

Primer for New Residents

in

Western New York

- ***Introduction***

- ***Patient Care Issues***
 - ~ Hospitalized Patients (*page 3*)
 - ~ Office/Clinic Patients (*page 3*)
 - ~ Medications (*page 3*)
 - ~ Prescription Writing (*pages 3 & 4*)
 - ~ Health Insurance (*page 4*)
 - ~ Relationship with patients/staff & Patient privacy (HIPAA) (*page 4*)
 - ~ Progress notes (*page 5*)
 - ~ Credentialing & Bedside Procedures (*pages 5 & 6*)
 - ~ Work Hours (*page 6*)
 - ~ Supervision (*page 6*)
 - ~ Patient Safety (*pages 6 & 7*)
 - ~ Moonlighting (*page 8*)

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The attached article, “The One Dozen Most Important Things You May Not Have Known, Understood or Realized about American Medicine”, provides additional information on some of the topics covered in the Primer.

Working in Western New York's Health Care Systems:

Tips for New Residents

Graduate Medical Education, or Residency Training is the second phase of medical education after medical school. It is the phase which "prepares physicians for practice in a medical specialty and focuses on the development of clinical skills and professional competencies." (Accreditation Council for Graduate Medical Education, General Requirements, 1992)

All residents are challenged to acquire the skills, knowledge, and attitudes required for assuming a progressively greater responsibility for safe & effective patient care. Over the course of training, residents must demonstrate competence in six core areas: Patient Care, Medical Knowledge, Communication, Professionalism, Practice-based Learning & Improvement, and Systems-based Practice. This can be a greater challenge for residents adjusting to a new culture with different customs and practices. The following information is intended to facilitate your adjustment to medical practice and education in Western New York.

University at Buffalo Graduate Medical Education Program

Resident Education in Buffalo is sponsored by the University at Buffalo and its affiliated hospitals. There are 74 resident training programs and up to 724 residents. The programs maintain educational excellence by conforming to the standards established by national Residency Review Committees for each specialty which are part of the Accreditation Council for Graduate Medical Education (ACGME – www.ACGME.org). Programs are regularly reviewed by the University and the ACGME to insure that standards are maintained.

The Office of Graduate Medical Education offers support and guidance for individual residents and programs. Staff can answer questions about the terms of your employment, benefits, immigration matters, resolving conflicts, diplomas, etc.... Contacts include:

Roseanne Berger, M.D., Sr. Associate Dean for Graduate Medical Education
Overall responsibility for GME

Richard Braen, M.D., Assistant Dean
(expertise: internal reviews and program information forms)

Donna Cumiskey, Director, Resource Management
(expertise: salary & benefits, resident work hours)

Susan Orrange, Ed.M., Director, Educational Programming
(expertise: Master sessions, Chief Resident orientation, Scholarly Exchange Day, Resident Ombudsman)

Valerie Kennedy, Director, Accreditation Operations
(expertise: New Resident Orientation, Accreditation Standards)

Jan Harsztrak, Ph.D., Grievance Administrative Consultant
(expertise: grievances)

Residency Program Management

A program director is responsible for the quality of education and progress of each resident in each residency. The program director **must give residents written goals and learning objectives** for each rotation. They must **evaluate the residents' knowledge, skills, and progress at least twice a year and review this information with the resident**. They must monitor resident stress and be available to **help the resident who is experiencing stress**. They are expected to help residents who are having problems related to drug or alcohol abuse.

Each program has one or more Chief Residents. These senior residents assist with program management and are active in teaching their fellow residents and medical students. They often develop "on-call"

schedules. The Chief can answer many questions about the program or direct you to the appropriate person.

Patient Care Issues

1. Hospitalized patients

Patients may be admitted to the hospital for acute or unstable medical conditions or surgery. All patients admitted to the hospital are assigned to an attending physician. Residents assist the attending in evaluating and managing hospitalized patients. They perform and document a thorough history and physical on each admitted patient, examine patients daily, write progress notes and write daily orders. **The attending has final responsibility for patients, and therefore must participate in management and be notified of changes in a patient's condition. Do not discharge a patient without the attending physician's approval.**

2. Office/Clinic Patients

Many medical problems are evaluated and monitored in outpatient settings. Residents should clearly explain diagnoses and treatment plans to patients. Sometimes it helps to give patients written instructions.

Your care in clinic must be supervised. Discuss expectations for supervision with faculty.

Scheduling follow up appointments is important. If a patient has trouble keeping appointments, try to learn if they need assistance with transportation or child care. Social workers, case managers, or nurses in hospitals and clinics will help deal with these problems.

3. Medications

Many drugs are manufactured by several companies under different brand names. The least expensive form of a drug is usually the non-brand name "generic" drug which is determined to be therapeutically equivalent. With the exception of a few drugs, it is safe and cost effective to prescribe generic drugs. Health insurance companies publish their preferred medication list or formulary. Patients typically pay less for preferred medications so learn how to refer to the formulary when prescribing. You may be asked to consider changing a prescription to an equivalent, but less expensive medicine. Attending faculty physicians receive reports on their prescribing habits.

Not all patients have health insurance and therefore they must pay for their medications themselves. This may affect their compliance.

4. Prescription Writing

Physicians are required to use New York State prescription pads for controlled as well as non-controlled medications. Residents will obtain their personal supply from the hospital pharmacies. The pharmacy keeps a record of the prescriptions assigned to each resident so they are not exchangeable. ***Safeguard the prescription pads. If you lose a prescription pad you must notify the pharmacy that provided it to you.***

A written prescription must include:

1. Name of medication (chemical, generic, or brand)
2. Dosage
3. Number to be dispensed (numerical as well as written out number for controlled substances)
4. Indications for Medication
5. Instructions for taking medication (do not use abbreviations such as qd, tid, hs etc.)
6. Signature and stamped name (stampers supplied during IRW)
7. Refills (Medicaid will permit up to five refills; write out number for controlled substances)

8. National Provider Identifier (NPI) number if applicable
9. Hospital DEA or license number for controlled substances
10. No stickers may be applied to prescriptions

Only licensed physicians are authorized to write prescriptions for Medicaid-insured patients in New York State. Talk to your program director to determine how this will be handled in your residency.

5. Health Insurance

Most patients carry some form of insurance to pay for health care. Insurance carriers in Western New York include Independent Health Association (IHA), Community Blue (CB), Excellus, and Blue Cross of Western New York (BCBS). The government provides health insurance for a segment of the population meeting certain income requirements (Medicaid/Fidelis). Coverage for patients over 65 or with selected chronic conditions is provided by the Federal government's Medicare program. Over 30 million Americans have no form of health insurance, and must pay for care themselves or the cost of care is absorbed by the hospitals.

Individual health insurance companies may restrict patient choice of doctors or other health professionals, pharmacies, or laboratories. A list of providers accepted by each company is available. **Ask your patient what type of insurance they have before making referrals to health care providers.** Check with office or hospital personnel about restrictions to determine whether the care you recommend is paid for. Most health plans require attending signature on prescriptions and referrals.

6. Relationship with patients and staff/Patient Privacy Issues (HIPAA)

Physicians are expected to be polite and show respect for patients and staff. We recommend addressing patients by their surnames unless permission is obtained to use their first names. Modesty must be respected by draping patients during examinations and not exposing their bodies unnecessarily. A medical staff member such as a nurse or medical office assistant must accompany physicians performing genital exams. These chaperones are reassuring to the patient and, by witnessing the exam, can testify to your professional behavior if it is challenged.

Include patients in discussions about their condition taking place in their presence. Use non-medical terms when speaking with patients. Patients commonly question doctors about their conditions and treatment. This should be encouraged! Clear answers and explanations of test results, descriptions of diagnostic procedures, common side effects of medications, etc. are greatly appreciated. Everyone is confronted with questions they do not know the answer to. **Doctors usually earn respect by acknowledging they do not know but offering to seek out the answer to such questions.**

Patient privacy must be maintained in accordance with the Health Insurance Privacy & Accountability Act (HIPAA). The essence of the law, in effect as of 4/14/03, is to restrict sharing patient information to those directly involved in their care or for billing purposes unless the patient signs a release. Similarly residents must avoid discussing patients in public places such as elevators, and minimize identifiers on written materials that may be viewed by individuals not involved in the patient's care. In accordance with HIPAA, all research involving patients or their records must be reviewed by UB's Institutional Review Board (IRB). Questions regarding HIPAA may be directed to HIPAA compliance officers posted on the GME website along with answers to some frequently asked questions (<http://wings.buffalo.edu/smb/gme/>).

7. Progress notes

Discuss recommended approaches to writing progress notes in medical records with your supervising resident or attending. A commonly used technique, the "S.O.A.P." format, divides notes into four sections:

Subjective: Record information obtained from sources such as the patient or patient's family including history, symptoms, reports of past treatments and response to those treatments. Be sure to identify the source of the information in your notes.

Objective: Record factual, observable data such as physical exam findings, lab data, x-ray reports

Assessment: Record your interpretation of factual data and subjective information. These may include problems, diagnoses, or progress of treatment.

Plan: Record your plans for each of the identified problems or diagnoses. This section should address both diagnostic and treatment plans and always document patient education.

The "S.O.A.P." format permits other clinicians and health providers to extract information from progress notes easily. It also facilitates teaching. Experienced clinicians can review subjective and objective information and determine if the assessment and plan is appropriate.

Supervising attendings must also write daily notes in the medical record both for financial and medico-legal reasons. (All insurance companies now require attending notes for reimbursement-also important to have attending notes in chart to clearly document participation/supervision in the case of adverse events...)

8. A. Credentialing

New York State physicians must receive approval to perform procedures without direct supervision (e.g. blood drawing, intravenous line insertion, spinal tap, thoracentesis etc.) regardless of their past experience. A menu of commonly performed procedures is posted on the GME website (<http://wings.buffalo.edu/smbs/gme/>). Residency program directors (e.g., Pediatrics, Family Medicine, Internal Medicine) may require successful completion of quiz questions based on this information prior to beginning inpatient rotations. The required procedures vary with specialty. Each resident must demonstrate their skill to a supervising physician and obtain their signature as verification that the skill was performed correctly and the resident understands the relevant indications, contraindications, anatomy and potential complications.

A computerized credentialing system can be accessed from all affiliated hospitals. Therefore, once you are credentialed in one hospital, you are credentialed in all affiliated hospitals. You may view your credentials by linking directly to the website from Kaleida or ECMC.

B. Bedside Procedures

New York State Department of Health (DOH) requires physicians to follow a "universal protocol" when performing bedside procedures. This includes verifying the identity of the patient, obtaining informed consent, and verifying the correct location and side for the procedure. Many refer to this process as "time out". Forms must be completed to document the process and prompt the required steps. The universal protocol applies to both inpatient and outpatient procedures.

In addition to this process:

- Review indications, contraindications, anatomy, equipment, technique, and how to manage potential complications. One resource is accessible from the GME web page by clicking on "procedures" (<http://www.buffalo.edu/smbs/gme/>)

- If English is not the patient’s primary language, request assistance from a trained interpreter or use phone translation, available at all hospitals. Use of a trained translator must be offered to the patient, even if an untrained interpreter (family member or friend) is present. If the patient declines the services of a translator, this should be documented in the chart.
- Confirm your supervisor is credentialed to perform the procedure. NEVER begin a procedure without adequate supervision.
- The procedure note should describe the procedure and document outcome, complications, status of patient post procedure, labs ordered, and follow up plans.

9. Work Hours

New York State and the Accreditation Council on Graduate Medical Education restrict the number of resident work hours.

- Hours should not exceed 80 per week. (including moonlighting activities if permitted in your program)
- On-call should not be more frequent than every third night.
- All residents must have one 24-hour period weekly, in which they are free of all clinical responsibilities, including beeper call.
- Work periods must be separated by a minimum of 10 hours.
- Continuous work periods must not exceed 24 hours with a maximum of 3 hours for activities that do not involve direct patient care such as sign-out.

If your program does not adhere to these requirements, please contact the Office of Graduate Medical Education for further instructions.

10. Supervision

New York State mandates that all patient care is supervised by an attending physician. If the attending is readily available, the direct on site supervision may be provided by a fellow, resident in their last year of training or, in the case of general surgery, their 4th or 5th year of training, who is properly credentialed. Contact the Office of Graduate Medical Education if you are concerned about your level of supervision. (see “Supervision Policy” on the GME website www.wings.buffalo.edu/smb/GME/)

11. Patient Safety

Residents, faculty, hospital staff, and health care organizations share responsibility for providing safe patient care. This demands that we all work together to minimize medical errors, adhere to systems designed to prevent an error, and thank, rather than blame, professionals who acknowledge mistakes or recognize the potential for error.

Residents spend more time in hospitals than any other employee. Residents, therefore, have a unique opportunity to recognize problems and call them to the attention of others. We encourage you to do so. Quality Improvement Officers reside at every facility.

What you can do:

1. DO NOT USE ABBREVIATIONS THAT ARE KNOWN TO BE MISINTERPRETED:

Do Not Use	Potential Problem	Use
U (for unit)	Mistaken as zero, four or cc.	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten)	Write "international unit"
Q.D. Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an "I" and the "O" can be mistaken for "I".	Write "daily" and "every other day"
Trailing zero (X.O mg), Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)
MS MSO ₄ MgSO ₄	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write "morphine sulfate" or "magnesium sulfate"
µg (for microgram)	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.	Write "mcg"
H.S. (for half-strength or Latin abbreviation for bedtime)	Mistaken for either half-strength or hour of sleep (at bedtime) q.H.S. mistaken for every hour. All can result in a dosing error.	Write out "half-strength" or "at bedtime"
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly resulting in an overdose.	Write "3 times weekly" or "three times weekly"
S.C. or S.Q. (for subcutaneous)	Mistaken as SL for sublingual, or "5 every"	Write "Sub-Q", "subQ", or "subcutaneously"
D/C (for discharge)	Interpreted as discontinue whatever medications follow (typically discharge meds).	Write "discharge"
cc. (for cubic centimeter)	Mistaken for U (units) when poorly written.	Write "ml" for milliliters
A.S., A.D., A.U. (Latin abbreviation for left, right, or both ears)	Mistaken for OS, OD, and OU, etc.	Write: "left ear", "right ear" or "both ears;" "left eye," "right eye," or "both eyes"

2. Communicate information during change of shifts effectively. An effective "hand-off" includes the following features:

- Interactive communication with opportunity to ask questions and clarify information
 - Up to date information about: problems, clinical status, condition, anticipated changes, what to do *or* **SBAR** (Situation, Background, Anticipated Changes, Response)
 - Conduct hand-offs in an environment that is conducive to minimizing interruptions
3. Carefully review a patient's medications at the time of admission and the condition they are treating.

When patients are transferred to another level of care or discharged, a complete list of medications and their indications must be provided to the next provider of service. (this is referred to as Medication Reconciliation).

4. Utilize pre-printed order sets designed for common conditions such as heart failure, pneumonia, acute coronary syndrome (myocardial infarction), stroke, and Deep Vein Thrombosis (DVT), prophylaxis.

5. Avoid giving verbal orders. When verbal orders are necessary, they must be signed within 24 hours.

6. Prior to performing procedures:

- Verify the identify of the patient
- Proposed procedure
- Correct site/side of the procedure
- Review the indications, contraindications, potential complications and their management, and the technique
- Obtain informed consent
- **Insure appropriate supervision!**
- Complete a procedure note
- Write post-procedure orders

12. Moonlighting

Employment as a physician outside of your residency program is only permissible with written approval from your program director. Residents who receive approval must include these work hours in their 80 hour work week allotment. Residents on J-1 or H Visas are ineligible for moonlighting.

MEMORANDUM from Women & Children's Hospital

To: All Residents in All Departments Writing Rx's for Patients with NYS Medicaid

From: Inpatient Pharmacy & Family Pharmaceutical Services, WCHOB

Chapter 442 of the Medicaid Laws of 2006 established the New York State Office of the Medicaid Inspector General (OMIG), as well as created a new Social Services Law §363-d, which requires that Medicaid providers develop and implement compliance programs aimed at detecting fraud, waste, and abuse in the Medicaid program. As of January 1st 2008, OMIG is authorized to define the coverage of applicability of this new law to Medicaid providers generally, as it sees fit.

The Department of Health Medicaid Update in January 2008 (Vol. 24, No.1) included a section entitled "Requirements and Responsibilities in the Medicaid Program," outlining OMIG's new policy regarding which practitioners may and may not prescribe for Medicaid patients. It states that a pharmacy claim for Medicaid coverage of a prescription must identify "the physician, dentist, or other practitioner who **actually provided the service**" by entering his/her Medicaid identification number in the "Provider Identification Number" field of the claim form. **In practice, this law restricts the ability of any outpatient pharmacy to bill any prescription to Medicaid that has not been written by a physician with a unique state-issued license number.** Previously when a resident or intern wrote a prescription, the pharmacy could enter the state license number of the *facility* under whose authority that practitioner was prescribing. However, effective January 2008, **Medicaid will no longer pay for prescriptions written by physicians under a facility's NYS license number.**

What does this mean for a resident or intern's ability to prescribe for Medicaid patients?

- **The prescriber who writes the prescription must have his/her own NYS license # or MMIS #**
 - Prescribers are not *required* to stamp their license # on the blank, but providing a 6-digit NYS license # will make these prescriptions easier for patients to fill.
- **A prescription that is signed only by a resident or intern who does not have his/her own NYS license # or MMIS# will not be covered at any outpatient pharmacy, including outpatient pharmacies contained within a hospital or facility**
 - Such prescriptions will only be covered provided that an attending physician with his/her own NYS license # or MMIS# counter-stamps AND counter-signs the blank
- **A prescription may still be written on a hospital-issued prescription blank, provided it is stamped with the name of the prescriber who signs the prescription**
- **Residents and interns under the prescribing authority of an attending physician with his/her own NYS license # or MMIS # may provide prescriptions to pharmacies utilizing a verbal order, as long as they also provide the name of the attending physician at the time of the order.**
 - **Note: Controlled substance laws regarding verbal orders still apply (i.e., maximum of 5 day supply for many drugs, follow-up signed/stamped order necessary if prescribing a C-II or benzodiazepine, etc.)**
 - Again, providing a state license # at the time of the verbal order is not required, but will make these prescriptions much easier for patients to obtain.

Disclaimer: This memo is being provided for convenience only due to the fact that OMIG did not make this new interpretation of the law generally well-known to prescribers or pharmacies. Please note that OMIG may change their interpretation of Medicaid law at any time. Following the above guidelines will ensure that all patients are able to obtain their prescriptions through active NYS Medicaid coverage at any outpatient pharmacy using OMIG's interpretation of NYS Medicaid law as of 2/29/08. Additional information is available at <http://www.emedny.org> or by calling the NYS Medicaid Billing Information Helpline at 1-800-343-9000.

The One Dozen Most Important Things You May Not Have Known, Understood or Realized about American Medicine

Gregory Cherr MD, Chair, Resident and Associate Society of the American College of Surgeons

Gerald P. Whelan MD, Director, IMG Acculturation Program, ECFMG

1. **The Doctor-Patient Relationship** - Although generally well respected, doctors in the United States do not have the unquestioned authority that is present in some other cultures. Patients expect to be treated with respect, be given appropriate information, have their questions answered, and participate in treatment decisions. Patients want clear explanations regarding the cause of their condition, their treatment plan, the risks and benefits of surgery, and prognosis. These expectations should not be seen as challenging the physician's expertise or judgment, nor should it suggest any distrust or disrespect. Patients want to be well informed so that they may contribute to, and participate in the decision-making process. American patients appreciate physicians who provide information and answer questions in clear, concise terms (using as little medical jargon as possible). Patients also have expectations relating to their personal comfort and modesty during physical examinations. Care should be given to proper draping, provision of chaperones for sensitive examinations, e.g., pelvic or breast examinations, and other accommodations to convey an environment of comfort and respect for the patient.
2. **The Role of the Patient's Family** - The primary therapeutic relationship is between the doctor and patient. Unless the patient is not competent (i.e. severe dementia), it should not be assumed that decisions regarding the patient's care will be made by, or shared with, the family. The family is not entitled to information about the patient without his or her expressed knowledge and consent. It is always important to ascertain from the patient what role they wish family members to play in their care. It is of equal importance to respect and abide by that decision.
3. **Confidentiality** - Information regarding the patient's identity, medical diagnoses, and treatment plans are considered confidential. The Health Insurance Portability and Accountability Act (HIPAA) describes precautions that regulate the sharing of a patient's health care information. In addition to maintaining the confidentiality of written medical records, physicians should also be aware of the risks to confidentiality posed by thoughtless conversation; patients and patient information should never be discussed in public areas such as hospital corridors, elevators, or dining areas.
4. **The Health Care Team** - American medicine is practiced in a team environment. Although in most cases the physician is the head of the team, he or she needs to understand, respect, and effectively utilize the skills offered by other team members including nursing staff, social workers, physical therapists, chaplains, and other professionals. This approach is particularly important in the care of very ill patients in the hospital. Diagnostic and treatment plans should incorporate input from all team members, each of whom should be comfortable questioning decisions and suggesting alternatives. The effective physician actively solicits input from team members and encourages an integrated team approach. Suggestions for alternative treatment plans are not a threat to the physician's authority, but rather a normal function of each member of the medical team.

Patients discharged from the hospital may require a coordinated plan for subsequent nursing home, rehabilitation, or home-based care. The discharge physician should pursue strategies that facilitate continued post-operative recovery as well as maintain continuity of care with the patient's primary care doctor (PMD). Skillful utilization of discharge-planning nurses, home care professionals, visiting nurses, and/or members of the outpatient team is important in assuring good long-term outcomes. Whenever possible, the patient's PMD should be kept apprised of the treatment plan and incorporated into the decision making process.

5. **America is a Litigious Society** - In America, remedies for perceived ills or injustice (such as post-operative complications) are commonly pursued through the legal system. Americans are probably more inclined than people in other countries to file lawsuits against physicians or hospitals when outcomes are poor or do not meet expectations. You may even see billboards or television advertisements from malpractice lawyers soliciting patients! High litigation rates and large settlements have dramatically increased the cost of medical care in the United States. An unfortunate result of this is the increase in "defensive medicine," whereby questionably indicated diagnostic tests and treatments are conducted in an attempt to decrease the likelihood of a "missed diagnosis" and/or potential lawsuit. This practice represents "bad medicine" and is not to be condoned. Nevertheless, physicians must be appropriately thorough in the diagnosis and treatment of patients, taking into account national guidelines and evidence-based medicine as well as the

local community's "standard of care." It is important to keep in mind that, while medical errors or incompetence may be a contributing factor in lawsuits, it is well documented that physicians who communicate poorly or have trouble establishing a rapport with their patients are far more likely to be sued or sanctioned by state medical boards.

6. **Document, Document, Document!** - The importance of good medical records cannot be overemphasized. Records that are clear, organized, complete, legible, and timely facilitate continuity of care among members of the health care team, minimize the risk of medical errors, offer protection from litigation, support hospital accreditation, and maximize reimbursement. When medical records are handwritten, they must be legible and clear. Only approved abbreviations should be used. With electronic medical records, the physician must become adept at utilizing the system appropriately. If something is done but not documented, in many ways it may just as well have never occurred. If complications or bad outcomes occur, immediate and thorough documentation decreases the risk of litigation and other adverse consequences. Even mundane details such as recording the date and time of a progress note may prove medicolegally important; therefore, thorough documentation is of great importance.

7. **Who Pays the Bills?** - America does not have universal health coverage and reimbursement or payment for medical care is extremely complex. The type and amount of a patient's medical coverage can significantly affect access to care and availability of treatment options for elective medical conditions. Many people have health insurance through their employer. Americans >65 years of age and those who are permanently disabled are typically covered by a national Medicare program. Medicaid programs are administered by individual states and provide coverage for some poor or disabled people. Military personnel and veterans are typically eligible for medical services within the extensive Veterans Administration system of hospitals and clinics. Unfortunately, there are more than 40 million Americans who have no medical coverage at all. To provide protection in the event of an acute medical emergency, a comprehensive set of laws (EMTALA) dictate that no patient may be turned away from emergency facilities regardless of ability to pay. Nevertheless, the uninsured poor are medically vulnerable with limited options for preventive and non-emergent care outside of free clinics and special public facilities. Physicians should be aware of the type of medical coverage their patients have and how it may impact their care. When ordering tests or writing prescriptions, it is a good idea to ask a patient if she or he will be able to get the test done, or pay for the medication (even generic drugs can be quite costly). Social workers and administrative staff can assist patients in determining eligibility and applying for public benefits (such as health insurance) and can aid the physician in determining optimal treatment within the context of the patient's care plan and financial resources.

8. **Gender Issues and Sexual Harassment** - In American society, the sexes are considered equals. American women are entitled to, and expect to be granted the same consideration and respect as men. Furthermore, women are guaranteed equal protections under the law. Although there remains progress to be made in terms of gender equality in the workplace, women have access to every occupation and career path, including all fields of medicine. Most American nurses are female and nearly half of all medical students in the U.S. are women. When interacting with patients and colleagues, the physician must always be respectful and avoid preconceptions or stereotypes based on sex or gender. The American workplace is intolerant of any form of gender discrimination or sexual harassment. Most hospitals have formal training in this area, and all have strict policies and procedures for dealing with potential violations, both legal and ethical. Prudence is advised in avoiding sexually charged comments, humor, and innuendo. There is no place for these in the medical workplace or in the doctor-patient relationship.

9. **Safety and Errors** - Following a recent landmark report by the Institute of Medicine, increasing attention has focused on patient safety and medical errors. Steps have been taken to eliminate or minimize errors, and all policies and protocols aimed at ensuring patient safety must be carefully adhered to. Nevertheless, occasional errors or unanticipated bad outcomes will occur. In these situations, immediate identification, proper documentation, and full reporting to the appropriate people is crucial (attending physicians, hospital administrators, patient, family, etc.). Under no circumstances may any entry or component of the patient medical record be deleted or altered, except by appropriately documented addendum.

10. **Informed Consent** – Before they are asked to provide consent, American patients have the legal and ethical right to receive all relevant information about possible outcomes and complications of proposed studies, interventions, or surgeries. In order to constitute informed consent, the potential risks, benefits, and alternatives to a proposed procedure must be discussed, and any patient questions or concerns must be addressed. Situations where emergencies preclude proper consent, or those involving unaccompanied minors and others who are not "competent" to make informed decisions require special procedures in accordance with state law and hospital protocol. In some cases, a relative or other person may have the legal responsibility (e.g. Power of Attorney or legal Conservatorship) to provide consent on behalf of the patient when he or she is unable to do so. In any situation when a patient is unresponsive or

unable to make informed decisions, an attempt should be made to locate the patient's Advanced Directives. Advanced Directives are a legal document that specifies the care a patient may or may not wish to receive in the event that he or she becomes terminally ill or unresponsive and cannot participate directly in the decision making process. Consultation with family members, social workers, the hospital ethics team, or other staff can be helpful in these situations. When in doubt regarding informed consent, ask for help!

A special situation that is frequently seen in American medicine relating to informed consent involves the "Do Not Resuscitate" (DNR) order. When these orders are legitimately in place, advanced resuscitative techniques must not be employed and intervention should be aimed at comfort measures rather than heroic efforts to resuscitate the patient.

11. U.S. Graduate Medical Education - Graduate Medical Education (GME) Programs are highly organized teaching and learning environments. Residency training programs and fellowships must be approved and accredited by the Accreditation Council for Graduate Medical Education (ACGME). This national organization sets strict requirements for what must be learned, the clinical experiences that must be made available, how many and what kinds of patients must be seen, and general working conditions (including a maximum of 80 working hours per week). Underlying all the requirements for training programs are the six core competencies:

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

Although physician residents and fellows in GME training programs have a great deal of responsibility and may even be licensed physicians, ultimate responsibility for patient care and safety rests with the attending physician. For this reason, attending physicians must always be kept informed of all patient care issues and it must be recognized that they have final authority in directing patient care and management. As physicians in training advance, attending physicians tend to give them more autonomy and responsibility for patient care. However, it is critical to communicate clearly and frequently with the attending physician, especially for the junior resident or fellow.

GME training programs are designed to be learning environments in which mistakes are expected and where the physician in training may be lacking in some knowledge relevant to the care of the patient. This is feasible only because of the redundancy and oversight built into the system. However, in such situations, it is not only acceptable, but mandatory that the resident or fellow be completely forthright in acknowledging the mistake or the lack of knowledge to the attending physician. Honest mistakes or deficiencies in knowledge or skill can always be appropriately addressed; conversely, hiding mistakes, blaming others, faking knowledge or any form of dishonesty is always wrong and could lead to termination from the training program and/or preclude medical licensure.

12. Above All, Professionalism - In the United States, physicians are among the most respected of all professionals. The practice of medicine must be more than a job or occupation and the physician must always be guided by the highest professional ethical and personal standards. Professionalism calls for dedication to the patient in which every aspect of his or her welfare (physical, emotional, psychological, spiritual, financial, etc.) is taken into account and served to the best of the physician's ability. Physicians are expected to commit themselves to the process of lifelong for on-going professional development. Professionalism in medicine requires the recognition that medicine involves both science and art, and is fundamentally devoted to the service of humankind.

A link to the ECFMG® webpage with additional materials related to acculturation is available on the GME website. Access can be found at:

- www.wings.buffalo.edu/smb/GME/
- Menu on left - choose "Training Resources"
- Scroll down and click on "ECFMG Acculturation Program"

ECFMG® is an organization committed to promoting excellence in international medical education.