin on Monday morning 8 AM and last through the Sunday night float shift, ending at 7:30 AM the following Monday.

If individual Sick Call days are traded, please note that each sick call shift runs from 8 AM of the scheduled day to 7:30 AM of the following day. This is necessary to cover the Night Float shift, and this means if a resident is on Sick Call on Saturday, s/he may need to cover any Saturday day shift OR any part of the Saturday night Night Float shift, which runs from10:30 PM Saturday to 7:30 AM Sunday.

The absent resident is expected to “pay back” the Sick Call resident later if called in to cover a shift.

Make-up clinical and education time will be made at the discretion of the Program Director in conjunction with the Clinical Competency Committee based on individual educational/competency circumstances, and taking into account appropriate ACGME and ABR policies. These circumstances will be discussed with the resident and the Program Director.

Our program supports an environment where residents are encouraged to utilize the policy (when appropriate) without fear of negative consequences or perceptions. When trainees must be absent because of health issues or for health care appointments, Program Directors should not query the trainee regarding the health issue, but can ask the trainee to seek confirmation of the need for clinical coverage through Occupational Health. Trainees are expected to utilize program backup clinical coverage systems only in appropriate situations, as defined by program and institutional policies.

These policies are in accordance with the Partners GME Backup and Coverage Policy (https://www.partners.org/Graduate-Medical-Education/Policies-Resources/Policies.aspx).

Supervision Policy

Effective July 2020, the Partners / Mass General Brigham GME Supervision Policy is in effect and can be found at:

https://drive.google.com/file/d/1f4VHw_yG7ug7-O5Hxie9KK9Y5LKZWud6/view

The following provisions apply to all Graduate Medical Education (GME) training programs sponsored by the Partners affiliated hospitals. Further, this policy applies to all trainees when assigned to any other institution or clinical site as part of their GME program. The term “trainee” in this document refers to interns, specialty residents and subspecialty clinical fellows enrolled in any GME program.

- Trainees will treat patients only under the supervision of an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner, as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care and for determining and implementing the appropriate level of supervision of the trainee.
- Patients must be notified of the name of the attending staff physician responsible for their care and that trainees participating in their care are supervised by such staff physician(s). Also, when providing direct patient care, trainees and faculty must inform each patient of their respective roles in that patient’s care.
- The supervising physician’s involvement in a patient’s care, and the involvement of trainees and other members of the health care team, must be documented in the medical record.
- In providing clinical supervision to trainees, the attending staff physician shall liberally provide advice and support, and shall encourage trainees to freely seek their input.
- The faculty must devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities and to demonstrate a strong interest in the education of trainees.
- Faculty should delegate an appropriate level of patient care authority and responsibility to each trainee, based on the trainees’ skills and the needs of the patient. Faculty supervision assignments must be of sufficient duration to allow assessment of the knowledge and skills of each trainee.

- Trainees are expected to make liberal use of the supervisory resources available to them and are encouraged to seek advice and input from the attending staff physician(s) and more senior trainees, as appropriate.
- The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care by a trainee must be assigned by the Program director and faculty members, guided by an assessment of each trainee's abilities based on specific criteria.
- With faculty oversight, senior trainees or fellows should have opportunities to serve in a direct supervisory role of junior trainees in recognition of their progress toward independence, taking into account the needs of each patient and the skills of the individual trainee or fellow.
- Additional guidelines regarding supervision of trainees shall be developed by individual departments and/or training programs in accordance with the ACGME Common Program Requirements and their respective RRC Program Requirements, where applicable.

Definitions

DIRECT SUPERVISION: The supervising physician is physically present with the trainee during the key portions of the patient interaction. The supervising physician and/or patient is not physically present with the trainee and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology, only if this degree of supervision is permitted by the Review Committee.

INDIRECT SUPERVISION: The supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the trainee for guidance and is available to provide appropriate direct supervision.

a) with direct supervision, immediately available – the supervising physician (attending faculty member) is physically present within the hospital or other site of patient care and is immediately available to provide direct supervision.
b) with direct supervision, available – the supervising physician (attending faculty member) is not physically present within the hospital or other site of patient care but is available by means of telephonic and/or electronic modalities and is available to provide direct supervision.

- During normal business hours, a scheduled, assigned attending faculty member will be available by pager or proximity to each clinically assigned resident always. (Indirect supervision with direct supervision immediately available.)
- An attending radiologist will review all diagnostic studies interpreted by residents. (Direct supervision)
- All procedures will have an assigned attending radiologist faculty member available by pager to the resident and will be available for consultation prior to approval of the procedure (Indirect supervision with direct supervision available) and will be immediately available to the resident by pager while the patient is in the procedure room. (Indirect supervision with direct supervision immediately available)
- For all critical portions of a procedure, an assigned attending radiologist will be present in the procedure suite with the resident performing the procedure. (Direct supervision) This presence must be documented accurately in the final radiology report. Attending radiologist faculty members are on-call 24 hours each day to cover emergency procedures.
- For residents assigned to the Night Float rotation in the Emergency Radiology Division, an assigned attending radiologist faculty member will review all Emergency Radiology Division diagnostic studies

interpreted by residents and will be available in the hospital for consultation always. (Indirect supervision with direct supervision immediately available)

- When on the Consult rotation, if a radiology resident believes a clinical situation requires either knowledge and/or skills beyond their level of training or comfort they are required to call the covering fellow or attending assigned for the service or modality related to the patient's clinical question. (Indirect supervision with direct supervision available)
- The Department will keep an accurate and complete on-call directory available to the residents and hospital operators, available on the Partners on-call directory. Therefore, it is the individual resident's and attending's responsibility to make sure their emergency personal contact information is made available to the hospital operator always.
- Backup: The resident should call for back-up when he/she feels that there is a) greater patient volume or acuity than he/she can appropriately handle, b) becomes ill while on duty, or c) experiences fatigue interfering with performance. Back-up is obtained during business hours or on-call by discussion with the attending radiologist faculty member who is present or immediately available and/or in consultation with the Chief Residents. On the Consult Rotation, back up is obtained by calling the sick-call resident and the Chief Residents.

Supervision policy for Angiography/Interventional Radiology Service (Angio/IR)

Lines of Supervision:

- All interventional radiology patients cared for by a fellow/resident will be evaluated and followed up under the supervision of an attending interventional radiologist faculty member. (Indirect supervision with direct supervision available)
- All vascular/interventional procedures (apart from central venous line removals) are to be performed only when an attending physician is present in the area (Direct supervision). The fellow/resident will not start a case without discussing the procedure with the attending in charge of the case. Central venous line removal can be performed independently at the bedside by the resident if approved by the supervising/on-call attending.
- An attending interventional radiologist faculty member will be on-call with the fellow/resident, available for consultation always (Indirect supervision with direct supervision available), and physically present (direct supervision) for all interventional procedures done on call (except for bedside venous line removal).

Cross Sectional Interventional Radiology

- All interventional radiology procedures utilize Direct Supervision and require the supervising physician (attending radiologist faculty member) to be physically present in the interventional radiology procedure room with the fellow/resident and patient during the entire radiologic portion of the procedure.
- For interpretation of diagnostic imaging examinations of CSIR patients, when the attending radiologist faculty member is not directly supervising case reading, the attending radiologist faculty member will provide indirect supervision with direct supervision immediately available
- See additional information on the CSIR rotation manual, a portion of which is only summarized here

Circumstances in which a trainee must call the supervising faculty

During usual working hours, residents are supervised by attending faculty members for readout of all studies and during the critical portions of all procedures (direct supervision). Residents discuss and plan all imaging

procedures that are requested or being planned with an attending radiologist faculty member prior to the procedure (indirect supervision with direct supervision available). Specific circumstances for calling supervising faculty and/or fellow during off hours include:

Consult Rotation (call fellow before attending):

- When the resident is in doubt about the interpretation of a study and the result is of immediate clinical importance
- When a diagnostic procedure is requested that is felt unnecessary or inappropriate by the consult resident
- When the volume of work becomes greater than can be handled safely by the resident, the Chief Residents are to be called for possible activation of sick call resident
- Communication with the fellow-on-call should be documented using a purple ANCR

Night Float Rotation:

- In house staff attending radiologist faculty member coverage is available always
- Residents contact staff when an examination requires immediate consultation or review (indirect supervision with direct supervision immediately available)
- Expeditiously when ultrasound examination is performed for high-risk cases (e.g. concern for ectopic pregnancy)
- When there is a question regarding the interpretation of a study and the results will have clinical significance, such as the need for immediate operative intervention or if the referring physician specifically requests staff review (Indirect supervision with direct supervision immediately available)
- When a diagnostic procedure is requested and there is a question regarding the appropriateness of the examination or the method of performing the examination. (Indirect supervision with direct supervision immediately available)

Angiography/Interventional Radiology (Angio/IR):

- Trainees must call supervising faculty for all new consultations, in-patient admissions, patient transfers, procedure requests, and questions regarding ongoing clinical inpatient and outpatient management.

Vacation

Details of the Partners / Mass General Brigham Vacation, Sick Time and Leave Policy can be found at: https://www.partners.org/Assets/Documents/Graduate-Medical-Education/Policies/GME-Trainee-Vacation-and-Leave-Policy.pdf

Residents are allocated 4 weeks of vacation per year, which must be taken during the academic year (July 1 – June 30). However, if the resident is not able to schedule vacation during that time period, 5 days may be carried over into the next academic year and must be used by September 30. Residents must request two 5-day blocks, which may be taken as one two-week block or two separate one-week blocks. The remainder of the available vacation days can be taken as “flexible” vacation days.

Generally, one of these 4 weeks of vacation must be taken during one of two weeks over the Winter Holidays, either Christmas or New Year’s week or at discretion of the Department Chair. Residents are not permitted to take both weeks off during that time, nor can these weeks be utilized at another time. Requests for week

preference will be channeled through the Chief Residents, but service staffing must be met before requests are granted.

Residents who are assigned to cover Saturday, Sunday, and holiday in-house day shifts may be granted an additional "flex" day for every shift worked. Flex days from in-house shifts can be used in the same year accrued, or carried over to be scheduled anytime in the following year (do not need to be used by September). The procedure and restrictions for scheduling flexible vacation days are summarized in the Vacation Approval section below. In brief, flexible days requested 90-days in advance do not require section approval unless requested for June or during a Winter Holiday week. Requests for vacation in the last 2 weeks in June are strongly discouraged. All vacation requests require adequate section coverage and Chief Resident approval.

Third- or fourth-year residents are given up to a total of 5 days for fellowship or job interviews, as needed. This is requested in the same manner as all other vacation requests. If this time is not used for interviews, it may not be used as additional vacation days or terminal leave.

Note that this section does not pertain to schedules disrupted by COVID-19 pandemic: A resident is allowed to miss only 5 days from any given section per year. No more than 2 weeks of vacation may be taken from a particular rotation over the 4-year residency period. If a resident is absent from a particular rotation for more than 2 weeks within the first three years, the difference may need to be made up during the fourth-year, as determined by the Clinical Competency Committee and the Residency Program Leadership. Exceptions to this policy can only be considered in extraordinary circumstances, such as alternative pathways, with the approval of the Program Director and Residency Program Leadership.

Vacation is discouraged from being taken from the Nuclear Medicine or Breast Imaging rotations due to ABR requirements. Any days absent from Nuclear Medicine or Breast Imaging rotation for any reason, including sick days, must be made up. No vacation may be taken during ED days, Night Float, or Consult rotations.

A maximum of five (5) days total vacation time may be requested during the three months spent at Children's Hospital if scheduled in advance and in accordance with the requested policies at Children's Hospital and the Radiology Program Director at Children's Hospital. In unusual circumstances, on an individual basis, meeting time may be considered at the discretion of Program Director at Children's Hospital.

Vacation Approval

All vacation requests are submitted to the Chief Residents via email. Requests will be considered on a first-come, first-served basis.

Approval for flex day and full week requests made greater than 90 days in advance requires approval of the Chief Residents to ensure adequate coverage; pre-approval by the division chief/resident liaison is highly encouraged. An email confirming the approved dates of the vacation will be sent to the division chief/residency liaison for scheduling purposes. Requests submitted fewer than 90 days in advance must be submitted to the division chief/resident liaison and will be considered but may not be granted due to service staffing requirements. The Chief Residents in conjunction with the division chief/resident liaison must approve all requests. When considering vacation requests, the divisional resident liaison should only consider section staffing, not the nature of the vacation request. An email from the resident to the division chief/resident liaison a week prior to the requested vacation time serves as an appropriate reminder. If changes to the original request are made, the Chief Residents must be notified. Once vacation time is submitted, changes will only be made in unusual circumstances. The exception to this policy is for Dana Farber rotations, which require

signature from the division chief/resident liaison and responsible parties for all vacation requests, even if requested >90 days in advance.

A resident who has in-house conference responsibilities (e.g. Medical Conference, RadPath, or Autopsy Conference) must personally arrange coverage prior to submitting a vacation request. If the resident is unable to find clinical coverage, the resident can seek to coordinate coverage through the Chief Residents for something of extreme personal significance.

If vacation will force resident to dip below minimum amount of time on rotation (see above discussion), this will be made up in the fourth year, or as determined by the Clinical Competency Committee and the Residency Program Leadership.

Well-Being & Fatigue Mitigation

As per the ACGME, our program is committed to addressing physician well-being for individuals as it relates to the learning and working environment. This responsibility includes:

- efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;
- attention to scheduling, work intensity, and work compression that impacts resident well-being;
- evaluating workplace safety data and addressing the safety of residents;
- policies and programs that encourage optimal resident and faculty member well-being;
- attention to resident and faculty member burnout, depression, and substance abuse;
- provide access to appropriate tools for self-screening;
- provide access to confidential, affordable mental health assessment, counseling and treatment, including access to urgent and emergent care, 24 hours a day, seven days a week. This is available through the Partners Employee Assistance Program (https://eap.partners.org/default.asp).
- residents will be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours

The program in partnership with the Partners GME office and institution-wide initiatives will educate faculty members and residents in the identification of symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members will be educated to recognize these symptoms in themselves and how to seek appropriate care, and residents are encouraged to alert the Program Director when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

In addition, education on fatigue mitigation is provided annually through a dedicated resident conference, in which residents are educated to recognize the signs of fatigue and sleep deprivation, in alertness management and fatigue mitigation processes to manage the potential negative effects on patient care and learning. A dedicated resident call room for sleep and safe transportation options are available for residents who may be too fatigued to safely return home. In the event a resident may be unable to perform their patient care responsibilities due to excessive fatigue, a hand-off process in available to ensure continuity of patient care, which may involve the use of Sick Call resident, in discussion with the Chief Residents and/or Program Director.

Additionally, a Residency Wellness Committee was established in 2017 to advocate and help coordinate the overall well-being of the residents and ensure compliance with ACGME established guidelines.

Wellness Benefits: Meal Subsidizing & Transportation Safety

Due to the ongoing Covid-19 pandemic and current institutional financial landscape, the current status of the meal and transportation subsidies are under review and subject to change, as of July 2020. The residents will be notified of updates/changes and policy below amended.

Meal Subsidy

Trainees will receive a meal card at the start of each academic year pre-loaded with a stipend for use at the BWH Cafeteria. Meals are subsidized at $5 while working on Night Float, Consult, ED weekend overnight, or weekend in-house shifts.

1st years will receive a total of $15 total for Angio/IR Call

For R2 and R3, each resident would have 2 weeks of consult **(6 shifts each) – formerly 5 shifts,** 2 weeks of night float (6 shifts each), 2 Saturday ED overnight shifts, and about **4** in-house shifts and **2 Evening shifts (newly created shift). $160/person**

For R4, each resident would have 1 week of consult (**now 6 day shift**), 1 week of night float (6 days), 1 Saturday ED overnight shift, and 3 in-house shifts, and **2 Evening shift (newly created shift)**. **$90/person**

Once you have used your annual stipend, please return empty cards to the Radiology Residency Office (Mellins Library).

It is the responsibility of each individual resident to maintain their meal card. If lost/stolen, please contact your program coordinator and we will attempt to find a replacement card; we cannot guarantee that a card will be replaced, so please guard it wisely.

Transportation Safety

Transportation usage is limited to the following circumstances:

1) Trainees who have driven to the hospital and:
    1. have worked for 24 (or more) consecutive hours and feel that they cannot safely drive home.
    --or--
    2. feel too fatigued to drive and are concerned about falling asleep.
2) Trainee falls acutely ill while on service and cannot drive or take public transportation.
3) Trainees who normally take public transportation into work and end their shifts at a time when public transportation is not available.

Lyft Rides thru Circulation are available from the Program Coordinators. Please contact the PC's to set up a ride if you are on night float, consult, ED, or in house coverage. Rides should be set up in advance and given notice prior to 3PM M-F.

The coordinator will set up your profile and input your home address. Your ride will pick you up from 75 Francis ST Location unless otherwise noted. When you are ready to be picked up, text the 5 digit code back to the phone number you received it from; a car will then be dispatched and you will receive text alerts.

Please make sure to take all your items when you exit the vehicle. Circulation is a third-party app and the PCs will work with them to contact Lyft to locate any missing items in the event.

Misuse of the transportation program can result in being banned from further use of the system.

Call Room:

Trainees have 24/7 access to a call room located in the Radiology offices suite with a bed, full workstation, linens, and a nearby microwave and mini-fridge.

Lactation Room:

All trainees who are nursing have 24/7 access to a lactation room located in the Radiology offices suite with a bed, full workstation, linens, and a nearby microwave and mini-fridge.