

University  
of  
Virginia  
Family **2008**  
Medicine  
Residency  
Program

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Residency  
Handbook

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MISSION

***Our Mission, Our Vision, Our Values***  
**Department of Family Medicine**  
**The University of Virginia**

***Mission Statement***

We strive to create a Department of Family Medicine

- ◆ where every member feels valued, heard and respected;
- ◆ where honesty is implicit in our daily work, and
- ◆ where communication is direct and open;
- ◆ where the teaching, practice and advancement of healing is paramount;
- ◆ where healthcare is delivered with compassion and respect;
- ◆ where balance is maintained in our professional and personal lives; and
- ◆ where all members feel integral to the mindful pursuit of these goals.

***Vision Statement***

We will change the way people think about health

We will change the way people deliver health care

We will change the way people care for themselves

***Values Statement***

We value:

**Compassion** and

**Respect** in our relationship with our patients, learners and colleagues

**Excellence** in all that we do.

**Wholeness** in those we serve and in ourselves.

GENERAL INFORMATION

**1.0 GENERAL INFORMATION**

**1.1 Purpose**

The purpose of this manual is to provide you with direction for navigating the next three years during your residency training and serve as a resource book for the University of Virginia, Department of Family Medicine Residency Program. It is a guide to the operations, procedures and structure of the program.

**1.2 Locker**

Each resident has a locker in/ near the Residents' Lounge. Lockers are assigned at the beginning of the year (July 1) by the Residency Program Coordinator.

**1.3 Mail**

Individual mailboxes are provided for each resident near the Residents' Lounge. The mailing address for our practice is:

University of Virginia Health System  
Dept. of Family Medicine  
Box 800729  
Charlottesville, VA 22908

**1.4 Emergency Notification**

*1.4.1 Resident Absence:*

If for any reason the resident is unable to meet rotation obligations, the chief residents should be notified promptly. The Residency Program Director should also be notified. Call his administrative assistant at 243-6638 from 9 A.M. to 5 P.M or page him through the hospital operator: 804-924-0000, pic # 2172. After hours, Dr. Gazewood can be contacted at home. If he is not available, contact the Associate Director, Dr. Lockman. If no response, contact the Residency Program Coordinator at 243-6638 (office), pic # 4321. If you will be absent from your patient care duties in the Primary Care Center, you must also contact the Clinical Director for Scheduling, Ursulla Courtney (pic # 2230). If you will be absent from patient care duties at Crossroads, Stoney Creek, or Western Albemarle Family Medicine, you must also contact the medical director of that practice (refer to list of contacts at end of this document).

When illness and absences occur, it is expected that other residents will work together to handle clinical and call responsibilities. The Chief Residents and Program Director are responsible for coordinating this process to assure an equitable division of responsibilities among the other residents.

GENERAL INFORMATION

1.4.2 *Family Notification of On-Site Incident:*

The Department of Family Medicine must be kept current with each resident's home address and phone number. Should an incident occur necessitating family contact, the Department will reach your "significant other" or permanent phone contact indicated on the resident's CV. Inform the Residency Program Coordinator (434-243-6638) of any changes as they occur.

1.4.3 *Resident Notification of Family Emergency:*

The Residency Program Coordinator will maintain up-to-date rotation schedules tracking resident activities. Should you be unavailable by pager, please notify the Coordinator so you may be contacted in the event of an emergency.

NATIONAL REQUIREMENTS

**2.0 NATIONAL REQUIREMENTS (American Board of Family Medicine)**

Program Directors must provide the Board with a signed acknowledgement from each resident indicating that, at time of entry into the program, the resident has read the following:

- (1) the ACGME “Essentials of Accredited Residencies” (General);
- (2) the “Special Requirements for Residency Training in Family Medicine”;
- (3) the “Requirements for Certification by the American Board of Family Medicine”; and
- (4) any additional requirements of the particular program into which the resident enters.

**It should be noted that any variance from the “Special Requirements for Residency Training in Family Medicine” or failure to comply with the ABFM Requirements for Certification places the resident at risk of being unable to qualify for the Board’s examination and certification.**

**2.1 Advanced Level Entry/Inter-program Transfers**

Transfer from one accredited Family Medicine program to another after the beginning of the PGY-2 year is strongly discouraged. The Board will consider only those requests for transfers that involve extenuating circumstances.

Any change that has not been approved by the Board and is at variance with the requirement for continuity will place the resident’s application for the Certification Examination in jeopardy.

The resident seeking transfer or advanced placement is responsible for having the previous Program Director provide the ABFM with final documentation of satisfactory performance by the resident.

**2.2 Part-time Residency in Family Medicine**

In order for the resident to qualify for the ABFM Certification Examination, the part-time resident must have prior written approval of the Board and must meet the conditions listed below:

- A. The resident should have participated in a PGY-1 year of full-time activity in an ACGME accredited Family Medicine residency program, a diversified ACGME G-1 year, or an AOA (osteopathic) rotating internship that has provided a broad experience equivalent to the PGY-1 year of a Family Medicine residency program.
- B. A detailed curriculum describing the manner in which the program meets the “Essentials” must be approved in advance by the ABFM and filed with the board. Any changes in curriculum must be approved by the ABFM.
- C. The part-time experience in the PGY-2 and PGY-3 years must provide continuity of training in the same Family Medicine program.
- D. Continuing comprehensive care for Family Medicine center patients must involve the resident in the care of patients for a minimum time equivalent to two half-days each week during the PGY-2 year and three half-days each week during the PGY-3 year.

NATIONAL REQUIREMENTS

**2.3 Double Boarding**

- A. The candidate must have satisfactorily completed 36 full calendar months of ACGME accredited training.
- B. The PGY-1 year (12 calendar months) must conform to the ACGME “Special Requirements for Residency Training in Family Medicine,” as well as the American Board of Family Medicine criteria for transfer to an ACGME-accredited PGY-2 year in Family Medicine if the PGY-1 year is not in an ACGME-accredited Family Medicine program.
- C. The remaining 24 calendar months (the PGY-2 and PGY-3 years) must be in the same ACGME accredited Family Medicine residency program, and the resident must be considered officially as a resident in Family Medicine under the supervision of the Family Medicine Program Director.

**2.4 Absence From Residencies**

2.4.1 *Continuity of Care:*

Residents should develop and maintain a continuing physician-patient relationship with a panel of patients throughout the three-year period. This relationship must be in continuity during the resident’s second and third years and include patient contacts in the Family Medicine center, inpatient facility, domiciliary facility and patients’ homes.

2.4.2 *Remote Site Experience:*

The use of remote sites or rotations on clinical services (associated with or external to the program) must not interrupt continuity of care at the Family Medicine center for longer than two months in each of the second and third years. Upon return to the Family Medicine center, the resident must provide continuity of care for his/her patients for at least two months before leaving for any additional remote experiences.

2.4.3 *Limitations on Absences:*

Family Medicine residents must have a deep feeling of personal responsibility for the continuing, comprehensive care of the patient. Outside activities that interfere with the proper discharge of this responsibility should not be permitted.

Time off from the residency, in excess of one month within the academic year (PGY-1, PGY-2 or PGY-3 year), must be made up before the resident advances to the next training level, and the time must be added to the projected date of completion of the required 36 months of training.

NATIONAL REQUIREMENTS

2.4.4 *Vacation/Illness/Other Absences:*

Residents are expected to perform their duties as resident physicians for a period of eleven months each calendar year. Therefore, absence from the program for vacation or illness must not exceed a combined total of one month (30 calendar days or 21 workdays) per academic year.

Time away from the residency program for educational purposes, such as workshops or continuing medical education activities, is not counted in the general limitation on absences but should not exceed 5 days annually.

Leaves of absences from the residency, exclusive of the one-month vacation/sick time, may interrupt continuity of patient care for a maximum of three months in each of the PGY 2 and PGY 3 years of training. Leaves may be interspersed throughout the year or taken as a three months' block of time. Following a leave of absence of any length duration, the resident must return to the program and maintain care for his/her panel of patients for a minimum of two months before any subsequent leave. Leave time must be made up before the resident advances to the next training level and the time must be added to the projected date of completion of the required 36 months of training. Residents will be permitted to take vacation time immediately prior or subsequent to a leave of absence.

In cases where a resident is granted a leave of absence by the program, or must be away because of illness or injury, the Program Director must promptly inform the Board in writing of the date of departure and expected return date. It should be understood that the resident may not return to the program a level beyond that which was attained at the time of departure.

Leaves of absence in excess of three months are considered a violation of the continuity of care requirement. Programs must be aware that the Board may require the resident to complete additional continuity of patient care time beyond what is expected to complete training requirements in order to be eligible to make application for certification.

Remote site training must comply with ACGME "Special Requirements" and will not be affected by any leave of absence taken by a resident.

Vacation periods may not accumulate from one year to another. Annual vacations must be taken in the year of the service for which the vacation is granted. No two vacation periods may be concurrent (e.g., last month of the PGY-2 year and first month of the PGY-3 year in sequence) and an intervening period of at least 3 months must separate any two vacation segments of one month's duration each. A resident does not have the option of reducing the total time required for residency (36 calendar months) by forgoing vacation time.

**2.5 In-Training Assessment Examination**

2.5.1 *General Information:*

The American Board of Family Medicine In-Training Examination is a cognitive examination given annually on the first Friday in November. The participating residents remain anonymous to the American Board of Family Medicine. The examinations are scored by the Board.

NATIONAL REQUIREMENTS

2.5.2 *Format/Design:*

The In-Training Examination is intended merely as an assessment of the individual resident and provides useful information to the Program Director as well as to the resident. It consists of items written to test the core of knowledge and patient management skills in eight major areas: Internal Medicine, Surgery, Obstetrics, Community Medicine, Pediatrics, Psychiatry and Behavioral Sciences, Geriatrics, and Gynecology.

**2.6 Requirements for Certification (ABFM)**

- A. All candidates for the American Board of Family Medicine Certification Examination must have:
- satisfactorily completed 3 years of training (a full 36 calendar months with 12 months in each of the PGY-1,2, and 3 years) in a Family Medicine residency program accredited by the Accreditation Council for Graduate Medical Education (ACGME) subsequent to receipt of the M.D. or D.O. degree from an accredited institution and when applicable, a Fifth Pathway Year, or
  - receipt of a Standard Certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), or
  - compliance with other ACGME requirements for entry into graduate medical training in the United States.
- If a physician does not meet the eligibility requirements of the ACGME for entry into residency training, his/her training will not be recognized by the Board.
- B. Candidates must complete all requirements of the Board no later than June 30 of the year of the examination. Complete documentation from the Program Director that the resident has or is expected to have satisfactorily completed the residency must be received by the Board by June 30.
- C. All candidates must hold a currently valid, full and unrestricted license to practice medicine in the United States or Canada.

No candidate will be allowed to take the examination until all fees are paid and all of the above requirements have been satisfactorily met.

NATIONAL REQUIREMENTS

**2.7 Institutional Requirements of the Essentials of Accredited Residencies in Graduate Medical Education (effective July 1, 1997)**

See Housestaff Manual for complete information on:

- 2.7.1 *Accreditation of Graduate Medical Education Programs*
- 2.7.2 *Responsibilities to Residents*
- 2.7.3 *Resident Financial Support and Benefits*
- 2.7.4 *Resident Supervision and Working Environment*
- 2.7.5 *Ancillary Support*
- 2.7.6 *Counseling and Support Services*
- 2.7.7 *Scholarly Activity*

**2.8 Special Requirements for Family Medicine Residency Training**

2.8.1 *Duration of Training:*

Residencies in Family Medicine must be at least 3 years in duration after graduation from medical school and must be planned so that a coherent, integrated and progressive educational program with progressive resident responsibility is assured. The training must be specifically designed to meet the educational needs of medical school graduates intending to become family physicians.

2.8.2 *Size of Program:*

In order to provide adequate peer interaction, a program should have a minimum of 12 residents at various levels of training. Residents accepted into the first year of training should be assured a position for the full 3 years, barring the development of grounds for dismissal. Except for periods of transition, the program should offer the same number of positions for each of the three years.

2.8.3 *Scope of Training:*

Family Medicine residency programs must provide experience and responsibility for the residents in those areas of medicine that will be of importance to their future practice. Since Family Medicine programs are, in part, dependent upon other specialties for the training of residents, the ability and commitment of the institution to fulfill these requirements must be assured. Specifically, the sponsoring institution must assure the existence and availability of those basic educational and patient care resources necessary to provide the Family Medicine resident meaningful involvement and responsibility in the necessary clinical specialties.

The existence of other programs sponsored by the residency, e.g. geriatric medicine, must not result in the dilution of experience available to the Family Medicine residents. Instruction in the other specialties must be conducted by faculty with expertise in these fields. The curricula and plans for such rotations or experiences must be developed by the Family Medicine faculty in concert with appropriate other specialty faculty.

There must be agreement regarding the residents' need to maintain concurrent commitment to their patients in the Family Medicine center during these rotations. The program should implement a plan

NATIONAL REQUIREMENTS

to assure that the residents retain their identity and commitment to the principles and philosophic attitudes of Family Medicine throughout the training program, particularly while they learn the appropriate skills, techniques and procedures of other specialties.

Family Medicine residency programs should provide the opportunity for the residents to learn, in both the hospital and ambulatory settings, those procedural skills, which can reasonably be anticipated as part of their future practices. There must be a method of documenting the procedures performed and of evaluating the residents' competence. Such documentation should be maintained by the program.

It is the responsibility of the residents to render patient care in the pursuit of their education without additional remuneration based on productivity. This does not preclude them from earning income from patient care during off hours provided this activity does not interfere with their education and performance as residents. In addition, such activity should not be in conflict with the policies of the program or the sponsoring institution.

The goal of the Family Medicine training program is to produce fully competent physicians capable of providing high quality care to their patients. To prevent impairment and promote physician well-being, residents should be trained to balance personal and professional responsibilities in a way that can be reenacted throughout their careers. Because impaired physicians cannot achieve these goals, the program must have in existence a mechanism to identify and prevent impending impairment. The program must be able to intervene appropriately on behalf of the impaired resident and to protect the welfare of patients.

Both educational and patient care activities are best conducted when residents have appropriate amounts and levels of supervised responsibility and when their schedules allow them to make full utilization of their educational experiences without resultant counterproductive stress, fatigue and depression.

There should be adequate resident staff to prevent excessive patient loads, excessive new admission work-ups, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation. The program must:

- A. Ensure that residents do not work more than 80 hours per week, averaged over a 4-week period.
- B. Permit residents to spend, on average, at least 1 day out of 7 away from the residency program.
- C. Assign on-call duty no more frequently than every third night on average.
- D. Ensure adequate back up if sudden and unexpected patient care needs create resident fatigue sufficient to jeopardize patient care during or following on-call periods.
- E. Ensure that continuous on-site duty not exceed 24 hours (with up to 6 additional hours for on-site rounds, transferring care, or continuity office hours). Afternoon clinics following overnight call are not allowed. Night float residents may have their clinic either immediately before or after their night duties, but must have at least 10 hours of rest between assigned duties.

**Formal written policies on these matters should be established and be available to the RRC, should they be requested.**

NATIONAL REQUIREMENTS

## 2.9 Curriculum

Every residency program must have the “core” or required curriculum as contained herein. However, it may be flexible enough to utilize the strengths of the program.

### 2.9.1 *Outpatient Family Medicine:*

The following curricular areas must be integral to each program. In addition, residents must be taught to demonstrate and clearly articulate the philosophy and concepts of Family Medicine to patients.

- A. Continuity of Care—Continuity of care is an important concept in Family Medicine and is expressed in the role and interrelationships that the system (e.g. solo or group), the professional, the individual patient, the patient’s family, the institution and the community play in maintenance of continuity of care.

Continuity of primary responsibility for patient care must be taught in a longitudinal way and include the following:

- ◆ ambulatory care
- ◆ in-patient care
- ◆ home care
- ◆ domiciliary care: e.g., nursing, extended care facilities
- ◆ referral and consultation
- ◆ integrative function of the family physician
- ◆ utilization of community resources

Residents may spend time away from the Family Medicine Center in outside rotations designed to meet the needs of their training. The educational value of these rotations must be clearly documented. At these remote sites, the same degree of constant on-site supervision is required as is required in the Family Medicine center. The use of remote sites or rotations on clinical services must not interrupt continuity of care at the Family Medicine center for longer than 2 months during the second and 2 months during the third year. Residents must return to the Family Medicine center and provide continuity of care for their panels of patients for at least 2 months before or after leaving for any additional remote experience.

- B. Family-Oriented Comprehensive Care—the residents must be given the opportunity to achieve high levels of competence in health maintenance, in disease and problem management, and in the development of knowledge, skills and attitudes which reflect expertise in comprehensive patient management. Residents must also be trained in patient education. Comprehensive care must be taught longitudinally in didactic and clinical settings during the entire period of residency training.
- C. Primary Setting for Family Medicine—while the resident’s acquisition of knowledge, skills and attitudes of family medicine should take place during all curricular elements, the primary setting for this training is in the Family Medicine center as the residents provide continuing, comprehensive care to their panels of patients.



















































