

## EDUCATION OF PHYSICIANS AND DENTISTS

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Directive delineates policies relating to the establishment and administration of residency and student training programs in allopathic and osteopathic medicine and in dentistry in VA medical facilities.

**2. SUMMARY OF MAJOR CHANGES:** This is a new Directive, written with specific emphasis on:

a. Roles and responsibilities of individuals involved with oversight and administration of VHA's medical and dental training programs.

b. Policies relating to the establishment and administration of medical and dental training programs for students and residents, including student supervision.

c. Policies relating to appointment and pay of medical and dental students and residents.

d. Policies relating to the supervision of medical and dental students.

e. Policies relating to due process for trainee performance, remediation and disciplinary action.

f. Policies relating to medical malpractice claims against VA in cases including trainees.

g. Policies pertaining to the use of quarters for medical and dental trainees.

h. Policies pertaining to the provision of meals for noncareer medical and dental residents.

i. Policies pertaining to travel reimbursement for medical and dental trainees.

j. Amendment, dated December 26, 2018 updates policies pertaining to medical student documentation.

**3. RELATED ISSUES:** VHA Directive 1400 and VHA Handbook 1400.01, Resident Supervision. VA Handbook 4003, Travel Reimbursement.

**4. RESPONSIBLE OFFICE:** The Office of Academic Affiliations (10A2D) is responsible for the contents of this directive. Questions may be referred to 202-461-9490.

**5. RESCISSIONS:** M-8 Part II, Chapter 1, is rescinded.

September 9, 2016

VHA DIRECTIVE 1400.09(1)

**6. RECERTIFICATION:** This VHA Directive is scheduled for re-certification on or before the last working day of September 2021. This Directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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## EDUCATION OF PHYSICIANS AND DENTISTS

### 1. PURPOSE

This Veterans Health Administration (VHA) directive delineates policies relating to the establishment and administration of residency and student training programs in allopathic and osteopathic medicine and in dentistry in VA medical facilities.

**AUTHORITY:** Title 38, United States Code (U.S.C.), 7406.

### 2. BACKGROUND

#### a. General.

(1) The education of future health care personnel is a statutory mission of VA. By establishing close relationships between VA and academic institutions, VA plays a leading role in health professions education. VA maintains effective affiliations with educational institutions, which contributes to excellence in VA patient care, education, and research. The sponsoring institution has primary responsibility for the integrated education programs conducted with VA, and VA retains full responsibility for the care of VA patients and operation of VA medical facilities and programs.

(2) All affiliated medical and dental training programs for students and residents must be accredited, with the sponsoring institution having primary responsibility for maintaining accreditation with the appropriate agency. All trainees in VA clinical facilities must be supervised by supervising practitioners (see VHA Handbook 1400.01, Resident Supervision). Residents may also supervise medical or dental students as appropriate, but the supervising practitioner ultimately has responsibility for all patient care. All trainees are subject to pertinent VHA regulations and policies. This Directive pertains to all clinical, research, and administrative settings in which medical or dental students and residents may be involved as part of their VA training experience.

(3) Medical and dental residents will be paid out of VHA centralized budget funds administered by the Office of Academic Affiliations (OAA) and distributed to facilities according to a defined resident allocation process. VA medical facilities may not pay residents out of local medical care funds.

b. **Medical and Dental Trainees.** Medical/dental trainees are expected to adhere to professional and program-specific standards during VA rotations. The education of medical or dental students and residents involves the acquisition of detailed factual knowledge in medicine or dentistry and the development of clinical skills and professional competencies. Professional standards of conduct include, but are not limited to, honesty, altruism, confidentiality, attendance, timeliness, proper appearance and hygiene, compliance with all applicable ethical standards, an ability to work cooperatively and collegially with staff and other health care professionals, and appropriate and professional interactions with patients and their families.

c. **Program Standards.** All physician and dentist residencies and student programs in VA medical facilities must be accredited by appropriate accrediting bodies. VA

medical facilities may accept trainees only when the affiliated sponsoring institution and the educational program are accredited by the appropriate accrediting bodies, which include for medical students the Liaison Committee on Medical Education (LCME) and for osteopathic medical students the Commission on Osteopathic College Accreditation (COCA), American Osteopathic Association (AOA). For physician residents, programs must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association. Dental students and residents must come from programs accredited by the American Dental Association, Council on Dental Education, Commission on Dental Accreditation (CODA). A program for which accreditation is withdrawn must be discontinued and all funded positions phased out. The Chief Academic Affiliations Officer must be notified as soon as possible of any program that is losing or likely to lose accreditation or is administratively withdrawing accreditation in order to plan for program closure.

(1) **Medical (Physician) Residency Training Programs.** The basic requirements for allopathic medical residency training programs are established and published by the Accreditation Council for Graduate Medical Education (ACGME) (available at: <http://www.acgme.org>). The basic requirements for osteopathic residency programs are established and published by the American Osteopathic Association" (AOA) (available at: <http://www.osteopathic.org>). **NOTE:** *An agreement between ACGME and AOA was reached in 2014 to incorporate the accreditation of AOA programs into ACGME program accreditation. This process will be phased in over a 5-year transition period.*

(2) **Medical Student Training.** The basic requirements for allopathic undergraduate medical students are described by the Liaison Committee on Medical Education (LCME) ([www.lcme.org](http://www.lcme.org)) and for osteopathic medical students by COCA, American Osteopathic Association (AOA) ([www.osteopathic.org](http://www.osteopathic.org)).

(3) **Dental Residency and Student Training Programs.** The basic requirements for dental residency and student training programs are described by the Council on Dental Education, Commission on Dental Accreditation (CODA), American Dental Association (available at <http://www.ada.org>).

**d. VA Independent Sponsorship of Physician Residency Training Programs.** Existing ACGME-accredited physician residency training programs sponsored independently by a VA medical facility may continue to function, as long as they maintain ACGME accreditation. New residency training programs seeking ACGME accreditation may not be sponsored by a VA medical facility and must be sponsored by an academic affiliate or an affiliated accredited teaching hospital. A program for which accreditation is withdrawn must be discontinued, and all funded positions phased out. The Chief Academic Affiliations Officer must be notified as soon as possible of any program that is losing accreditation or for which accreditation is being withdrawn (even voluntarily) in order to plan for program closure. **NOTE:** *Historically, a few VA medical facilities independently sponsored residency training programs. The decision not to approve new, independently VA-sponsored programs is based upon the observed difficulty that VA-sponsored programs have in meeting accreditation standards relating to program requirements, especially those regarding gender mix in the patient*

population and in sustaining the required level of scholarly activity and other curricular program requirements.

### 3. DEFINITIONS

a. **Accreditation.** A status of public recognition that an accrediting agency grants to an educational institution or program that meets the agency's established standards and requirements. Accreditation represents a professional opinion about the quality of an educational program.

b. **Accrediting Agencies for Physician Education.** Authorized accrediting agencies recognized by VA for undergraduate medical education are the Liaison Committee on Medical Education (LCME) for allopathic medical schools; and the American Osteopathic Association's Commission on Osteopathic College Accreditation (AOA COCA) for predoctoral osteopathic medical education in the United States. Allopathic medical postgraduate training is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The AOA, through its Program & Trainee Review Committee (PTRC), approves osteopathic postdoctoral training programs, determines program eligibility requirements, and evaluates interns and residents as well as the postdoctoral programs. ***NOTE: AOA programs are, by agreement with ACGME, being phased out and will be included under ACGME oversight in the future.***

c. **Accrediting Agency for Dental Education.** The Commission on Dental Accreditation (CODA) is the national accreditation entity for undergraduate and graduate dental education.

d. **Accrediting Agency.** An external educational association of regional or national scope, which develops and publishes criteria by which it conducts evaluations to assess whether or not those criteria are met. Institutions and/or programs that request an agency's evaluation and that meet an agency's established criteria are deemed "accredited" by that agency.

e. **Adverse Action.** Adverse actions are disciplinary actions, which may include dismissal, based upon the seriousness of conduct or performance problems. VA has no jurisdiction over adverse actions taken by an affiliated program, but may independently reach a decision not to allow an affiliated trainee to continue VA training experiences.

f. **Affiliation.** A relationship between VA and an educational institution or other health care facility for the purposes of education and enhanced patient care. An affiliation may also involve research. VA and the affiliate have a shared responsibility for the educational enterprise.

g. **Associate Chief of Staff for Education.** A designated education leader with expertise in GME and health professions education. ***NOTE: ACOS/E is the preferred organizational title for individuals assigned the responsibilities for the role of Designated Education Officer (DEO).***

h. **Chief of Staff.** The VA medical facility Chief of Staff is the local management official who is responsible for establishing, maintaining, and evaluating the quality of

clinical training programs at the VA medical facility, and the quality of care provided by supervising practitioners and residents. An ACOS/E or similar education leader may assist the chief of staff in fulfilling these requirements.

i. **Chief Resident.** The Chief Resident is an individual who is considered senior in the training program and who may or may not be a licensed independent practitioner. Chief residents are designated by the Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents fall into one of two categories:

(1) **Chief Resident – In Training.** Chief residents who are currently enrolled in an accredited residency program, but who have not completed the full academic program leading to board eligibility. These chief residents are not independent practitioners and cannot be privileged to work in the discipline for which they are being trained. This model is common in surgery programs.

(2) **Chief Resident – Post Training.** Chief residents who have completed an accredited residency program, but engage in an additional, non-accredited year of training and responsibility. These chief residents have completed their primary training for board eligibility or are board-certified and may be privileged in the discipline of their completed specialty-training program. These chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

j. **Computerized Patient Record System.** Computerized Patient Record System (CPRS) is the VA primary patient record system that stores information in the Veterans Health Information Systems and Technology Architecture (VistA), or other automated systems using electronic storage. CPRS supports entry of notes and orders, rules-based order checking, and results reporting. Also integrated into CPRS is VistA imaging, which permits display of radiological images, Electrocardiograph (ECG) tracings, imaging from other sources, and document scanning.

k. **Continuity Clinics.** Continuity clinics are ambulatory experiences in providing ongoing continuity care (comprehensive patient care management including health maintenance provided via a patient's long-term relationship with the practitioner or practice group) to a defined panel of enrolled patients.

l. **Co-signer.** A "co-signer" is the supervising practitioner or person ultimately responsible for the patient-related documentation. A co-signer may also be a service chief or designee as defined by the organization's bylaws and/or policies. Absent an addendum to the contrary, a co-signature alone implies that the signer agrees with the specifics of the note (see also "electronic signature").

m. **Designated Education Officer.** The VA Designated Education Officer (DEO) is the single, designated VA employee who has oversight responsibility for all clinical trainees and their training programs at each VA medical facility that either sponsors or participates in accredited training programs. The organizational title for this education leader may be the ACOS/E (preferred), Director of Education, Chief Education Service Line, or other similar title. **NOTE:** *The DEO describes a functional assignment and not an organizational title. Each VA medical facility involved with residency programs must*



appoint a DEO for coordination of local GME and other education activities as assigned (see paragraph 4.g).

n. **Designated Institutional Official.** The Designated Institutional Official (DIO) is an individual employed by the sponsoring entity who has the authority and responsibility for the oversight and administration of trainees in discipline-specific programs. The ACGME requires that each institution sponsoring ACGME-accredited programs have an individual appointed as the DIO who is responsible for ensuring compliance with ACGME institutional requirements. For affiliated, sponsoring institutions with osteopathic training programs, the comparable individual is called the "Director of Medical Education." ***NOTE: A VA medical facility that sponsors ACGME-accredited programs independently must have a DIO, although the responsibilities and functions overlap with those described for the DEO. See Designated Education Officer.***

o. **Didactic Sessions.** Didactic sessions are formal, structured meetings such as conferences and seminars for exchange of medical/dental information. Didactic sessions include lectures and Grand Rounds, but not clinical assignments.

p. **Disbursement Agreements.** A disbursement agreement is a payroll mechanism by which VA allows an affiliated, sponsoring institution to centrally administer either salary payments and fringe benefits (full benefits agreements) or fringe benefits alone (fringe benefits only) for physician and dental residents training at a VA medical facility (see VHA Handbook 1400.05, Disbursement Agreements Procedures).

q. **Educational Activities.** Activities in which trainees may participate in order to meet educational goals or curriculum requirements of a training program. These may include clinical duties under appropriate supervision, research, literature searches, assigned independent study, attendance at committee meetings (e.g., medical resident attendance of quality improvement or pharmacy committees), participation on root cause analysis teams, or scholarly activities undertaken as part of an accredited training program (e.g., preparation and presenting a clinically-related conference), and didactic sessions.

r. **Educational Detail.** An authorized training experience at a non-VA, non-sponsoring institution or non-participating site or at a VA site different from the VA medical facility where the majority of the resident's training occurs.

s. **Electronic Signature.** VA's electronic health record defines three types of electronic signature (see VHA Handbook 1907.01, Health Information Management and Health Records)

(1) A "signer" is the author of the document.

(2) A "co-signer" is the supervising practitioner. A co-signer may also be a service chief, or designee, as defined by the organization's bylaws and/or policies.

(3) "Identified signer" and "additional signer" are synonymous and either is a communication tool used to alert a clinician about information pertaining to the patient.

This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer does not constitute a co-signature. This nomenclature in no way implies responsibility for the content of or concurrence with the note. **NOTE:** *“Identified signer” is nomenclature used by CPRS, VistA, and Text Integration Utilities (TIU); “additional signer” is nomenclature used by graphic user interface (GUI).*

t. **Gifts and donations to VA.** A gift or donation may be cash or in-kind from for-profit, non-profit, public, or private entities or individuals, provided to further a mission of VA with no expectation of receiving anything in return.

u. **Participating Institution.** A participating institution is any site to which a resident (in a given residency training program) may rotate for required educational experience and/or those that require explicit approval of the accrediting body. Assignments to participating institutions require advance approval of the accrediting body and may include elective rotations. Generally, to be designated as a major participating institution, in a 1-year program, residents must spend at least 2 months in a required rotation; in a 2-year program, the rotation must be 4 months; and in a program of 3 years or longer, the rotation must be at least 6 months. The accrediting body may grant exceptions to this formula. **NOTE:** *In most cases, VA is a “participating institution” in the academic affiliate-sponsored program.*

v. **Payments.** Provision to VA of funds or in-kind compensation from for-profit, non-profit, public or private entities, or individuals in exchange for goods or services rendered by VA.

w. **Performance Problems.** Failure to meet expected competencies as defined by the training program, regardless of cause. Performance problems may include, but are not limited to, the following:

(1) Failure to develop expected skills, knowledge, and attitudes.

(2) Impaired status is a condition or state in which a trainee is rendered less capable of fulfilling program requirements adequately because of a variety of emotional or medical conditions, including physical or mental illness and substance use. **NOTE:** *Examples may include reporting for duty under the influence of drugs or alcohol, sleep deprivation, emotional distress, or altered mental status.*

(3) Disruptive behavior is abusive, intimidating, or other behavior that disturbs the workplace environment or that interferes or might reasonably be expected to interfere with patient care. **NOTE:** *Examples include profane or demeaning language, sexual comments or innuendoes, outbursts of anger, throwing objects, boundary violations with staff or patients, inappropriate health record notes, and unethical, illegal, or dishonest behavior.*

x. **Preceptor (Supervising Practitioner).** The preceptor (supervising practitioner) is the individual responsible for directly supervising the activities of the trainee. The preceptor is generally of the same discipline or specialty in which the trainee is being

educated. The preceptor provides clinical care or performs a service within the clinical environment, and teaches trainees primarily using the apprenticeship model of education. Preceptors may also convey information via more formal methods of instruction.

y. **Residency/Training Program Director.** The residency/training program director is the individual designated by the sponsoring institution who is responsible for the maintenance, evaluation, and improvement of a particular education and training program across all affiliated sites. This individual is responsible for ensuring that the program is in compliance with standards and policies of the respective accrediting and/or certifying bodies. He/she is responsible for program operations and logistics, educational objectives and curriculum development, evaluation methodologies and mechanics, and relationships with external accrediting agencies and certifying bodies. This individual may or may not be based at the VA medical facility.

z. **Residents.** Individuals who are engaged in an accredited graduate training program in medicine (that includes all physician specialties, e.g., internal medicine, surgery, psychiatry, radiology, etc.) or dentistry, and who participate in patient care under the direction of supervising practitioners. ***NOTE: The term “resident” includes individuals in their first year of training often referred to as “interns” and individuals in approved subspecialty graduate medical education programs who may be referred to as “fellows.”***

aa. **Scholarly activities.** Scholarly activities include educational experiences that may involve any of the following or similar types of experiences: active participation in clinical discussions, rounds, and conferences in a manner that promotes a spirit of inquiry and scholarship; active participation in journal clubs, research conferences, regional or national professional and scientific societies, particularly through presentations at the organizations' meetings and publications in their journals; participation in research, primarily, but not necessarily, in projects that are funded following peer review and/or result in publications or presentations at regional and national scientific meetings; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation in scholarly activities. ***NOTE: The definition above is modified from the ACGME. Additional or more specific scholarly activities may be delineated in program requirements set by the accrediting or certifying body.***

bb. **Site Director (VA Residency Site Director).** The site director (VA residency site director) is the individual responsible for implementing the training program curriculum at a particular site. This individual develops the local educational program based on the educational plan of the residency/training program director, specifically ensuring that core curricular objectives are met. The site director is generally of the same discipline as that of the trainees, but may be assisted in his or her duties by a clerical or administrative assistant.

cc. **Students.** Individuals assigned to a VA medical facility during the clinical phase of their undergraduate medical or dental education prior to obtaining a graduate degree

from their respective accredited schools (medicine or dentistry). Students must be under the direct supervision of a supervising practitioner. Residents may participate in the education and clinical training of students. Students do not have either the responsibility or the authority for providing independent patient care. **NOTE:** *Students have also been referred to as clinical clerks, sub-interns, externs, or acting interns.*

dd. **Supervising Practitioner.** Supervising practitioner refers to licensed, independent physicians and dentists, regardless of the type of appointment, who have been credentialed and privileged at VA medical facilities in accordance with applicable requirements. A supervising practitioner must be approved by the sponsoring entity, generally in a Program Letter of Agreement, in order to supervise residents. (See ACGME's Common Program Requirements, at <http://www.acgme.org>.) Supervising practitioners can provide care and supervision only for those clinical activities for which they have clinical privileges. **NOTE:** *The term "supervising practitioner" is synonymous with the term "attending" or "preceptor."*

ee. **Supervision.** Supervision is an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care through direct or indirect contacts with patients. The relationship of the supervising practitioner to the resident is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the resident while monitoring the quality of professional services delivered. Supervision is exercised through direct involvement with the patient and resident, observation of care provided by the resident, oversight of patient care, directing the learning of the resident, and role modeling communication and professional skills

ff. **Resident Credentials Verification Letter.** Previous name for a Trainee Qualifications and Credentials Verification Letter (TQCVL) (see paragraph 4.ii.)

gg. **Trainee Qualifications and Credentials Verification Letter.** A letter from the sponsoring entity to the local VA listing every trainee expected to be at the VA medical facility for a portion of their clinical training. The letter attests that each trainee has appropriate qualifications and verified credentials.

hh. **Trainees.** A general term to describe undergraduate, graduate, and continuing education students; interns, residents, fellows, and VA advanced fellows; and pre- and post-doctoral fellows whose time at a VA medical facility is spent in clinical or research training experiences to satisfy program, degree, or continuing education requirements.

ii. **User Class.** User Classes (e.g., attending physician, podiatrist, resident physician, medical student, dental student, associated health student, provider, medical record technician, nurse, Chief, Health Information Management Service (HIMS)) and sub-classes are defined in the VistA User Class File (8930). Responsibilities and privileges (for accessing, entering, signing, co-signing, editing, deleting, etc.) are defined through this file through the application of CPRS/VistA business rules.

#### 4. POLICY

It is VHA policy that undergraduate and graduate dentist and physician trainees are enrolled in appropriately accredited and affiliated schools or residency programs, meet minimum qualifications for appointment to VHA facilities, and are appointed to VHA facilities according to VHA policy. These trainees must function under appropriate supervision by licensed and appropriately credentialed VHA staff, must provide documentation in the Veteran's medical record according to VHA policy, and must have their performance evaluated by supervising staff. VHA must abide by appropriate policy in administering trainee pay and in providing quarters and meals for trainees.

## 5. RESPONSIBILITIES

a. **VA Medical Facilities.** All VA medical facilities that either sponsor or participate in accredited undergraduate and graduate training programs in medicine (allopathic or osteopathic) or dentistry must have a single individual identified as having VA education oversight, i.e., the Designated Education Officer (DEO). The DEO is an education leader (often titled as ACOS/E) who serves in a capacity similar to the DIO as described by the ACGME. The DIO at the sponsoring institution has authority and responsibility for the oversight and administration of all accredited training programs at the sponsoring institution, and assures compliance with institutional requirements.

b. **Chief Academic Affiliations Officer.** The Chief Academic Affiliations Officer is responsible for defining national policies pertinent to medical/dental trainees in VA medical facilities. The Chief Academic Affiliations Officer presents pertinent decision-making information to VHA's leadership, participates in VHA strategic planning, and consults with other program and Veterans Integrated Service Network (VISN) offices on matters pertaining to or impacting upon VA's education mission.

c. **Veteran Integrated Service Network Director.** The Veterans Integrated Service Network (VISN) Director is ultimately responsible for addressing trainee program needs and obligations in VISN planning and decision-making, and making necessary resources available to the respective affiliated medical centers for educational programs as outlined in this Directive.

d. **Network Academic Affiliations Officer.** The Network Academic Affiliations Officer is responsible for assisting the VISN Director by:

(1) Ensuring that educational needs and obligations are considered in VISN planning and decision-making.

(2) Assisting medical centers in implementing medical/dental training policies.

(3) Providing guidance to network educational institutions.

(4) Helping ensure VISN-wide educational goals are accomplished and comply with system-wide education policies.

(5) Providing guidance and assistance to individual medical centers regarding education program management and oversight.

e. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that local policies and procedures are in place to fulfill the requirements of this Directive.

(2) Appointing the facility DEO.

(3) In cases of serious infractions, dismissing a medical or dental resident from VA assignment in accordance with VA Handbook 5021, Part VI, Paragraph 18 (upon the advice of or after consultation with the Chief of Staff and/or DEO).

f. **Chief of Staff.** The Chief of Staff (COS) is responsible for:

(1) Oversight of all VA clinical programs including clinical education of trainees.

(2) Supervising or serving as the VA DEO.

g. **VA Designated Education Officer (DEO; Associate Chief of Staff for Education or similar organizational title).** The VA DEO shall have general oversight of all undergraduate and graduate trainees at a local VA medical facility or consolidated facilities for which the DEO is responsible. DEO oversight responsibilities include:

(1) Serving as VA point of contact (POC) for the institution to deal with clinical trainee issues for the VA medical facility and for the affiliated institution.

(2) Ensuring that medical/dental students or residents rotating to a VA medical facility are enrolled in or sponsored by affiliated institutions.

(3) Reviewing and ensuring that minimal qualifications and credentials are met for medical/dental trainees coming to VA for academic programs as attested to by the TQCVL.

(4) Ensuring that all trainees complete the onboarding process, including appropriate security screening.

(5) In collaboration with Human Resources staff, ensuring that appropriate appointments of medical/dental trainees are in place, including without compensation (WOC) appointments for all medical/dental students and for medical/dental residents, if appropriate. Providing orientation or assurance that necessary aspects of orientation are covered at the service level (e.g., Health Insurance Portability and Accountability Act (HIPAA), computer security, CPRS training).

(6) Ensuring that affiliation agreements are executed for all programs that send medical or dental students or residents to VA medical facilities for educational purposes.

(7) Ensuring that the requirements of the affiliation agreements, particularly those responsibilities assigned to the VA medical facility, are fulfilled.

(8) Interacting with affiliated institutions as appropriate on matters pertaining to trainee assignments and curricula and on evaluation of the VA medical facility as a training site.

(9) Acting as a consultant to other VA medical facility staff on educational matters and interpreting policies according to VA requirements.

(10) Acting as the principal liaison with the sponsoring institution's DIO and other education leaders in the academic programs of education and research.

(11) Advocating for sufficient VA resources for appropriate conduct of all educational programs.

(12) Exercising oversight and administration of all clinical training programs at the VA medical facility, and ensuring compliance with all pertinent requirements. This oversight responsibility includes fiscal matters, disbursement agreements, credentials of trainees, appointment and payment of trainees.

(13) Reviewing, approving, and signing all correspondence and documents prior to submission to accrediting bodies (if program accredited in VA's name).

(14) Presenting an Annual Report to the Medical Staff and the Governing Body that summarizes training program activities for the past year. This annual report should cover such issues as resident supervision, resident duty hours, resident credentials, resident graduated levels of responsibilities, etc. The medical staff, governing body, and the DEO should regularly communicate about the safety and quality of patient care provided by the trainees. Presentation and discussion of the Annual Report on Residency Training Programs (ARRTP) with the Medical Executive Committee of the medical staff (sometimes called the clinical executive board) would meet this requirement. **NOTE:** *The term "governing body" is recognized by the Joint Commission. Within VA, the medical center director serves in place of the governing body.*

(15) Chairing the local VA Residency Review Committee (if applicable) or Graduate Medical Education Committee, if appropriate (see paragraph 6.c).

(16) Encouraging the appointment of qualified health care professionals as full-time or part-time staff who will provide supervision of trainees and patient care.

(17) Encouraging faculty appointments at the sponsoring institution for VA supervising practitioners.

(18) Monitoring and ensuring that VA staff members with appropriate credentials and faculty status supervise trainees. **NOTE:** *This responsibility will be enhanced if the VA DEO is a member of the Professional Standards Board.*

(19) Reviewing and signing appropriate residency training program letters of agreement prepared by the affiliated institution.

(20) Dealing with special situations and issues pertaining to medical/dental trainees and advising the director of the VA medical facility and the program director of the affiliated institution (or program) concerning trainee competence, conduct, and compliance with VA regulations and policy.

(21) Facilitating the appointment of VA staff and appropriate affiliate institution program faculty to the VA Academic Partnership Council and its subcommittees. The VA DEO acts as executive director for the Council.

(22) Serves as the VA liaison to the Graduate Medical Education Council of the affiliated institution(s).

(23) Participates in the internal reviews of each VA clinical training program.

h. **Residency Program (or Training) Director.** The Residency Program Director is responsible for the quality of the overall education and physician or dentist residency training program in a given discipline and for ensuring that the program is in compliance with the policies of the respective accrediting and/or certifying bodies. The Residency Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform. **NOTE:** *In affiliated programs, the Residency Program Director is customarily at the affiliated institution, but will be a VA practitioner if the program is sponsored by VA.*

i. **VA Residency Site Director.** The VA Residency Site Director is responsible for site logistics, ensuring at a minimum that trainees are oriented to site, policies, and practices; that the details of rotations, schedules, and objectives are communicated to the trainees; and that evaluations of trainees, preceptors/supervisors, and the training site are performed. The site director is responsible for assessment and improvement (if necessary) of trainee supervision. He/she is responsible for ensuring that supervising practitioners are appropriately fulfilling their responsibilities to provide supervision to residents and that ongoing evaluation of supervisors, residents, and the VA site are conducted. The VA Site Director is responsible for ensuring that medical/dental residents or students function within their assigned graduated level of responsibility.

j. **Supervising Practitioners (or Preceptors).** The supervising practitioner is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident or a student is involved in the care of the patient, the responsible supervising practitioner must continue to maintain a personal involvement in the care of the patient. A supervising practitioner must provide an appropriate level of supervision. Determination of this level of supervision is a function of the experience and demonstrated competence of the resident and of the complexity of the Veteran's health care needs. Students require a higher degree of supervision and oversight than residents. The supervising practitioner may also provide practice-based learning opportunities and/or didactic teaching to trainees. The responsible supervising practitioner is also responsible for periodic evaluation of trainees and of the instruction program as required by accrediting bodies.



k. **Trainees.** Medical and dental trainees (students and residents) must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each trainee is responsible for communicating significant patient care issues to the supervising practitioner. Discussion and interaction with the supervising practitioner must be documented in the record. During VA educational rotations, trainees are expected to adhere to professional and program-specific standards as well as VA regulations and applicable laws. Trainees will be asked periodically to evaluate their VA preceptors/supervising practitioners and their training.

## **6. EVALUATION OF PROGRAMS, TRAINING SITES, TRAINEES, AND SUPERVISORS**

### **a. Program and Training Site Evaluation.**

(1) Education relationships thrive in a climate of communication, cooperation, and trust. Both VA and the affiliated site (academic institution or clinical care site) bring assets to the relationship and are motivated to provide high quality training. Assessment activities, formal or informal, provide a framework for evaluating the scope, operations, value, and outcomes of all health professions training programs.

(2) On a regular basis (i.e., annually or as authorized), input or feedback from medical and dental trainees regarding the VA training site and environment will be solicited by VHA's OAA through a survey process. The local use of other, more frequent methods of obtaining feedback from trainees is encouraged.

### **b. Trainee and Supervising Practitioner Evaluation.**

(1) See VHA Handbook 1400.01, Resident Supervision, for procedures regarding medical and dental resident evaluations and their evaluations of supervising practitioners.

(2) At a minimum, medical and dental students will be evaluated according to the standards, format, and frequency prescribed by the sponsoring institution and the appropriate accrediting body. The supervising practitioner will discuss the evaluation with the student at the end of each rotation. Evaluations of student performance are stored and aggregated by the sponsoring affiliated institution, although they may be reviewed prior to submission by the local facility service chief or site director, based upon local policy. Students will be offered the opportunity to evaluate their supervising practitioners according to processes established by the affiliated institution.

## 7. MEDICAL AND DENTAL RESIDENCY PROGRAMS

a. **General.** Each VA medical facility with residency training programs must have an administrative review mechanism in place. Review mechanisms vary depending on whether the VA medical facility is the sponsoring institution or a participating institution. For ACGME-accredited programs, the sponsoring entity must meet the ACGME requirements.

b. **Graduate Medical Education Committee (when the affiliated institution sponsors the program).** This committee is established at the affiliated institution that serves as the sponsoring institution for the VA's integrated training programs. Training programs are accredited in the name of the Sponsoring Institution ("Affiliate"). The VA medical facility is a participating institution (see paragraph 4.w.) in the training program. This committee functions according to standards set forth by the ACGME for Graduate Medical Education Committees (GMEC). The GMEC has the responsibility for monitoring and advising on all aspects of residency education at all affiliated sites. Voting membership on the committee must include residents nominated by their peers. It must also include appropriate program directors, administrators, the accountable DEO, and may include other members of the faculty. VA medical facilities must participate in the GMEC as appropriate to the number and integration of the training programs. A minimum of one VA faculty member (preferably the DEO or ACOS/E) must be a standing member of the affiliated institution's GMEC.

c. **Graduate Medical Education Committee.** When VA sponsors the program, this committee must be established at each VA medical facility that serves as a Sponsoring Institution (i.e., has one or more graduate medical or dental education residency training programs that are accredited in the name of the VA). The committee functions according to standards set forth by the ACGME for GMECs. The VA-based GMEC has the responsibility for monitoring and advising on all aspects of residency education. Voting membership on the committee must include residents nominated by their peers. It must also include all or appropriate program directors, administrators, and may include other members of the faculty. This committee is chaired by the DEO (ACOS/E or other education leader). The GMEC must:

(1) Establish and implement policies and procedures regarding the quality of education and the work environment for the residents in all accredited programs.

(2) Annually review and make recommendations regarding resident stipends, according to PGY levels, benefits, and funding for resident positions that are paid directly by VA. The provisions of VA Handbook 5007, Part II, Appendix E, will be followed.

(3) Establish and maintain appropriate oversight of and liaison with program directors and ensure that program directors establish and maintain proper oversight of and liaison with appropriate personnel of other institutions participating in the training program.

(4) Establish and implement formal written policies and procedures governing resident duty hours, and establish and implement procedures to regularly monitor resident duty hours.

(5) Develop and implement written procedures to review and endorse requests from programs requesting an exception in the weekly limit on duty hours.

(6) Ensure that all programs provide appropriate supervision for all residents consistent with proper patient care, educational needs of residents, and applicable program requirements.

(7) Ensure that each program provides a curriculum and an evaluation system to ensure that residents demonstrate achievement of the six general competencies for graduate medical education (GME).

(8) Establish and implement formal written institutional policies for the selection, evaluation, promotion, and dismissal of residents. These policies must be consistent with VA Handbooks 5005 and 5021.

(9) Frequently review all correspondence with accrediting bodies and monitor action plans for the correction of concerns and areas of non-compliance.

(10) Conduct internal reviews of all accredited programs to assess compliance with institutional and program requirements.

d. **Dental Residency Training Programs.** If a VA medical facility sponsors dental residency training programs, then dental training program oversight is included with the GMEC, which would then become the Graduate Resident Education (GRE) Committee. Dental training programs would be part of the sponsoring program's GRE committee. If not aligned with the local GRE committee (or GMEC), dental training programs must have their own oversight committee.

e. **Resident Supervision.** See VHA Handbook 1400.01, Resident Supervision, for details of resident supervision policy, documentation, monitors, evaluation, and oversight.

## **8. MEDICAL AND DENTAL STUDENT PROGRAMS**

a. **Overview.** Any undergraduate student from an affiliated medical or dental school sent by the affiliated institution to a VA medical facility for short-term clinical training is considered under VA's medical and dental student program. Students are neither licensed practitioners nor resident trainees. In order to receive clinical training within a VA medical facility, the student must be enrolled in an affiliated medical or dental school. A VA medical facility must have a signed affiliation agreement in place prior to offering clinical training to medical or dental students. As part of their clinical training, students participate in clinical care teams in both inpatient and outpatient settings and complete rotations on a variety of clinical services. All clinical activities performed by students must be appropriately supervised by a VA supervising practitioner.

Supervision of students must necessarily be more rigorous and methodical than for physician or dental residents. The overriding concern is the safe and effective care of patients, including accurate and timely documentation in the medical record.

b. **Supervision of Medical and Dental Students.** The following statements about student supervision and student documentation in the health record are meant to be minimum national standards. Individual VA medical facilities may impose more restrictive local policy stipulations.

(1) Medical/dental students must function at all times under the supervision of an assigned licensed independent supervising practitioner. Each supervising practitioner must be appropriately credentialed and privileged at the VA medical facility where supervision occurs. **NOTE:** *A resident physician or dentist when functioning in the context of a residency training program is not a licensed independent supervising practitioner.*

(2) Supervising practitioners may delegate some of the supervision of students to residents. However, the supervising practitioner retains the primary responsibility for patient care conducted by all levels of trainees, supervision of all trainees, and ensuring the timely and accurate documentation of that care and supervision in the health record. **NOTE:** *The only types of notes that could be delegated to a resident for supervision of a medical or dental student would be for documentation of those situations which do not require attending involvement such as a daily progress note on a relatively stable patient.*

(3) Participation of Medical and Dental Students in Performance of Procedures. Routine Bedside and Clinic Procedures. Routine bedside and clinic procedures include: skin biopsies, central and peripheral lines, lumbar punctures, centeses, and incision and drainage. Medical or dental students may participate in routine bedside and clinic procedures under direct supervision by the supervising practitioner. Depending upon the complexity of the procedure and due to the level of training and lack of clinical experience of the medical student, the role of observing and/or assisting the resident or staff physician performing the procedure is appropriate. The supervising practitioner may delegate supervision of students to a resident or fellow who has had an appropriate level of responsibilities defined by the Program Director, according to the VHA Handbook 1400.01, Resident Supervision. Nevertheless, the ultimate responsibility for the patient, for oversight of the care delivered, and for compliance with the provisions of this Directive resides with the supervising practitioner. Documentation standards must follow the setting-specific guidelines and the documentation requirements listed in paragraph 7c below.

(4) Non-routine, Non-bedside Diagnostic, or Therapeutic Procedures. Non-routine, non-bedside, diagnostic, or therapeutic procedures (e.g., endoscopy, cardiac catheterization, invasive radiology, epidural injection or other spinal injections or procedures) require a high level of expertise in their performance and interpretation. Such procedures may be done only by residents with the required knowledge, skill, and judgment and under an appropriate level of supervision by a supervising practitioner.

Medical or dental students may not perform these procedures, even under direct supervision. Dental students may perform simple, non-complex exodontia and oral biopsies if directly supervised.

(5) Operating Room (OR) Procedures. Medical or dental students may participate in OR procedures as observers or as assistants, but may not perform OR procedures even under direct supervision with the exception of simple, non-complex exodontia and oral biopsies performed by dental students who are directly supervised. **NOTE:** *Assisting in OR procedures may be understood as participation in routine functions such as holding retractors or cameras for laparoscopic surgery and with the superficial suturing required for skin closure at the end of a case. Such tasks could only be performed under the direct supervision of an attending physician or dentist.*

c. **Documentation by Medical Students in the Health Record.** Medical students must learn to communicate effectively in the health record and medical record documentation is an appropriate part of a medical student curriculum. Medical students are pre-degree students and are not capable of delivering care independently. Asking medical students to serve as “scribes” or transcriptionists for other providers places service needs over the educational needs of students and is not appropriate. However, there is value in having medical students, under proper supervision, contribute to the care of the patient by assisting with examinations and documenting this work. Medical student documentation alone is *insufficient* documentation for patient care or billing purposes. However, when appropriately validated by the responsible physician attending, medical student documentation can be used for the care of the patient and for billing purposes.

(1) Medical students may document services in the medical record. However, the responsible physician attending (teaching attending) must verify any student findings including history, physical exam and/or medical decision making in the medical record. The responsible physician attending must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed, but may verify any student documentation in the medical record, rather than re-documenting this work. The responsible physician attending must be identified as a co-signer (not an additional signer) for all student notes but must also provide an additional note or addendum as described below. Co-signature alone is *insufficient* for student documentation.

(2) Physician residents are not permitted to serve as the responsible physician for medical students in the medical record. The physician resident may be added as an additional signer to documentation in the medical record or they may add an addendum to the student’s note since they are involved in the care of the patients. They may provide contributions to the medical student documentation that would be verified by the attending physician. Residents’ contributions to the notes should accurately reflect their true role/participation in the care of the patient (i.e. contributing to the medical students’ notes to show their actual involvement in the care of the patient). In lieu of a student writing a note on a patient, the physician resident may write a patient note that is consistent with supervision requirements in VHA Directive 1400.01 (previously

Handbook 1400.01). **NOTE: Supervising physicians have the ultimate clinical and legal responsibility for the care provided to the patient and must be personally involved in supervising the medical student and delivering care.**

(a) Documentation Standards: The attending/teaching physician must document that they personally performed (or re-performed) the physical exam and medical decision-making activities of the E/M service being billed and must verify any student documentation in the medical record. The medical student note must include an addendum or additional note entry in the medical record by a responsible physician attending to meet documentation and billing standards. An additional addendum by a resident may be necessary to adequately reflect his/her role in the care of the patient. The documentation from the attending physician may be accomplished by one of two methods, addendum or additional note referencing the medical student documentation. The addendum or additional note authored by the responsible physician attending must include and address the required following items:

1. Presence: A statement should be made about whether the attending was present during the student's examination or if the attending re-performed the history and examination at a later point in time.

2. Performance: The attending physician must document whether they performed or re-performed the examination documented in the student's write up.

**Sample language:**

*I hereby attest to the accuracy of the student's note as to history, physical examination, and medical decision making with any exceptions or corrections noted. I was present for the medical student history taking and examination. I independently performed or re-performed the history taking, physical examination, and medical decision making."*

**NOTE:** *The teaching physician's note or addendum must provide appropriate and accurate documentation of the clinical encounter, clinical thinking, presumed diagnosis and treatment plan. A co-signature alone by the teaching practitioner of a note entered by a trainee is not sufficient for billing or supervision purposes. As is true with any individual writing in a medical record, **medical students are not permitted to write a note and change the author to the teaching physician or resident physician. Resident physicians may add an addendum to the student note thus contributing to the medical record but ultimately it is only the attending physician who can cosign and provide attestation of the medical student's work.***

(b) Medical students **may not** enter the following types of documentation into the health record (even with an attending physician signature). This list may be modified by local medical staff bylaws, which may be more but not less stringent than this policy.

1. Advanced directives.

2. Against medical advice (AMA) discharge documentation

3. Treatment plans

4. Informed consent.

5. Discharge summaries.

6. Reports or notes for procedures performed in a procedural suite, such as cardiac catheterization, interventional radiology, or endoscopy. **NOTE:** *The prohibition does not apply to those procedures normally performed in a clinic or at the bedside, which are commonly documented via a progress note rather than a formal procedure report.*

7. Operative notes and reports.

8. Do not resuscitate notes.

9. Seclusion and restraint notes.

(c) Billing for services by teaching physicians supervising medical students in their teaching capacity:

1. The responsible physician attending must be identified in the medical record in the documentation of each encounter and this may be accomplished by co-signature and an appropriate addendum or note. The responsible physician attending is the primary physician provider of record for billing purposes. The identification of the responsible physician attending, while necessary, is not sufficient for billing the encounter.

2. The responsible physician attending must create an independent note OR an addendum to a note initiated by a medical student for the encounter to be billable in addition to co-signature. The responsible physician attending's note or addendum must provide appropriate documentation of the clinical encounter and clinical thinking. A co-signature by the supervising practitioner of a note entered by a medical student alone is not sufficient for billing purposes.

3. Patient co-payment guidelines are different from billing guidelines.

d. **Documentation by Dental Students in the Health Record.** Dental student note requirements are different from medical students. History and physicals by dental students still must be re-performed and re-documented by the responsible dental supervising practitioner (unlike medical students). Dental students must learn to communicate effectively in the health record. Dental student documentation alone is insufficient documentation for patient care or billing purposes. Asking dental students to serve as "scribes" or transcriptionists for other providers places service needs over the educational needs of students. Dental student documentation does not replace any other practitioner documentation and must always be accompanied by documentation

entered independently by the supervising practitioner or dental resident. Co-signature of dental student notes is not sufficient to show adequate supervision or appropriate medical care. Dental student-authored notes must be accompanied by an addendum or independent note by the supervising practitioner in addition to co-signature. For notes requiring attending-level documentation, the supervising practitioner function cannot be delegated to a resident. If the individual facility chooses to allow student entries in the electronic health record:

(1) **Dental student-authored notes are subject to the following requirements:**

(a) Dental students are not allowed to initiate an entry on behalf of another person or change authorship of notes for another person's signature. Dental student notes shall be validated as described below.

(b) A dental student-authored note must be co-signed either by the responsible supervising practitioner.

(c) An assessment or evaluation by a dental student must be validated by the responsible supervising practitioner and documented in an independent note or addendum to the student note. Dental resident documentation must reflect adherence to the standards detailed in VHA Handbook 1400.01, Resident Supervision. Any treatment delivered or diagnostic evaluation performed by a student must be directly and closely supervised by the responsible supervising practitioner. Co-signature of a dental student note is not sufficient documentation for patient care or any other purpose. The medical record must contain detailed documentation of patient assessment by the supervising practitioner, who may not copy and paste material from a dental student-authored note. A dental student note cannot be taken to be an official record of patient care. **The responsible supervising practitioner's independent note or addendum to the student's note may reference the dental student's past medical history, family and social history, and review of systems (ROS) ONLY.** An independent patient examination, assessment, and management plan must be provided by the supervising practitioner. **NOTE:** *"Sub-interns" or "Acting Interns" are students (see paragraph 4.ee.) and their notes are not sufficient to document adequate patient care.*

(2) Dental students **may not** enter the following types of documentation into the health record (even if cosigned by an attending supervisor). This list may be modified by local medical staff bylaws, which may be more but not less stringent than this policy.

(a) Advanced directives.

(b) Against medical advice (AMA) discharge documentation

(c) Treatment plans

(d) Informed consent.

(e) Discharge summaries.



(f) Reports or notes for procedures performed in a procedural suite, such as cardiac catheterization, interventional radiology, or endoscopy. **NOTE:** *The prohibition does not apply to those procedures normally performed in a clinic or at the bedside, which are commonly documented via a progress note.*

(g) Operative notes and reports.

(h) Do not resuscitate notes.

(i) Seclusion and restraint notes.

(j) History and Physical notes

**e. Both Medical and Dental Students Documentation:**

(1) Students must be registered in the electronic health record and assigned an appropriate medical or dental student designation prior to entering any notes into the electronic health record. Proper assignment of a medical or dental student designation ensures that the electronic signature identifies the signer as a medical or dental student and that appropriate supervision and business rules are applied. *Medical or Dental students should not be entered as physicians/dentist or physician/dental residents as they are not yet licensed practitioners.*

(2) Medical and dental student-authored notes are subject to the following requirements:

(a) There must be mandatory identification of a co-signer for all medical and dental student-authored notes. *Identification of an “additional signer” is not sufficient.*

(b) Medical and dental student notes shall always identify the student creating the note. Student notes shall be validated as described below.

**Documentation Guide: Medical Students and Dental Students**

	<b>Medical Students May Enter into System</b>	<b>Medical Students notes May be used after Attending Verification</b>	<b>Dental Students May enter into System for learning purpose only</b>	<b>Dental Students notes May be used after Attending Verification</b>
Inpatient Admission Notes	Yes	Yes	Yes	<b>No</b>
History & Physical	Yes	Yes	<b>No</b>	<b>No</b>
Inpatient Consultation Notes	Yes	Yes	Yes	<b>No</b>
Inpatient Progress Notes	Yes	Yes	Yes	<b>No</b>

	<i>Medical Students May Enter into System</i>	<i>Medical Students notes May be used after Attending Verification</i>	<i>Dental Students May enter into System for learning purpose only</i>	<i>Dental Students notes May be used after Attending Verification</i>
Outpatient Consultation Notes	Yes	Yes	Yes	No
Outpatient Clinic Visit Notes	Yes	Yes	Yes	No
Extended Care Admission Notes	Yes	Yes	Yes	No
Extended Care Progress Notes	Yes	Yes	Yes	No
Emergency department notes	Yes	Yes	Yes	No
Progress Notes for Procedures (bedside or in clinic)	Yes	Yes	Yes	No
Discharge Summaries	No	No	No	No
Advanced Directives	No	No	No	No
Treatment Plans	No	No	No	No
AMA Documentation	No	No	No	No
Informed Consent	No	No	No	No
Reports for procedures performed in procedural suite	No	No	No	No
Operative notes/reports	No	No	No	No
DNR Notes	No	No	No	No
Seclusion & Restraint Notes	No	No	No	No

f. **Appointment and pay of medical and dental students.** Medical and dental students may be appointed as without compensation (WOC) trainees under 38 U.S.C. 7405 and 7406; appointments are made in accordance with VA Handbook 5005, Staffing, Part II, Chapters 2 and 3. Each VA medical facility must have a process in place to ensure the completion of onboarding requirements for all trainees prior to an

appointment or re-appointment irrespective of appointment type and length of training. Medical and dental students are not eligible to receive trainee stipends.

**g. Special Situations.**

(1) **Visiting Students.** Medical or dental students from domestic or foreign medical or dental schools other than the affiliated school may receive elective training within a VA medical facility only if the affiliated medical or dental school sponsors the student(s) and takes full responsibility for their education while at the VA medical facility. Visiting students must complete the appropriate appointment papers (as a WOC) and undergo the same fingerprint and background checks as the other students from the affiliated institution. Documentation of visiting students sponsored by the affiliate will be identified to the VA medical facility through a TQCVL from the affiliate.

(2) **Student Stipends and Other Benefits.** Medical and dental students are not eligible for VA-paid stipends or incentive awards. They may qualify for certain benefits, such as parking, meals for in-house on-call duties, use of on-call rooms, and use of library facilities, at the discretion of and as determined by the VA DEO. With permission of the Chief Academic Affiliations Officer (CAAO), medical or dental students may qualify for travel reimbursement or use of quarters when the travel is to remote VA clinical sites as part of a rural health rotation or experience.

(3) **Employment.** Medical and dental students may be employed at VA medical facilities in positions for which they are qualified, provided the employment is unrelated to their medical or dental school course of study. When so employed, the individual will not be designated as a trainee, may only function within scope of the relevant Functional Statement for which he/she is hired, and will be assigned duties in a manner similar to other employees in a comparable, non-training capacity (see also paragraph 8.)

(3) **Disciplinary Actions and Terminations.** See paragraph 9, Due Process for Trainee Performance, Remediation, and Disciplinary Actions.

## **9. APPOINTMENT AND PAY OF MEDICAL AND DENTAL RESIDENTS**

a. **General.** Physician and dental residents are appointed under 38 U.S.C. 7406 and appointments are made in accordance with VA Handbook 5005, Staffing, Part II, Chapter 3, Section H. Each VA medical facility must have a process in place to ensure the completion of onboarding requirements for all residents prior to an appointment or re-appointment irrespective of appointment type, pay status, and length of training. All trainees are prohibited from being appointed in a volunteer status. Paragraph 8 pertains only to physician and dental residents in accredited training programs and does not apply to VA Advanced Fellows (non-accredited).

b. **Minimum qualifications.** For appointment and matriculation as a first post-graduate year (PGY-1) resident and for advancement to subsequent PGY levels in VA-sponsored programs:

(1) No license to practice medicine or dentistry is required during the first year of a VA-sponsored residency.

(2) Prior to matriculation, PGY-1 physician residents must have passed Step 2 of the U.S. Medical Licensing Examination (USMLE) or equivalent examination and step (or “part”), such as the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) or part 1 of the Medical Council of Canada Qualifying Examination (MCCQE). **NOTE:** *Passing Step 2 of the USMLE is currently required for ECFMG certification. Since 1992, the USMLE has replaced the FLEX (Federation Licensing Examination), and NBME (National Board of Medical Examiners) licensing examinations for allopathic medical school graduates.*

(3) Physician residents in VA-sponsored programs must have passed Step 3 of the USMLE or COMLEX or be a Licentiate of the Medical Council of Canada (LMCC) prior to appointment at a PGY-3 or higher level

(a) A resident who has not taken the USMLE (Step 3), COMLEX (Level 3), or MCCQE (Part 2) examinations by May 1 of the PGY-1 training year must receive a Formal Written Warning of Academic Deficiency from the Program Director and must take the exam within 6 months.

(b) A resident who does not pass the USMLE (Step 3), COMLEX (Level 3), or MCCQE (Part 2) examination on the second attempt will be placed on Academic Probation, will not advance to the PGY-3 level, and must re-take the exam within 6 months.

(c) A resident who does not pass the USMLE (Step 3), COMLEX (Level 3), or MCCQE (Part 2) examination on the third attempt will be dismissed from the training program.

(4) Dental residents must have passed Part II of the National Board Dental Examination (NBDE) prior to matriculation as a PGY-1 dental resident.

c. **VA-sponsored programs.** VA-sponsored training programs must have and communicate to prospective candidates clear local policy statements regarding minimum criteria for:

- (1) Selection of candidates.
- (2) Matriculation or appointment of selected residents;.
- (3) Promotion of residents to PGY-2 and higher.

d. **In non-VA sponsored, affiliated programs.** First-year residents (physician or dental) do not need to be licensed, but may be subject to state or program requirements for registration, obtaining a permit or limited (training) license, or other state-required certification of trainee status.

(1) Licensing requirements of physician and dental residents appointed as PGY-2 or higher will be set by the sponsoring institution.

(2) VA appointment and matriculation will depend upon the resident's meeting all qualification and credential requirements specified by the sponsoring institution.

e. All residents will provide VA with their National Provider Identifier (NPI).

f. **Eligibility of Non-Citizens and U.S. Citizen International Medical Graduates (IMG) and International Dental Graduates for Appointment.**

(1) **For physician training programs sponsored by and accredited in the name of the affiliate.** Non-citizen or IMG residents may be selected by the sponsoring institution. For non-citizen or IMG residents in ACGME-accredited residency training programs, non-U.S. citizen visa status and certification by the Educational Commission for Foreign Medical Graduates (ECFMG) must be attested to in the TQCVL. The sponsoring institution must ensure that each IMG, non-citizen resident meets all requirements of the specific visa type. An alternative version of the TQCVL for non-citizens may be used. The VA DEO should verify, at a minimum, that specific requirements for VA rotation by IMG noncitizen residents have been met. Depending on the visa type, additional documents may be necessary for rotation of an IMG from the affiliate to VA. Verification of all documents by the program director or DIO is part of the TQCVL certification process. U.S. citizens who have graduated from a non-US medical school must have ECFMG certification. Graduates of a Canadian medical school, accredited by the Liaison Committee for Medical Education (LCME), do not require ECFMG certification, but do need an appropriate visa to enter the U.S. for training. Canadian citizens or Canadian medical school graduates who seek J-1 visa sponsorship must go through the ECFMG. **NOTE:** *ECFMG certification (required for J-1 sponsorship, but not for H-1B) assures sponsors of graduate medical education that international medical graduates have met the minimum standards to enter residency programs in the United States. For additional requirements, see <http://www.ecfmq.org/evsp/j1fact.pdf>. VA will not sponsor residents on H-1B visas.*

(2) **Dental residents.** Irrespective of citizenship status, dental residents must have graduated from either:

(a) An ADA-approved school in the U.S. or Canada, or

(b) A dental school accepted by the licensing body of a state, territory, or commonwealth of the U.S. (i.e., Puerto Rico or Guam). **NOTE:** *For dentistry, there is no certification agency equivalent to the ECFMG. Therefore, if an international dental graduate holds a full and unrestricted license to practice dentistry in a U.S. state, Puerto Rico, or Guam, that will satisfy proof of acceptability.*

(3) **For VA-sponsored medical and dental residency programs.** Non-U.S. citizen trainees may be appointed to VA-sponsored and accredited medical programs only when it is not possible to recruit U.S. citizens who meet qualification standards.

(a) Consultation with HRM and the DEO is advisable prior to considering appointment of non-citizen physician or dental residents. The Exchange Visitor Program (J-1) visa is preferred over the Temporary Worker Program (H-1B) visa, because the J-1 ensures that the resident has been certified by the Educational Commission for Foreign Medical Graduates (ECFMG). Non-citizen dentists must have graduated from a dental school in the U.S., Canada, or U.S. territories, or hold an unrestricted license to practice dentistry in a U.S. state or territory.

(b) Graduates of a Canadian medical school, accredited by the Liaison Committee for Medical Education (LCME), do not require ECFMG certification, but do need a visa to enter the U.S. for training. Canadian citizens or Canadian medical school graduates who seek J-1 sponsorship must go through the ECFMG. Irrespective of citizenship status, dental residents must have graduated from an approved or accepted school of dentistry in the U.S., Canada, Puerto Rico, or Guam except as noted in paragraph 8.f.(2)(b) above. **NOTE:** *ECFMG certification (required for J-1 sponsorship) assures sponsors of graduate medical education that international medical graduates have met the minimum standards to enter residency programs in the United States. For additional requirements, see <http://www.ecfmq.org/evsp/j1fact.pdf>. For dentistry, there is no certification agency equivalent to the ECFMG.*

(4) International medical graduates who are U.S. citizens must have an ECFMG certificate in order to be appointed to a position in a VA-sponsored ACGME-accredited residency program.

**g. Procedures for Medical and Dental Resident Appointments.**

(1) **General.** The appointment process for all medical and dental residents and students must conform to VA Handbook 5005.

(2) **Determination of VA Pay Status.** Residents participating in graduate medical or dental education at a VA medical facility are either paid directly or are appointed as without compensation (WOC). Residents paid indirectly via a Disbursement Agreement are to be given WOC appointments,

(a) Residents will be paid directly by the VA medical facility if the program is sponsored by and accredited in the name of the local VA medical facility.

(b) Residents in affiliated programs may be paid directly; however, the preferred method of payment is via a disbursement agreement with the sponsoring institution. See VHA Handbook 1400.05, Disbursement Agreement Procedures.

(c) Residents in an affiliated program where the local VA facility has a disbursement agreement with the sponsoring institution are paid indirectly via a disbursing agent of the sponsoring institution and are given WOC appointments.

(d) WOC appointments are appropriate for residents who are not paid by the VA, either directly or indirectly via a disbursement agreement. **NOTE:** *Examples of appropriate WOC appointments include (but are not limited to) residents paid by*

*another Federal agency (e.g., the Department of Defense, DoD) or affiliated residents whose presence would exceed the number of OAA-approved, allocated positions. Of note, at some sites, program directors may rotate residents to the VA for purely educational purposes, without expectation of remuneration, when allocated positions have been exceeded.*

(3) **Matching Programs for Medical Residencies.** For VA-sponsored programs, VA participates in the matching program for graduate physician residency appointments. The plan is administered by the National Resident Matching Program (NRMP, see [www.nrmp.org/](http://www.nrmp.org/)). Some residencies may be matched by a separate matching program (e.g., ophthalmology, plastic surgery, and others, see [www.sfmatch.org/](http://www.sfmatch.org/)). Medical graduates are encouraged to participate in the NRMP or other recognized specialty match. VA appointments may be given to participants who applied through the NRMP or other match but only when positions have remained unmatched following the announcement of the match results and to medical graduates whose date of graduation or arrival in this country did not permit their enrollment and matching through NRMP. VA resident appointments may also be given to DoD residents through collaborative arrangements with DoD and VA's affiliated institutions.

(4) **Period of Training Appointment.** An appointment is made for the duration of training in the specialty program in which the trainee is enrolled. An individual is normally appointed or reappointed as a physician or dental resident in a given specialty or subspecialty for the number of years of residency training accredited by the ACGME or AOA for a given program. **NOTE:** *These provisions do not apply to individuals appointed as VA Advanced Fellows or Chief Residents.*

(5) **Post-Graduate Year (PGY) Level of Training.** PGY levels are designated for purposes of determining the per annum rate of pay. PGY levels may be used for local determination of graduated levels of responsibility and supervision requirements as described in VHA Handbook 1400.01, Resident Supervision. The PGY level of training to which each appointed resident will be assigned will be determined by a review of the considerations as specified in VHA Handbook 1400.05, Disbursement Agreement Procedures.

(6) **Subspecialty Training.** Residents who have completed their primary or core specialty board requirements may be appointed to an accredited subspecialty residency, often referred to as a "fellowship," for the period of time required by the subspecialty Board or Boards and accredited by the appropriate accrediting body, in the case of added or dual certification. Subspecialty residents (or "fellows") will be assigned a cumulative PGY level based upon the total number of years completed according to the principles specified in paragraph 8.g.(5) above. The PGY level is assigned for the purposes of graduated responsibility and stipend reimbursement or pay.

(7) **Pay Level.** For each individual resident appointee, the amount of stipend remuneration will be based upon the VA-approved PGY level of training. In situations in which the VA pays a resident directly, see VA Handbook 5007, Part II, Appendix E, Compensation of Non career Residents, for additional details. With the exception of

residents appointed through VA's Advanced Fellowship Program and approved chief resident positions, residents in non-accredited training experiences will not be funded. Examples of non-accredited training include additional years of training beyond the number of years approved by the ACGME, AOA, or CODA. **NOTE:** *VA-determined PGY levels are not necessarily the same as PGY levels assigned by affiliated institutions. Chief Academic Affiliations Officer approval of PGY levels is not required, but facilities may seek the advice and consultation of the OAA in making PGY determinations. Within VA medical facilities, "fellows" in non-accredited fellowships are NOT classified as trainees or residents and may not be reimbursed as residents. The only possible way to facilitate any VA-based experience is to have them appointed as WOC (without compensation) or as paid medical staff and to have them credentialed and privileged. Their privileges should be as "licensed independent practitioners" for procedures and practice relating to the specialty in which they have completed their primary or "core" residency and they should then be given "dependent" privileges (i.e., requiring supervision) for any procedures or activities related to their non-accredited training.*

(8) **Chief Residents.** Chief residents are designated by the Residency Program Director and may assume advanced administrative responsibilities necessary for the operation of the residency program. Chief residents may be either "in training" or "post training."

(a) **In-training chief residents.** In-training chief residents are appointed and paid in a manner similar to all other residents of the same PGY level. **NOTE:** *Only "post-training" chief residents are eligible for a pay differential.*

(b) **Post-training chief residents.** Post-training chief residents may be appointed as paid medical staff by a VA facility, according to local practice, and if thus appointed, they are not considered trainees. Chief residents appointed as medical staff and paid through local medical care appropriations fall outside the jurisdiction of this policy.

(c) Alternatively, application for a funded allocation of one or more post-training chief resident positions may be made to the OAA as part of the annual resident allocation process (RCS 10-0144). In order to receive approval as a 1 year, non-accredited training position(s), the following conditions must be satisfied:

1. The residency training program has a minimum of eight residents in the core residency program at the VA medical facility throughout the academic year, not including the chief resident, or eight residents for each chief resident position for which application is made (nine positions total per program to support one chief resident position).

2. The chief resident will function in the context of an ACGME- or AOA-accredited, affiliated program (even though the chief resident's experience is non-accredited) in programs where there is an established, ongoing practice of funding one or more chief resident positions at the sponsoring institution. **NOTE:** *Chief residents typically serve as instructors to more junior residents, assist with program and/or clinical service administration, arrange for educational conferences and sessions (such as grand rounds), and serve as a liaison between the residents and faculty.*



3. The appointment of a post-training chief resident is part of the accepted, established practice at the local VA affiliate(s) and the affiliated sponsoring institution.

4. The chief resident must have completed the minimum years of residency training to satisfy board requirements to apply for board certification.

5. The affiliate has an established stipend rate for chief residents or “chief resident differential,” which must be communicated in writing to the VA medical facility.

**NOTE:** OAA may approve a chief resident differential of not to exceed 25 percent over the applicable PGY pay rate (with appropriate supporting documentation). (See also VA Handbook 5007, Pay Administration, Part II, Chapter 2 and Appendix E for more information on stipend rates.)

6. The appointment of any one individual as “chief resident” may not exceed 1 year.

7. Each allocated chief resident position may be shared by two or more chief residents (e.g., two residents, each with 6 month rotations to VA).

8. At the discretion of the local facility, a post-training chief resident may be credentialed and privileged as a licensed independent practitioner (see VHA Handbook 1100.19, Credentialing and Privileging). If thus granted clinical privileges, the post-training chief resident may serve as an attending for billing purposes. The chief resident may also act as a supervising practitioner to supervise residents in the appropriate specialty, provided such service is approved by the Residency Program Director. However, the chief resident may not accept additional remuneration from VA for attending duties if the position is funded through OAA allocations as a training position.

**NOTE:** See VA Handbook 5007, Pay Administration, for the prohibition of dual compensation. There is an exception to this stipulation for service as Emergency Department Physician (“admitting physician” or “AOD”). See VHA Handbook 1400.01, Resident Supervision, for information relating to resident supervision policy.

**(9) Residents Appointed as Emergency Department Physicians or as Medical Officer of the Day.** Residents may be appointed to serve as emergency department physicians in accordance with the provisions of VA Handbook 5007, Pay Administration, VHA Handbook 1400.01, Resident Supervision and VHA Handbook 1101.04, Medical Officer of the Day. Residents who are appointed, outside of their training program, to work on a fee basis as an Emergency Department Physician must be licensed, credentialed, and privileged in order to qualify for such an appointment. Such residents (commonly called subspecialty fellows or post-training chief residents) must have completed their primary specialty training, as required to apply for board certification. If appointed as an independent “Emergency Department Physician” or Medical Officer of the Day (MOD) for nights and/or weekend duty, the resident is not working under the auspices of a training program and must meet the same requirements as all staff physicians and dentists appointed for emergency department or acute inpatient coverage duties at the facility. However, in both cases, the time worked as Emergency Department service or MOD coverage is viewed as “moonlighting” under accreditation standards and counts towards duty-hour restrictions. See also VHA Handbook 1100.19, Credentialing and Privileging and VHA Handbook 1400.01, Resident Supervision; for additional stipulations, see VHA Handbook 1101.04, Medical Officer of

the Day. **NOTE:** *The provision for physician residents with a current VA assignment to serve as fee basis “Emergency Department admitting physicians” (if specified criteria are met) is allowable under an exemption to the dual compensation restrictions governing VA employment.* No other exemptions are allowed for trainees (as specified in VA Handbook 5007). Moreover, residents on current VA assignments may neither act as Medical Officer of the Day (MOD) nor in any other capacity (e.g., fee basis for compensation and pension examinations) for remuneration. They may engage in activities considered as a part of their training, if appropriately supervised. However, they may not be paid additionally or appointed on a fee basis for activities that are a part of their training programs (e.g., taking night or weekend in-house call) that are reimbursed under a disbursement agreement. Likewise, even when not assigned to the VA or paid under a disbursement agreement, residents who have not completed their core training for board eligibility may not act in any capacity for pay. See VHA Handbook 1400.05, Disbursement Agreements Procedures; see also Accreditation Council for Graduate Medical Education, “Common Program Requirements,” regarding duty hour restrictions and “internal moonlighting” (<http://www.acgme.org>).

**(10) Residents Performance of Compensation and Pension or Other Examinations.** Residents may perform compensation and pension examinations as part of their training, provided they are supervised by an appropriately credentialed and privileged practitioner (see VHA Directive 1603, Certification of Clinicians Performing Compensation and Pension Examinations). Residents who are appointed and paid by the VA medical facility either directly or via a disbursement agreement may not perform compensation and pension or other examinations for remuneration in addition to their resident stipends as such payments would violate the restrictions against “dual compensation” of full-time residents (see VA Handbook 5005, Part II, Chapter 3, Section A, Paragraph 3.) Residents who are enrolled in an affiliated program, but who are neither presently serving on a VA rotation nor being paid by the VA as a resident, may perform compensation and pension or other examinations on a fee basis provided all of the following criteria are met:

(a) The resident has completed his/her primary specialty training, as required to apply for initial board certification. **NOTE:** *Only residents commonly called subspecialty fellows or post-training chief residents meet this requirement.*

(b) The post-training chief resident or subspecialty fellow must be credentialed as a licensed independent practitioner (LIP) (see VHA Handbook 1100.19) and be granted appropriate, but restricted privileges, i.e., privileged as a LIP only in the primary specialty in which he/she has completed training. If the fellow will perform compensation and pension examinations, then he/she must be additionally certified to perform compensation and pension examinations (see VHA Directive 1603). **NOTE:** *For all other activities involving clinical training, subspecialty fellows or chief residents are considered dependent practitioners, subject to appropriate graduated supervision in the clinical course of study which is the basis of the fellowship.*

(c) The subspecialty fellow or post-training chief resident’s program director must certify (in writing) that the resident’s performance of comp & pen or other exams is

outside the scope of the training program and that such performance would not conflict with other responsibilities or duty-hour restrictions (as such service would qualify as “internal moonlighting”).

(d) All proposals to have residents or fellows serve outside their training programs to provide patient care services as a licensed independent practitioner must be reviewed and approved by the DEO.

(e) The Chief of Staff certifies that no other qualified licensed independent practitioners are available to perform compensation and pension or other examinations in a timely manner (see VA Handbook 5007, Appendix F).

**(11) Residents Paid via Disbursement Agreements.** Physician and dentist residents paid under a disbursement agreement from VHA centrally-allocated funds (based upon the allocation process managed by OAA) will be given a WOC appointment (see VHA Handbook 1400.05, Disbursement Agreements Procedures). **NOTE:** *Local facilities may not use appropriated local medical care funds to pay resident stipends and benefits.*

**(12) Residents Paid Directly – Either in VA-Sponsored Programs or Affiliated Programs.** Residents in VA-sponsored programs must be appointed and paid directly by the VA from VHA centrally-allocated funds, based upon the allocation process managed by OAA. Residents in programs sponsored by an affiliate may be appointed and paid directly by VA, although payment through a disbursement agreement is preferred. See VA Handbook 5007, Part II, Appendix E, for details regarding stipend determinations and other provisions. **NOTE:** *Local facilities may not use appropriated local medical care funds to pay residents.*

(a) Physician and dentist residents appointed to VA will adhere to the educational requirements of the program and the schedule of duties assigned by the program director. The program requirements include participation in patient care, research, and educational activities.

(b) For record-keeping purposes, training program directors are required to maintain accurate records of all activities of residents in the program, including hospital and outpatient clinical activities, continuity clinics, didactic sessions, required clinical activities at non-VA sites, and research and scholarly activities

(c) In affiliated programs, where a certain proportion of residents are paid directly by VA, VA-paid residents will follow title 38 assignment policy (see VA Handbook 5011, Hours of Duty and Leave). Rotations to a non-VA site may be allowed as long as absences are covered by a WOC exchange. A WOC exchange occurs when a VA paid resident rotates to a non-VA setting and is replaced at VA by a comparable WOC resident of the same PGY level.

(d) Educational details are absences from VA in order to be at a non-VA, non-sponsoring institution or non-participating site and must be handled under the

procedures for approving an “educational detail.” Educational details for which foreign travel is requested will NOT be approved.

(1) **For residents paid via a disbursement agreement in an affiliated program or paid directly by VA, but in a program not sponsored by VA.** educational details are reserved for educational experiences that cannot be provided either at VA or at a sponsoring and participating institutions and which are part of providing a complete hospital and medical service to Veterans – that is, VA may reimburse for residents’ time outside VA medical facilities when those activities help meet VHA’s primary (see VHA Handbook 1400.05, Disbursement Agreements Procedures, for details). **NOTE:** *The so-called “one-sixth rule” does not apply to residents paid under a disbursement agreement (i.e., they are not entitled to one-sixth time in off-site activities), but does apply to residents paid directly in programs that are sponsored by the local VA medical facility. See VA Handbook 5007, Part II, Appendix E.*

(2) **For residents in VA-sponsored programs.** Residents who are paid directly by VA must have requests for educational details submitted in writing by the Program Director to the DEO for advance approval. Records of approvals of educational details should be kept on file for a minimum of 5 years. OAA approval of educational details is not required, but consultation is encouraged. All 3 of the following conditions must be met.

(a) A specific experience is required for accreditation of the program that cannot be provided at the VA medical facility as stated either in the ACGME “Program Requirements” and/or in the accrediting letter from the ACGME for medical programs. For dental programs, the specific experience must conform to requirements published by the ADA Commission on Dental Accreditation for Dental General Practice, or for Advanced Dental Specialty Educational programs.

(b) An affiliation agreement must be in place between the VA and the off-site entity providing the off-site experience. An affiliation agreement is essential to allow coverage under tort claims for off-site rotations. Affiliation agreement form “k” – VA Form 10-0094k, should be used.

(c) One-sixth rule the time away from the VA-sponsored training time paid by the VA medical facility may not exceed one-sixth (1/6) of the total training time in any given year. (See VA Handbook 5007, Part II, Appendix E.) Applies only to residents in VA-sponsored training programs.

a. **Authorized absences.** All of the following types of leave must be approved by the VA Site Director or the Service Chief.

(1) **Military leave.** Military leave residents who are members of the U.S. National Guard or a reserve component of the Armed Forces may be granted military leave, not to exceed 15 calendar days per year, for the performance of active military duty.

(2) **Examination leave.** Examination leave residents may be relieved from VA physical presence to undergo examinations for state medical licensure and U.S.

specialty boards. The amount of absence authorized will not exceed the time actually required for taking the examination and for travel to and from the place of examination.

(3) **Authorized absence for educational purposes.** as part of their scholarly activities, residents who are assigned to VA may be approved by the Program Director and the Site Director for authorized absence to attend or present at an off-site national or local meeting for up to 5 days annually based upon the proportionate share of assigned resident positions. Absences of greater than 5 days must be approved by the DEO.

b. **Annual and Sick Leave.** For residents paid under a disbursement agreement, see VHA Handbook 1400.05, Disbursement Agreements Procedures. All leave must be approved by the VA Site Director. **NOTE:** *Residents who take more than 30 days of leave (for any reason) from their respective program activities risk having to make up training time in order to satisfy board requirements.* The following stipulations apply to residents paid directly by the VA whether in VA-sponsored or affiliated programs:

(1) **Annual leave.** Annual leave is granted to residents according the allowable amount of leave awarded by the sponsoring institution or the comparable practice of granting leave to residents, but not to exceed 30 days per year. Annual leave may be considered under a leave pool arrangement, which allows annual leave to be available throughout the academic year and encourages distributed usage throughout the year (see VA Handbook 5011, Part III, Chapter 3). There is no need for an individual resident to accrue leave under the leave pool arrangement, but leave usage must be tracked to ensure that service and individually allowed leave is not exceeded. Unused leave is non-reimbursable.

(2) **Sick leave.** Sick leave will be governed by the policy at the sponsoring institution as long as the sponsoring institution does not allow more than 15 days per academic year of training for each VA-assigned resident position for which residents appointed to and paid directly by the VA. Resident sick leave days do not accrue from year to year. Unused sick leave is non-reimbursable. Sick leave days may be used for maternity leave, bereavement, or family leave, provided these usages are included in the policy of the sponsoring institution.

(3) **Unpaid leave.** Unpaid leave (i.e., leave without pay) may be granted in accordance with the provisions of the Family & Medical Leave Act of 1993 (Public Law, P.L. 103-3) (see VA Handbook 5011, Part III.).

**NOTE:** *Information on appointment, pay, and benefits can be found in the 5000 series of VA Handbooks (particularly VA Handbook 5005, Staffing; VA Handbook 5007, Pay Administration; VA Handbook 5011, Hours of Duty and Leave; and VA Handbook 5021, Employee/Management Relations). The information in paragraph 8 of this Directive is intended to summarize key aspects of recruitment and compensation, but employees should rely on guidance from VA's Office of Human Resources and Administration for comprehensive, accurate, and up-to-date information.*

## 10. DUE PROCESS FOR TRAINEE PERFORMANCE, REMEDIATION, AND DISCIPLINARY ACTIONS

a. **General Academic Issues.** VA has undertaken the responsibility to provide organized education programs with guidance and supervision of trainees, facilitating the professional and personal development of the trainees, while ensuring safe and appropriate care for patients. If the supervising practitioner is concerned that a medical or dental trainee is not acquiring detailed factual knowledge, developing clinical skills and professional competencies, or demonstrating professional standards of conduct, at an acceptable standard, these concerns must be raised with any or all of the following: the Program Director (VA or affiliate), the VA Site Director (if sponsored in the name of an affiliate), the VA Service Chief, or the DEO.

(1) Acquisition of knowledge, skills, and professional attitudes and behaviors are the goals and expectations of training. Medical and dental trainees come to VA with a wide range of developing competencies and are still in the formative stages of their careers. Trainees are not expected to be fully competent in all areas of medical or dental practice and in their manifestation of professional attitudes and behaviors, but rather to exhibit or acquire the clinical knowledge, skills, and attitudes appropriate to their levels of training as expected by a given training program.

(2) Trainees may exhibit a spectrum of competencies. A minimum level of accomplishment must be met. Failure, termination, or a need for corrective action may occur for any of the following reasons, depending upon the severity of the problem. Reasons are not limited to this list:

(a) Inability to perform clinical services appropriate to the trainee's level of education or training.

(b) Violation of the ethical standards of the training program or VA.

(c) Failure to meet the minimum standards for patient contact (e.g., neglect of clinical duties), didactic training, testing competence, or maintenance of appropriate professional records (e.g., falsification of medical records).

(d) Engaging in behaviors judged as unsuitable or which hamper the trainee's professional performance or that of other trainees or VA staff (e.g., disruptive behavior).

(e) Violation of VA regulations or applicable Federal, state, or local laws. **NOTE:** VA can only "terminate" or impose corrective action on trainees from programs which are sponsored and accredited in VA's name. Trainees enrolled in affiliated programs can only be "terminated" from those programs by the affiliate. VA can dismiss and prohibit any trainee from participating in VA teaching sites based upon an assessment by the VA medical facility. (See paragraph 10.d.).

(3) Trainee performance deficiencies or failures (hereafter referred to as "performance problems") may take a variety of forms and result from a number of causes, including physical, mental, or behavioral disorders (e.g., due to psychiatric illness or substance abuse), or disruptive behavior (i.e., abusive, antagonistic,

intimidating or demeaning behavior, outbursts of anger, violation of boundaries with staff or patients, sexual harassment, unethical or dishonest behavior).

(4) Supervising practitioners are expected to be cognizant of the stresses of training and the vulnerability of medical/dental trainees. Supervisors must take into account the well-being of trainees and to remain alert for signs of fatigue, illness, impairment, or disruptive behavior on the part of trainees. In addition, trainees must receive appropriate educational experiences and supervision for all patient care provided during their VA training. Whenever possible, supervising practitioners will deal with performance deficiencies in a formative and evaluative manner.

b. **Obtaining and using information about trainees.** Peer or focused reviews conducted for quality improvement purposes are protected as confidential by 38 U.S.C. 5705 and its implementing regulations (38 CFR 17.500 through 17.511). In order to be “protected” under 38 U.S.C. 5705, a review must be identified as such and cannot be used for disciplinary purposes. However, the results of non-protected administrative investigations (for VA-sponsored residents, as described in VA Handbook 0700, Administrative Investigations) or management reviews (for residents in programs sponsored by an affiliate) may be disclosed. In addition, periodic trainee evaluations will be shared with the affiliate as described in paragraph 6.

c. **Corrective actions.** Performance problems that are unlikely to result in an adverse action may benefit from corrective action or other intervention and should be handled within the context of the academic training program. Such instances shall be resolved at the lowest level possible and in a manner that enhances the professional education and development of the trainee. The supervising practitioner and the trainee should attempt to resolve performance issues and are encouraged to discuss their concerns with one another. Formative (as contrasted to evaluative) discussions and solutions may be appropriate depending upon the nature and severity of the performance problems. However, any performance problems or deficiencies shall be reflected in formal evaluations of trainee performance and discussed with the trainee (see paragraph 6).

(1) Substantive problems based on academic or professional deficiencies often require further corrective actions. These actions may include formal remediation for knowledge deficits, treatment of conditions resulting in impairment, or other actions including the possibility of dismissal or non-renewal of the trainee from further VA training.

(2) In all cases, the appropriate corrective action will be determined after consultation between the DEO and the Program Director (for VA or affiliated programs) or the VA Site Director (for affiliated programs). (See paragraph 10.d.)

(3) Use of medical staff peer review processes is inappropriate for trainees in medical or dental programs as they are not licensed independent, privileged practitioners.

d. **Adverse actions or dismissal from VA training sites.** If a trainee engaged in a VA training experience has performance problems of a serious or egregious nature, a non-protected, fact-finding review may be required. If a trainee is thought to pose a threat to the health or safety of the public, patients, or staff, or there is concern that the health or safety of the trainee may be compromised, the trainee may be immediately placed on administrative leave. The purpose of the leave is to review and investigate the alleged performance problem(s). The authority to dismiss a medical or dental resident from VA assignment is found in VA Handbook 5021, Part VI, Paragraph 18. Procedures outlined in VA Handbook 5021 must be followed if dismissal of a resident is considered.

e. **Off-site performance problems or change in a trainee's status.** The affiliate is responsible for reporting to VA any serious performance issues involving trainees at any of its other training sites. The Program Director (VA or non-VA affiliated) will inform the VA DEO and VA Site Director of the nature of the performance issues and any changes in supervision needs or competency levels. Examples of serious performance issues that must be communicated to the VA DEO and VA site director include the following:

(1) academic probation, remediation for significant professionalism or competency issues.

(2) other adverse action based upon findings of an academic or management review or other non-protected inquiry process.

(3) changes in health status that pose a risk to the safety of trainees, other employees, patients.

(4) any other adverse information that may impact a trainee's appointment or performance.

f. This communication, either written or oral, should occur as soon as feasible (no later than the next business day) after the affiliated Program Director is informed of the issue if the trainee is currently at VA or before the next VA rotation if the trainee is not currently at VA. Trainees who withdraw early from the program must also be reported to the VA DEO and VA site director. For programs sponsored by the VA, the VA Program Director or the VA DEO is obligated to notify other participating institutions of changes in the status or credentials of individual trainees. Information affecting professional competency or adverse information regarding clinical incidents may be disclosed only if discovered during a non-protected administrative review. Information containing patient identifiers will not be disclosed.

***NOTE:*** Information on due process for performance, remediation, and disciplinary action can be found in the 5000 series of VA Handbooks (particularly VA Handbook 5005, Staffing, and VA Handbook 5021, Employee/Management Relations). The information in paragraph 9 of this Directive is intended to summarize these issues, but employees should rely on guidance from VA's Office of Human Resources and Administration for accurate and up-to-date information.



**11. MEDICAL MALPRACTICE CLAIMS AGAINST VA IN CASES THAT INCLUDE TRAINEES**

a. Under the Federal Employees Liability Reform and Tort Compensation Act (28 U.S.C. 2679(b)-(d)), Federal employees who are medical care providers are immune from personal liability for malpractice claims arising out of care rendered within the scope of their employment. Residents and students in both VA-sponsored and affiliate-sponsored training programs are similarly protected against personal liability for malpractice claims for care rendered within the scope of their educational program while on VA premises or under the direction and control of VA employees.

b. Medical and dental residents and students must be supervised by practitioners with relevant clinical privileges during all clinical activities related to their specific educational program (see VHA Handbook 1400.01, Resident Supervision). The supervising practitioner is medically and legally responsible for the care provided by resident trainees. Contract providers, while credentialed and privileged by VA and designated as supervising practitioners of resident trainees, are not covered under the Federal Tort Claims Act. The contracted providers are not federal employees and their protection from malpractice claims is included as a part of their contract.

c. The policy for notification of licensed practitioners (including trainees) that a claim for malpractice has occurred is specified in VHA Handbook 1100.17. Under this policy, the VA medical facility Director will provide written notification to all identified practitioners involved in the episode of care that led to the claim. This notification must occur within 30 days from the date that a District Counsel notifies a director that a claim for medical malpractice has been filed under the Federal Tort Claims Act.

d. The VA medical facility director must assign responsibility, as a part of the facility's monitoring procedures for resident supervision, to review any incident reports and tort claims involving physician and dentist residents (see VHA Handbook 1400.01, Resident Supervision). The DEO and the training program director of any trainee(s) listed in a tort claim must be notified. If the program is sponsored by an affiliate, the DIO (or Director of Medical Education) of the sponsoring institution must also be notified. Licensed resident trainees will only be reported to the National Practitioner Data Bank if a panel convened to review a paid tort claim determines that an individual resident was grossly negligent (e.g., disregarded the instructions of the supervising practitioner) or acted with willful professional misconduct (38 CFR part 46, Policy Regarding Participation in National Practitioner Data Bank).

e. VA-sponsored residents who engage in clinical activities at a non-VA site are provided the same protection by the Federal Tort Claims Act as if they were at the VA as long as this provision is appropriately addressed in the relevant affiliation agreement with the non-VA site. (See VA Form 10-0094k).

**12. ACCEPTANCE OF PAYMENTS, GIFTS, OR DONATIONS IN SUPPORT OF HEALTH PROFESSIONS TRAINEE EDUCATION**

a. Occasionally, payments, gifts, or donations are offered to VA in support of health professions trainee educational programs. These payments, gifts, or donations may be offered from academic affiliates (including associated health professions schools), other hospitals or healthcare organizations, commercial vendors (device or pharmaceutical manufacturers), other entities (federal or non-federal, commercial or non-profit), or the trainees themselves. **NOTE:** *This policy does not apply to education programs for staff other than trainees, such as for Continuing Education of VA staff.*

b. The Standards of Ethical Conduct for Employees of the Executive Branch, 5 CFR Part 2635, govern VA employees' personal acceptance of gifts including payments, goods, or services. Those Standards generally prohibit an employee from accepting a gift given because of their official position or by a prohibited source, e.g., vendor, affiliate. 5 C.F.R. 2635.202(a). Such prohibited gifts would include one offered to influence an employee in the performance of an official act, such as the provision of health professions education services (e.g., clinical supervision). See 5 CFR section 2635.202(a): see also 18 U.S.C. 201. *Contact the [Ethics Specialty Team \(EST\)](#) to discuss questions with a VA government ethics official.*

c. The offer of payments, goods, or services, either direct or indirect, to VA in exchange for allowing trainees to receive health professions education and training within VHA may not be accepted.

d. VA medical facilities and training programs may not charge tuition to trainees in exchange for VA-sponsored or VA-delivered education or training

e. Financial relationships between VHA Health Care Professionals and Industry are also addressed by VHA Handbook 1004.07.

f. Gifts and donations to VA in support of a VAMC's health professions education programs generally may be accepted with approval of the facility's Education Committee and the facility Director. Donated funds shall be handled through the local VA-Nonprofit Research and Education Corporation (NPC) or the General Post Fund (GPF), and are subject to VHA policy on acceptance and handling of gifts. (See VHA Handbook 1200.17 "VA Research and Education Corporations" VHA Handbook 1200.2, paragraphs 3b(2)(d), "Research Business Operations," and VHA Directive 4721 "VHA General Post Fund" and VHA Handbook 4721. Gifts and donations in support of a particular trainee health professions education program or programs at a VAMC may not be accepted. For gifts and donations for official travel to attend a meeting or similar function, see VHA Directive 4721 "VHA General Post Fund Procedures."

g. Intergovernmental Personnel Agreements (IPAs) may be used for faculty sharing arrangements with authorization of the facility's Medical Center Director and the local Human Resources Management Service (See 5 U.S.C. Sections 3371-3376 and VA Handbook 5005 on *Staffing*, Section C).

h. Contracts to sell VA health professions education services cannot violate the policy in paragraph 8.c. above and must comply with VHA Handbook 1660.01, Health

Care Resources Sharing Authority – Selling. In particular, note that contracts for the sale of services require prior approval from the VA Central Office Rapid Response Team and certification from the VISN Director or the facility director that certain conditions have been met.

i. The Medical Center Director is responsible for ensuring that an appropriate individual (such as the facility Chief of Staff or the Designated Education Officer) is assigned oversight responsibility for implementation of this policy.

### **13. VA QUARTERS FURNISHED TO RESIDENTS AND STUDENTS**

a. VA may furnish free quarters to medical or dental residents or students who serve short rotations (6 months or less) at a VA medical facility and establish the need for a second residence because the substantial distance to the VA medical facility makes commuting from the affiliated sponsor of the accredited program impractical while the brevity of the training assignment rules out a permanent change of residence. In this situation, free quarters would be furnished to both residents on the VA payroll and residents or students appointed to VA WOC. Any expenses associated with the provision of free quarters to trainees would be paid by the local VA medical facility.

b. VA may provide free quarters to VA medical and dental residents whose index hospital counterparts receive free quarters as partial compensation.

c. The use of the provisions according to the criteria specified in paragraphs 12.a. or 12.b. requires the written approval of the Chief Academic Affiliations Officer and the Office of Construction and Facilities Management (CFM). The requesting facility must outline the justification for use of quarters and the benefit to the VA in a memo to the Chief of CFM, through the Chief Academic Affiliations Officer.

### **14. MEALS FURNISHED TO MEDICAL AND DENTAL RESIDENTS BASED UPON ACCREDITATION REQUIREMENTS AND LOCALITY PRACTICES**

a. ACGME Institutional Requirements provide that residents must have access to appropriate food services 24 hours a day while on duty in all institutions. Hence, VA medical facilities must provide food or food services to residents on in-house overnight or weekend call.

b. VA medical facility directors may establish matching meal plans for noncareer medical and dental residents based on practices found at the facility's index hospital (affiliated sponsoring institution of the accredited clinical training program or programs). Plans thus established will provide VA-paid (directly or indirectly via a disbursement agreement) or WOC residents with gratuitous or reduced-cost meals under terms and in amounts comparable to those made available to residents at the index hospital. For example, if the index hospital provides 3 meals a day "in kind," 5 days a week at no cost to residents, the matching VA meal plan may provide up to 3 gratuitous meals a day, 5 days a week. Local management considerations may result in the VA matching meal plan being less permissive than the index hospital's meal plan. The locally developed and approved meal plan, however, may not be more permissive. Written exceptions

may be granted by the Chief Academic Affiliations Officer, under unusual circumstances.

c. Facilities establishing matching meals plans for residents will maintain close liaison with the index hospital in order to ensure that practices remain as comparable as practicable.

## 15. TRAVEL REIMBURSEMENT FOR PHYSICIAN AND DENTIST RESIDENTS

a. **Residents Paid Directly by VA and assigned to a VA Community-Based Outpatient Clinic or Other Remote Clinical Facility.** If a VA-paid resident is assigned to a community-based outpatient clinic (CBOC), the resident may be entitled to reimbursement of those costs that are in excess of the normal daily commute, i.e., outside the “designated local commuting area” of the duty station (as determined by VA policy). See VA Financial Policy, Volume XIV, Chapter 7, <http://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIVChapter07.pdf>.

b. **For residents paid under a disbursement agreement and assigned to a VA CBOC or Other Rural or Remote Facility, or for Training Essential to VA Duties.** Residents are eligible for “invitational travel,” which is authorized travel of individuals who are not paid directly by VA when they are acting in a capacity that is directly related to, or in connection with, official VA activities. Travel allowances authorized for such an “invitational traveler” are the same as those normally authorized for employees in connection with temporary duty. See VA Financial Policies and Procedures, Travel Administration, XIV, Chapter 1, Appendix G, <http://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIVChapter01.pdf>. Such travel may be used to cover the estimated expenses of those residents who are assigned to a VA CBOC or other approved VA rural or remote clinical site that is outside the normal “designated commuting area” of the teaching hospital or medical/dental school. Invitational travel may also be used for travel expenses associated with training at an off-site location or other travel related to VA duties. See VA Financial Policies and Procedures, Volume XIV, Chapter 3, Transportation Expenses, <http://www.va.gov/finance/docs/VA-FinancialPolicyVolumeXIVChapter03.pdf>. **NOTE:** *When entering such requests for authorization into the governmental electronic travel system, under “Trip Purpose,” select “Invitational Travel.”*

c. **Alternative transportation or sleeping facilities for residents who are too fatigued to drive themselves home after being on duty for more than 24 hours of continuous in-house duty or in other situations where the safety of the resident may be compromised.**

(1) Residents who are too fatigued to drive themselves home safely (e.g., after having been on continuous in-house duty for greater than 24 hours) may require alternative transportation. Hence, a taxi voucher program, other alternative transportation program, or adequate sleep facilities may be provided in order to ensure that the safety of the resident is not compromised.

(2) Other situations where VA-provided transportation from one VA clinical site to another may be necessary and appropriate: for example, if a resident is called at night to see a patient in one VA medical facility, and at the time of return to the original VA facility there is no public transportation or VA shuttle bus operating, then VA will pay or arrange for alternative transportation between the two VA sites.

d. **Other situations in which the provision of transportation for residents and other trainees clearly benefits the care provided to veterans.** Specifically, VA medical facilities may provide transportation (e.g., a shuttle service) between the VA medical facility or VA clinic(s) and affiliated sites in order for residents, other health professions trainees, and VA staff to attend grand rounds or other required educational sessions.