

Beth Israel Deaconess Medical Center

**PAIN MEDICINE FELLOWSHIP PROGRAM**

Daily Expectations for Fellows

- Welcome to your Pain Fellowship! We are extremely excited to have you as a member of our Beth Israel Pain Management Team. Our faculty comprises of a multidisciplinary group committed to excellence in clinical care while providing the highest caliber training to fellows and residents in all aspects of pain management. During this fellowship, you will be mentored to develop graduated autonomy as you learn to provide ethical, evidence based, compassionate, respectful, cost effective, multidisciplinary patient centered care.
- A tentative monthly schedule will be emailed to you ahead of time. **HOWEVER, a final daily updated schedule will be sent to you on the previous work day.** Fellows are expected to review their assigned schedule the day before and acquaint themselves with the patients to be seen. Please discuss all the patients with your attending before the day starts and **INFORM THE ATTENDING AHEAD OF TIME IF YOU ARE DOING A PROCEDURE FOR THE FIRST TIME.**
- If you are sick, please email Dr. Peeters-Asdourian, Dr. Rana, Menrika Louis, Susan Herlihy Kilbride and the attending physician of your assigned room before 7am in the morning. . Also, please call the nursing desk @ 617-278-8008 at 7.00 am. A sick day is counted toward your ACGME 20 day allotment for the year.

**CLINIC PROCEDURES:**

- No food is allowed in the clinic area. All meals and drinks must be kept in the conference room.
- Patient Telephone Calls: On weekdays, all the incoming patient telephone messages will be triaged by the triage nurse. **All emergency calls will be answered by the triage nurse but the fellows will be assisting the nurses with the other calls.** Patient phone calls must be answered on the same day and a note should be entered on the OMR.
  - **Fellows working in OR are responsible for calling those patients the day after the procedure.**
  - **The fellows will be asked to call the patients that were seen by them during their most recent visit.** Fellows are expected to call these patients, gather information and discuss the patient's care with their respective primary pain attending.
  - If the fellow involved in the care is not in the clinic on a particular day, **the Room 4 fellow will be expected to call that patient.**
  - If the patient's primary pain attending is on vacation, **the attending in Room 4 will be the resource attending responsible to assist the fellow with these phone calls.**
  - Fellows will notify the **triage nurse that they have contacted the patient before leaving for the day.**
  - On weekends and evenings, the CPS Fellow (under the supervision of the CPS attending) is responsible for returning **ALL THE TELEPHONE CALLS.**

- Documentation: All dictations must be done by the end of each day, before leaving the clinic. All OMR notes will be reviewed, edited and signed daily.
  - Fellows must review and comply with the Beth Israel Medical Records – Ambulatory Completion Requirements (ADM-24-A) which states in part “Ambulatory clinical documentation should be completed as soon as possible after each clinical encounter, **but no later than 7 calendar days following the date of service.** Under special circumstances, this time period may be extended to accommodate providers who are ill, on vacation, or away on leave. Authentication of documentation may be done by computer key only. Any corrections to documentation must be done as an addendum to the original note. In all cases, the author of the entry is solely responsible for complying with all the requirements in this policy.” The full policy is included as part of your fellowship orientation materials. <S:\Anesthesia\Pain1\Fellows Resources\Hospital Policies\Ambulatory Record Completion Policy.doc>
  
- HIPAA Policy: All patient interactions need to be done in a confidential, respectful and professional manner in accordance with HIPAA and hospital policy (Doors kept closed).
  
- RADIATION SAFETY: Fellows **MUST** wear their **individual radiation safety badge (no sharing of badges is permitted) daily. This badge will be collected and changed at the end of every month to ensure appropriate radiation level monitoring.**
  
- CPS CENSUS: Fellows **MUST UPDATE THE CPS CENSUS DAILY.** When signing off a patient, the fellow must verbally communicate with the next assigned fellow before 7:00am.
  
- PROCEDURE/CASE LOGS: Fellows **MUST KEEP THEIR PROCEDURE LOGS CURRENT IN NEW INNOVATIONS.** It is the Fellow’s responsibility to ensure that this log is completed in a timely manner. Your logs will be monitored on a monthly basis, if any issues are noted, the program leadership will contact you.
  
- Fellows are expected to remain in the clinic **UNTIL 5:00PM.** If your room finishes early, please check with the Resource Attending and Resource Nurse (names are on the Board by the Nurses’ Station) for assistance with telephone calls and other pending matters.
  
- Fellows will take an active role in keeping the room running on time. Phone calls, dictations, e-mails, etc. will not interfere with patient flow.

- Chief Fellow will be a rotating assignment; each fellow will assume this role for a seven to eight week block.
  - Responsible for recording attendance at daily didactic sessions
  - Sounding board for any fellowship related issues, which can then be brought to the attention of Dr. Peeters-Asdourian or Dr. Rana, such that appropriate steps can be taken to address the situation.
  - Coordinating one Friday lunch round table discussion per month. The chief fellow will be responsible for identifying a date, speaker (co fellow or resident) and approve a topic of discussion. An email will be sent to the Pain Attending, Fellows, and Residents to identify the day and topic to facilitate attendance. You will also be given access to a discretionary fund to order lunch for that day.
  - Track and record the number of advanced interventional procedures performed by each fellow on a monthly basis including
    - Spinal Cord Stimulation Phase I
    - Spinal Cord Stimulation Phase II
    - Spinal Cord Stimulator System Explant
    - Kyphoplasty
    - Discography Cervical
    - Discography Lumbar

These totals should be forward to the Susan Herlihy Kilbride on a monthly basis.

#### **CLINIC ETIQUETTE:**

- Patient Communication: Communication with patients, their families and the other staff members is an important part of becoming a good physician. How we listen to, talk with, and instruct patients is an important area of growth expected during training. Learning to explain illness and treatment instruction in simpler terms that are clear to everyone is essential. Fellows will take an active role in keeping the room running on time. Phone calls, dictations, e-mails, etc. will not interfere with patient flow.
- Professionalism: The Pain Management Team at Beth Israel Medical Center values professionalism as being of utmost importance in the career development of fellows. The Pain Management Team seeks to maintain the highest standards of professionalism. The Fellows are expected to adhere to hospital guidelines for attire. If you wear scrubs in the evaluation/follow-up rooms or on the inpatient service, please make sure to wear a white coat

over your scrubs. It is expected that all team members will remain polite and professional at all times.

- Cell Phone Use: The use of cell phones for personal use and texts while in patient areas is strictly prohibited.

### **DIDACTIC CURRICULUM:**

- The comprehensive didactic curriculum at the core of the Pain Medicine Fellowship program is based on the ACGME requirements for training in Pain Medicine, as well as the Content outline for the Pain Medicine subspecialty Certification exam, the International Society for the Study of Pain, and evolving trends in Pain Medicine.
- There is a daily morning didactic conference at 7:00am. Every first Monday of the month, there is a Combined Indication Spine Conference held at 6:30am on the 4<sup>th</sup> Floor of the Rosenberg Building (*formerly Clinical Center*), Beth Israel Deaconess Medical Center West Campus.
  - **Attendance at scheduled lectures is MANDATORY. This includes all didactic conferences and weekly Grand Rounds and Mortality and Morbidity Conferences.**
  - Fellows are expected to sign each conference's attendance sheet. The Chief Fellow will be responsible for ensuring accurate attendance is kept.

A description of each didactic activity is below.

Core Fellowship Didactic Lectures: Provided by pain medicine core faculty as well as multidisciplinary faculty and guest speakers from, neurology, physical medicine and rehabilitation, toxicology and other disciplines. Additional topics in Patient Safety/Quality Improvement methodologies, epidemiology, basic science research and statistics are included in the core lecture series, as well as, areas of faculty clinical and academic interest.

Journal Club: Critical evaluation of the medical literature, understanding evidence based approach and current advances in the field of basic and clinical pain research is a key component of the fellowship. Fellows are encouraged to choose meaningful articles with faculty for discussion at journal club and spearhead discussions. Additionally residents rotating to Pain Medicine are also expected to participate and engage fully in journal club presentations.

Fellowship Roundtable Conference: This is a fellow-led lunchtime discussion forum that takes place on Fridays in the conference room and focuses on practical questions in pain management. The chief fellow is responsible for assigning fellows to choose a topic and lead a discussion. It is helpful if the designated fellow works with an attending. CA-2 and CA-3 residents may also lead these discussions on a voluntary basis. Moderators should email relevant materials well ahead of time. PowerPoint slides are optional, but the moderator should nonetheless be prepared to furnish relevant information from recent literature. – *Intermittent*

Case Conferences: This multidisciplinary conference includes all Pain Medicine faculty/staff, trainees and residents. Selected cases are presented and discussed. In addition to being an educational forum, this conference serves to improve patient care through the open discussion of treatment successes and failures. As such, this conference is an integral part of the Quality Improvement/Patient Safety process. These conferences also provides a structured curriculum to enable fellows to concentrate on psychopathology as well as

behavioral interventions targeting patients with acute, chronic and cancer pain.

Spine Conference: 1st Monday 6.30 – 7.30 AM Pain Fellows participate in the Interdisciplinary Spine conference conducted with Orthopedic Spine and Neurosurgeons.

### **FELLOWS PARTICIPATION IN THE EDUCATION OF OTHER LEARNERS**

The Pain Faculty and Fellows play an active role in resident and medical student education. The fellows prepare and present introductory series of lectures in pain management to the rotating anesthesia residents. This provides an opportunity to enhance their own teaching skills and develops their ability to be future consultants and role models who demonstrate quality improvement and patient safety in the context of their everyday practice.



# Etiquette-Based Medicine

Michael W. Kahn, M.D.

Patients ideally deserve to have a compassionate doctor, but might they be satisfied with one who is simply well-behaved? When I hear patients complain about doctors, their criticism often has nothing to do with not feeling understood or empathized with. Instead, they object that “he just stared at his computer screen,” “she never smiles,” or “I had no idea who I was talking to.” During my own recent hospitalization, I found the Old World manners of my European-born surgeon — and my reaction to them — revealing in this regard. Whatever he might actually have been feeling, his behavior — dress, manners, body language, eye contact — was impeccable. I wasn’t left thinking, “What compassion.” Instead, I found myself thinking, “What a professional,” and even (unexpectedly), “What a gentleman.” The impression he made was remarkably calming, and it helped to confirm my suspicion that patients may care less about whether their doctors are reflective and empathic than whether they are respectful and attentive.

I believe that medical education and postgraduate training should place more emphasis on this aspect of the doctor–patient relationship — what I would call “etiquette-based medicine.” There have been many attempts to foster empathy, curiosity, and compassion in clinicians, but none that I know of to systematically teach good manners. The very notion of good manners may seem

quaint or anachronistic, but it is at the heart of the mission of other service-related professions. The goals of a doctor differ in obviously important ways from those of a Nordstrom’s employee, but why shouldn’t the clinical encounter similarly emphasize the provision of customer satisfaction through explicit actions? A doctor who has trouble feeling compassion for or even recognizing a patient’s suffering can nevertheless behave in certain specified ways that will result in the patient’s feeling well treated. How could we implement an etiquette-based approach to patient care?

The success achieved by Peter Pronovost and colleagues in solving a different kind of complex problem — reducing the likelihood of central-line infections in critical care patients<sup>1</sup> — provides a thought-provoking suggestion. Instead of taking an elaborate, “sophisticated” approach — say, tackling infections by developing more advanced antibiotics or clarifying the genetic basis for drug resistance — Pronovost et al. introduced a checklist to enforce the use of hand washing, thorough draping of the patient, and other tasks that could be easily performed. The results of this simple intervention were swift and dramatically effective. I would propose a similar approach to tackling the problem of patient satisfaction: that we develop checklists of physician etiquette for the clinical encounter. Here, for instance, is a possible checklist for the first

meeting with a hospitalized patient:

1. Ask permission to enter the room; wait for an answer.
2. Introduce yourself, showing ID badge.
3. Shake hands (wear glove if needed).
4. Sit down. Smile if appropriate.
5. Briefly explain your role on the team.
6. Ask the patient how he or she is feeling about being in the hospital.

Such a checklist has the advantages of being clear, efficient to teach and evaluate, and easy for trainees to practice. It does not address the way the doctor feels, only how he or she behaves; it provides guidance for trainees whose bedside skills need the most improvement. The list can be modified to address a variety of clinical situations: explaining an ongoing workup, delivering bad news, preparing for discharge, and so forth.

Training for an etiquette-based approach to patient care would complement, rather than replace, efforts to train physicians to be more humane. Pedagogically, an argument could be made for etiquette-based medicine to take priority over compassion-based medicine. The finer points of patient care should be built on a base of good manners. Beginning pianists don’t take courses in musicianship and artistic sensibility; they learn

how to have proper posture at the piano and how to play scales and are expected to develop those higher-level skills through a lifetime of study and practice. I may or may not be able to teach students or residents to be curious about the world, to see things through the patient's eyes, or to tolerate suffering. I think I can, however, train them to shake a patient's hand, sit down during a conversation, and pay attention. Such behavior provides the necessary — if not always sufficient — foundation for the patient to have a satisfying experience.

Furthermore, it's simpler to change behavior than attitudes. Although reading medically relevant literary classics and writing reflection pieces (as is now done in many medical schools) may make some students more mature

and humane, I wonder whether these exercises are most helpful for those students who arrive at medical school already in possession of those qualities to some degree. For many students, I suspect that these exercises may have a more limited effect, if only because they are too brief to allow the student to comprehend, practice, and master the intended values. It isn't easy to modify a person's character or outlook in a classroom; besides, clinical training is more effective when it resembles apprenticeship rather than graduate school. Trainees are likely to learn more from watching colleagues act with compassion than from hearing them discuss it.

Etiquette-based medicine would prioritize behavior over feeling. It would stress practice and mastery over character development.

It would put professionalism and patient satisfaction at the center of the clinical encounter and bring back some of the elements of ritual that have always been an important part of the healing professions. We should continue our efforts to develop compassionate physicians, but let's not overlook the possibly more immediate benefits of emphasizing good behavior.

No potential conflict of interest relevant to this article was reported.

Dr. Kahn is a psychiatrist at Beth Israel Deaconess Medical Center and an assistant professor of psychiatry at Harvard Medical School — both in Boston.

1. Pronovost P, Needham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. *N Engl J Med* 2006;355:2725-32. [Erratum, *N Engl J Med* 2007;356:2660.]

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Beth Israel Deaconess Medical Center  
Pain Medicine Fellowship Program

**Chronic Pain Service Expectations and Protocol**

As per ACGME Program Requirements, fellows will be scheduled on the Chronic Inpatient Pain Service (CPS) throughout the academic year. By the end of the year, fellows will have an equal share of call. Each assignment will consist of a full week (beginning on Monday morning and ending on the following Monday morning or Tuesday if Monday is a holiday). During the assigned week, the fellow will be available on beeper at all times including evenings, nights, and weekends. Rarely, a clinical scenario will require the fellow come to the hospital in the evening.

CPS is an excellent learning opportunity for the management of complex chronic pain patients, both malignant and nonmalignant. Fellows will start each weekday at the morning didactic session and then proceed to their CPS duties thereafter. On weekends, rounding will begin at a time decided by the attending on call. The remainder of this document will provide a basic template of CPS fellow responsibilities. It is subject to change at any time, however. **All CPS call schedule changes must be formally requested and approved by Dr. Peeters-Asdourian via email and Susan Kilbride must be cc'd.**

**OUTLINE:** Basic responsibilities include consulting on various inpatient services, rounding on those patients (both pre-rounding independently in the morning and rounding with the attending in the afternoon), facilitating (assessments, consents, staying available as needed) at the infusion center, fielding after hours calls from clinic patients, participating in CPS procedure (e.g. blocks on in patients and EBPs), and occasionally helping out in the clinic.

**SIGN OUTS ARE TO BE COMPLETED ON MONDAY (OR TUESDAY AFTER A MONDAY HOLIDAY) BEFORE 7:00am (prior to didactics).** Sign outs must take place verbally.

The page ID for Inpatient CPS is **3-OUCH (3-6824)**. Following weekly sign out, fellows will switch 3-OUCH “covered by” status to the oncoming fellow. **DO NOT SIGN OUT THE PAGER TO A TELEPHONE NUMBER OR TO ANOTHER PAGER NUMBER.**

**THE CPS FELLOW MUST ATTEND MORNING DIDACTIC SESSIONS THROUGHOUT THE WEEK AND THEN REPORT TO THE INFUSION CENTER AFTER, IF NEEDED.**

**CPS Census:** Fellows **MUST UPDATE THE CPS CENSUS DAILY.** Fellows will write daily updates including changes in medications and patient condition in the team census.

## **Pheresis Center**

Fellows should check the schedule for infusion therapy and report to the pheresis unit in a timely manner. Fellows are expected to attend lecture from 7-8am, and should be at the phereis unit by 8:15am (if needed). Fellows must remain readily available **in the pheresis unit for 30 minutes** for all patients receiving sedation and/or ketamine. Please check the Pain Infusion Operations Process Flow for the details. The pheresis schedule can be accessed through the Online Medical Record (OMR).

## **CPS Patients Staffed by APS Attending**

For the majority of patient consults, the CPS attending will staff the consult with the fellow. However, for consults on patients with acute perioperative pain, the APS attending will staff the consult. Subsequent follow up should occur with the APS attending. The CPS attending will serve as a resource for the APS Attending. Note, however, that the CPS attending also serves as the APS attending on weekends.

## **Patient Referrals:**

Generally, a house officer will page the CPS fellow on call (via 3-OUCH) regarding an inpatient referral. During this initial call, please clarify the specific question being asked of CPS, the name and pager number of the person to be contacted regarding the Inpatient CPS recommendations, and the level of urgency. **Inpatient consultations are to be seen promptly** minimally within 24 hours. Check OMR to see if the Pain Service has seen the patient in the past. Remember that each and every consult request needs to be seen and documented as an official consult. **Please refer to the BIDMC consult policy.**  
<S:\AnesthesiaPain1\Fellows Resources\Hospital Policies\Consult Policy.doc>

For floor nurses calling in a chronic pain consult, please confirm that a follow-up call is received from the patient's primary team so that the consult may be executed.

**MOST IMPORTANTLY, BE COURTEOUS, AVAILABLE AND APPROACHABLE. REMEMBER, CPS IS OUR APPEARENCE TO MOST HOSPITAL PROVIDERS.**

## **Patient Evaluation:**

Please **DO NOT CURBSIDE CONSULTS.**

Review the pain center and other relevant notes regarding the patient. CPS Fellows will pre-round on all patients and perform the initial evaluation (history and physical examination) in the patient's room. Inform the CPS attending physician of the initial evaluation who will then round with you, assess the patient, and formulate a plan with

you. History, review of the systems, physical exam, differential diagnosis and treatment plan should be thorough and documented appropriately on the consult note in OMR. The OMR note should also include a brief note by the attending physician. This note should be printed and inserted in the patient's physical hospital chart.

Communicate the plan directly with the primary team, and leave your beeper number on the consult sheet (mandated by the hospital on all notes) so that the referring team may call you with any questions.

**PLEASE MAKE SURE ALL NOTES ARE TIMED DATED AND SIGNED LEGIBLY WITH CREDENTIALS AND BEEPER NUMBERS.** The hospital's "Cut and Paste Policy" contains further instructions on cutting and pasting notes from OMR. <S:\Anesthesia\Pain1\Fellows Resources\Hospital Policies\Cut, Copy Paste Policy.doc>

We provide a consultation service and only make treatment recommendations. **The final orders in the computer are written by the primary team, except for ketamine infusions or IT pumps and/or epidural catheter trial orders.**

The Inpatient CPS follows patients daily until the appropriate time when they are discharged from the Service. Daily, concise notes will be written in the progress note section. These notes must include all pertinent changes in the patient's condition and a list of their analgesics. The decision to discharge from the Inpatient CPS is made by the CPS attending. If needed, the CPS fellow will arrange outpatient follow-up at the clinic for the patient.

Rarely, patients are admitted to the hospitalist service for the primary purpose of obtaining chronic pain services. These patients typically have either acute exacerbations of chronic pain or have undergone interventions such as a pump trial, implantation of pump or stimulator, continuous regional, epidural or intrathecal catheters, etc. CPS is the primary consult team for these patients and follows these patients until discharge. As for other patients, ensure that the detailed initial OMR note and also daily, hand-written progress notes are placed in the patient's hospital chart and that the team census is updated daily.

## **Procedures**

Some inpatients may require an interventional procedure to be performed. These most often take place either in the Arnold Pain Management Center or in the West Procedure Center on Fridays. If indicated and agreed upon, the fellow will notify the resource RN in the clinic (617-278-8008) regarding any procedures on the inpatient service. The patient's primary team needs to be informed and in agreement regarding the procedure planned. Ask the primary team to write the NPO orders if needed, the order for transportation, hold the heparin if indicated, check coagulation status if needed, and all other necessary orders.

**Always assess and verify all THE COAGULATION ISSUES BEFORE the patient is transported to the pain management center.**

**The CPS fellow must see and examine the patient the morning of the procedure to ensure that the patient is ready for the procedure.**

Promptly type or dictate a note in OMR after the procedure.

### **Billing**

The attending physician is responsible for the e-ticket billing on the Inpatient CPS.

### **Telephone Calls**

On weekday evenings and weekends, the fellow may receive phone calls from clinic patients. Patients may require reassurance, an urgent clinic appointment the next day, or an immediate emergency department evaluation. Telephone calls must be documented in OMR. Call the CPS attending for any assistance. Notify the appropriate primary pain physician the next day. Do not give any specific times for the patients to come to the clinic. If a patient needs to be seen urgently, inform the resource nurse (noted on the daily schedule) in person or by phone on the ensuing clinic morning. If you instruct a patient to go to the Emergency Room, call the ER physician and inform them.

Occasionally, the Acute Pain Service (APS) resident may call CPS fellow for assistance with complicated patients. As indicated above, the CPS fellow will handle opioid-tolerant patients with acute, peri-operative pain even if the consult is initially routed to the APS. Additionally, the fellow is responsible for all consults for trauma patients in the ER or ICU's.

For telephone calls from Dr. Pettinato's headache patients, please refer to his instructions.

### **Blood Patches**

The CPS fellow may be called for a presumed PDPH by another service. These calls are often from the ED or a neurologist and follow after a spinal tap. If the patient is in-house, please evaluate the patient and discuss with the CPS attending for possible blood patch vs. conservative management. If the is an outpatient, please evaluate/triage via phone for the next step. Remember, PDPH is not an emergency, but still needs immediate attention for recommendation.

<b>Weekday Protocol</b>	<b>Weekend Protocol</b>
For weekdays, if a decision is made to proceed with a blood patch, please check in with the Resource Nurse for a potential	For weekends, occasionally patients with PDPH at the ED, could have a blood patch done at the ED blindly.

time and arrange for patient to be seen.	<p>If the patient is at home, then provide with a conservative recommendation and plan for a blood patch on the next working day</p> <p>For patients unable to manage at home, please refer to the ED.</p>
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**IT Pumps**

- 1.) IT Pumps need to be interrogated before and after a surgical procedure or MRI studies. Please notify your attending in any of these situations for assistance.
- 2.) Any IT Pump dose changes **REQUIRES THE PRESENCE OF TWO PROVIDERS (i.e. attending and fellow) and their signatures.**
- 3.) There are two programmers: one in the Pain Clinic and one in the West Campus Clinical Center in the 5<sup>th</sup> Floor Fishbowl (Anesthesia Offices).

**Rib Fractures**

<b>Weekday Protocol</b>	<b>Weekend Protocol</b>
For weekdays, all patients should be referred to APS.	Goes to the CPS Fellow for a consult. After patient is seen and evaluated, some of these patients may be candidates for epidurals. Discuss with your attending for future steps.

Beth Israel Deaconess Medical Center – Needham

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Needham MA 02492

Clinical Responsibilities and Work Flow:

- Fellows will be assigned to BIDMC Needham with Drs. Gill and Aner, generally on Wednesdays
  - Kyphoplasty
  - Spinal Cord Stimulator Phase I and Phase II implants
- Parking is free and available onsite
- If you do not have a vehicle you may use Uber and submit receipts for reimbursement
- First case starts on Wednesday mornings are typically 9AM, plan arrive at the patient's bedside by 830AM for preoperative evaluation, consent etc.

Be sure to confirm start time with your assigned attending Dr. Aner or Dr. Gill by phone, email or page the night prior to your cases

- Locker Rooms are located on the second floor, scrubs are available. Staff at the front desk will be able to direct you if needed.

\*\* Further details regarding pre operative, intra operative and post operative responsibilities of the fellows are detailed under Implantation Guide for Spinal and Peripheral Nerve Stimulation drafted by Dr. Thomas Simopoulos.

**Beth Israel Deaconess Medical Center  
Pain Medicine Fellowship Program**

**Core Competencies for the Pain  
Fellowship:  
Goals and Objectives**

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

Pain Medicine Fellows must continue to build on their experience of patient care as obtained in their Anesthesiology, Neurology, Psychiatry or Psychiatry residency. Pain Medicine fellows rotate through in-patient care rounding at the BIDMC and are involved in the care of patients with acute and chronic pain syndromes on a daily basis in the outpatient clinic. In addition they do rotations at BID-Needham, New England Baptist Hospital and Boston Children's Hospital. Pain medicine fellows are supervised by attendings on a one on one basis in these settings. Each rotation has a well-defined set of goals and objectives prior to the beginning of the rotation. This competency is addressed and evaluated by the faculty throughout the fellow's training both written and verbally.

Pain Medicine fellows are expected to:

1. Understand special problems associated with the care of patients with acute and chronic complex pain problem
  2. Be able to perform a thorough Medical History and Physical Examination
  3. Be able to assemble pertinent laboratory and imaging studies.
  4. To present findings from the Medical History and Physical Examination, Lab and Imaging studies that are focused on the pain problems
  5. To list most probable diseases responsible for the patient's problems in a short but appropriate differential diagnosis
  6. To outline several therapeutic options appropriate for the patient's pain problem.
2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care.

Pain Medicine fellows are required to apply medical knowledge to patients by demonstrating and applying investigatory and analytical thinking to clinical situations. They are taught these life-long learning skills by our faculty using structured approaches. Required inpatient clinical experiences include rotations on the inpatient service and the outpatient clinic. Didactic sessions consist of required daily noon conferences. These core conferences topics include:

- a) Anatomy and physiology of the pain projection system.

- b) Epidemiology, economic impact, and sociology of pain.
- c) Pharmacology of opiates, non narcotic analgesics, and non steroidal anti- inflammatory agents.
- d) Pharmacology of centrally acting drugs used in pain management.
- e) Measurement and assessment of pain and function.
- f) Know the principles of neural stimulation.
- g) Understand the principles and indications for diagnostic testing.
- h) Understand the role of nerve blocks in pain management.
- I) Know the role of neuroablative procedures.
- j) Understand behavioral, cognitive, and supportive psychotherapeutic treatment principles, including rehabilitation and the role of team management.
- k) Know the principles and techniques of cancer pain management, including death and dying, and the ethical principles involved.
- l) Discuss the principles and techniques of management of other chronic pain problems.
- m) Understand the principles of physical therapy, occupational therapy, and rehabilitation of the chronic pain patient.
- n) Know the principles of multidisciplinary approaches to pain management.
- o) Discuss the management of pain in children.
- p) Understand the principles and ethics of pain research in humans and animals.
- q) Describe and be able to perform the organization and management of a pain management center.
- r) Participate in continuing quality improvement, utilization review, and program evaluation.
- s) Understand disability assessment and rehabilitation procedures

Chronic pain management - Fellows will understand the theory, indications, side effects, and be able to perform the following skills:

- a) Perform a broad range of peripheral nerve block procedures.
- b) Perform epidural and subarachnoid injections.
- c) Perform joint and bursal sac injections.
- d) Understand cryotherapeutic techniques.
- e) Perform epidural, subarachnoid, and peripheral neurolysis.
- f) Utilize electrical stimulation techniques.
- g) Implant epidural and intrathecal catheters, ports, and infusion pumps.
- h) Understand acupuncture and acupressure.
- I) Understand behavioral modification.
- j) Utilize modality therapy, physical therapy, and occupational therapy.
- k) Utilize hypnosis, stress management, and relaxation techniques.
- l) Know the indications and side effects of chemonucleolysis, trigeminal ganglionectomy, cordotomy, rhizotomy, and dorsal root entry zone lesions.
- m) Perform peripheral neurolysis.
- n) Perform sympathectomy techniques.



- o) Be knowledgeable of ablative neurosurgery, thalamotomy, tractotomy, cingulotomy, central neuroaugmentative procedures.
- p) Perform radiofrequency lesioning.
- q) Perform spinal cord stimulation techniques

The daily didactic program is formatted as formal conferences, journal clubs, case presentations and multidisciplinary conferences. Also mention here reading assignments.

Board certification exams are a critical evaluation of this core competency.

3. **Practice Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence and improvements in patient care.

This competency is assured through review of case in groups and presentation of scientific data relevant to the care of the patient. The Pain Medicine Fellows are expected to lead journal club discussion and present patients at case conferences and multidisciplinary conferences.

The fellows get a thorough orientation to the use of the Countway library at Harvard medical School and to the use of the various ways of searching the medical literature online via tutorials from the Countway librarians.

The Fellows are asked to analyze any complications using QI tools and implement changes, i.e. whenever there is a complication they should have to determine what they would do differently next time. All complications are presented at the departmental Clinical Conference/ Morbidity & Mortality Conference.

4. **Interpersonal and Communication Skills** that result in effective information exchange and learning with patients, their families, and other health care professionals.

The Pain Medicine fellow learns about special needs of patients with acute and /or complex chronic pain problems in terms of personal and psychological support. The Pain Medicine fellows learn to understand the importance of listening to patients and trying to help them as the psychological aspects of their disease require help.

The Pain medicine fellow learns to develop a significant doctor patient relationship that allows the patient to feel comfortable discussing their problems with the fellow who they now recognize as one of their important care givers.

The pain Medicine fellows learn to discuss medical and emotional problems and to feel comfortable talking with patients and their family.

Teamwork training is done in the simulator training offered by the Anesthesia Department.

Role playing session on interpersonal skills is offered at one of the noon didactic conferences.

5. **Professionalism** that demonstrates a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Evaluation of this competency occurs by direct observation, as well as evaluation given by other physicians and health care professionals such as nurses, and administrative professionals.

Pain Medicine fellows are expected to be punctual, complete all tasks as asked, follow directions, have a timely response to staff needs including pages and messages from patients, be honest, have appropriate use of coding and billing, demonstrate respect for patients and co-workers including understand issues of culture, age, sex, sexual orientation and disability.

Fellows are expected to keep accurate and thorough medical records.

The Pain Medicine fellows will act as leaders and role models for the residents and students on various rotations. Pain Medicine fellows will communicate with referring providers and learn to anticipate needs of other health care providers.

6. **System-Based Practice** where residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

The Pain Medicine fellows interact with a number of health systems ranging from HMOs, hospital based practice and free standing outpatient facilities as well as numerous payer types. The Pain Medicine fellows learn about the need for prior authorization for medications and medical devices. They learn to draft letters of medical necessity for their patients for certain procedures and/or medical devices.

They learn about the workman's compensation system and disability.

Some didactic conferences are dedicated to the business aspect of pain medicine and are given by the business administrator for the practice.

The Pain medicine fellows are involved in the Quality Assurance program of the Anesthesia Department and present complications and interesting cases at the department clinical conference (morbidity and mortality conference)

## CLINICAL ROTATION EXPECTATIONS FOR PAIN MEDICINE FELLOWS

The Pain medicine fellows are expected to:

1. Be able to perform a thorough History and Physical Examination.
2. To be able to assemble pertinent laboratory and imaging studies.
3. To present findings from History and Physical, Lab and Imaging studies that are focused on pain problem.
4. To list most probably diseases responsible for the patient's problems in a short but appropriate differential diagnosis.
5. Understand the broader range of available treatment options, choose which therapeutic approach is best for the patient under discussion and understand why alternative treatment options are not optimally suited for the needs of the particular patient being discussed.

# ACGME PROGRAM REQUIREMENTS

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows: (Outcome)

IV.A.5.a).(1).(a) must demonstrate the following competencies in neurology: (Outcome)

IV.A.5.a).(1).(a).(i) eliciting a directed neurological history; (Outcome)

IV.A.5.a).(1).(a).(ii) performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in **fifteen patients**; and, (Outcome)

IV.A.5.a).(1).(a).(ii).(a) Faculty members must verify this experience in a minimum of **five observed patient examinations**. (Core)

IV.A.5.a).(1).(a).(iii) identifying significant findings of basic neuro-imaging. (Outcome)

IV.A.5.a).(1).(a).(iii).(a) Neuro-imaging studies must include at least magnetic resonance imaging (MRI) and computerized tomography (CT) of the spine and brain on a minimum of **15 CT and/or MRI studies**. (Core)

IV.A.5.a).(1).(a).(iii).(b) Neuro-imaging studies must be drawn from the following areas: brain, cervical, thoracic, and lumbar spine. (Core)

IV.A.5.a).(1).(b) must demonstrate the following competencies in physical medicine and rehabilitation: (Outcome)

IV.A.5.a).(1).(b).(i) performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain problems; (Outcome)

IV.A.5.a).(1).(b).(i).(a) Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of **15 patients**. (Core)

IV.A.5.a).(1).(b).(ii) developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and, (Outcome)

IV.A.5.a).(1).(b).(ii).(a) Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of **five patients**. (Core)

IV.A.5.a).(1).(b).(iii) integrating therapeutic modalities and surgical intervention in the treatment algorithm. (Outcome)

IV.A.5.a).(1).(c) must demonstrate the following competencies in psychiatry: (Outcome)

IV.A.5.a).(1).(c).(i) carrying out a complete psychiatric history with special attention to psychiatric and pain

comorbidities; (Outcome)

IV.A.5.a).(1).(c).(ii) conducting a complete mental status examination; and, (Outcome)

IV.A.5.a).(1).(c).(ii).(a) A complete mental status examination must be conducted on a minimum of **15 patients**. (Core)

IV.A.5.a).(1).(c).(ii).(b) Each fellow must demonstrate this ability in **five patients** to a faculty observer. (Core)

IV.A.5.a).(1).(c).(iii) explaining psychosocial therapy to a patient and making a referral when indicated. (Outcome)

IV.A.5.a).(2) Fellows must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Fellows: (Outcome)

IV.A.5.a).(2).(a) must demonstrate the following competencies in anesthesiology: (Outcome)

IV.A.5.a).(2).(a).(i) obtaining intravenous access; (Outcome)

IV.A.5.a).(2).(a).(i).(a) Intravenous access must be obtained in a **minimum of 15 patients** (Core)

IV.A.5.a).(2).(a).(ii) basic airway management; (Outcome)

IV.A.5.a).(2).(a).(ii).(a) This must include a **minimum of mask ventilation in 15 patients**; (Core)

IV.A.5.a).(2).(a).(iii) endotracheal intubation; (Outcome)

IV.A.5.a).(2).(a).(iii).(a) Endotracheal intubation **must be performed on 15 patients**. (Core)

IV.A.5.a).(2).(a).(iv) basic life support and advanced cardiac life support; (Outcome)

IV.A.5.a).(2).(a).(v) management of sedation; and, (Outcome)

IV.A.5.a).(2).(a).(v).(a) This must include direct administration of sedation to a **minimum of 15 patients**. (Core)

IV.A.5.a).(2).(a).(vi) administration of neuraxial analgesia, including placement thoracic or lumbar epidural injections using an interlaminar technique. (Outcome)

IV.A.5.a).(2).(a).(vi).(a) A minimum of **15 thoracic or lumbar epidural injections using an interlaminar technique must be completed**. (Core)

IV.A.6. Curriculum Organization and Resident Experiences

IV.A.6.a) Each fellow must have a distinct clinical experience in each of the of the four cooperating disciplines involved in pain medicine (anesthesiology, neurology, physical medicine and rehabilitation and psychiatry), with the exception of the fellow's primary discipline.(Core)

IV.A.6.b) Fellows must have education in specific areas of pain medicine practice, and many of these experiences will be undertaken in parallel. These experiences must include: (Core)

IV.A.6.b).(1) Outpatient (Continuity Clinic) Pain Experience; (Core)

IV.A.6.b).(1).(a) Continuity experience will provide the fellow with supervised experience in the ongoing management of a diverse population of patients with chronic pain, including cancer pain. The experience allows interaction with other specialists in a multidisciplinary model of chronic pain management. To this end, **the pain medicine fellow should attend a supervised outpatient clinic, approximately weekly, throughout the year of the program.** Fellows may be absent from continuity clinic experience only if the rotation site is more than one hour from the core institution. The maximum allowable time away may be no more than four months. **This will provide a minimum of eight months experience (full-time equivalent of at least 60 half-days).** (Detail)

IV.A.6.b).(1).(b) **Primary responsibility for 50 different patients followed over at least two months each should be documented.** (Detail)

IV.A.6.b).(2) Inpatient Chronic Pain Experience; (Core)

IV.A.6.b).(2).(a) Inpatient chronic pain experience should be supervised on a pain team responsible for the assessment and management of inpatients with chronic pain including cancer pain. Patients should be seen through either a consultation team or while on a designated inpatient pain medicine service. (Detail)

IV.A.6.b).(2).(b) **To establish this experience, the fellow should document involvement with a minimum of 15 new patients assessed in this setting.** (Detail)

IV.A.6.b).(3) Acute Pain Inpatient Experience; (Core)

IV.A.6.b).(3).(a) Acute pain inpatient experience should be supervised in the assessment and management of inpatients with acute pain. (Detail)

IV.A.6.b).(3).(b) **To establish this experience, the fellow should document involvement with a minimum of 50 new patients.** (Detail)

IV.A.6.b).(4) Interventional Experience; (Core)

IV.A.6.b).(4).(a) The ACGME recognizes that interventional pain medicine is an evolving discipline. Programs shall not be required to offer all techniques to their trainees. However, the program director of an ACGME-accredited Pain Medicine Training Program must demonstrate that fellows are exposed to a didactic curriculum that includes topics in Interventional Pain Treatment (see Medical Knowledge), and that fellows receive direct, hands-on experience with a range of interventional pain treatment techniques. At the conclusion of the training period, the program director must prepare a final report for each fellow that clearly documents the specific interventional techniques with which fellows demonstrate competence. (Core)

**IV.A.6.b).(4).(b) To establish this experience, the fellow must document involvement with a minimum of 60 patients who undergo interventional procedures in the following categories: (Core)**

**IV.A.6.b).(4).(b).(i) at least 25 image-guided spinal intervention; (Detail)**

**IV.A.6.b).(4).(b).(ii) at least 10 trigger point injection; (Detail)**

**IV.A.6.b).(4).(b).(iii) at least 10 neuroablative procedures; (Detail)**

**IV.A.6.b).(4).(b).(iv) at least five joint and bursa injections; (Detail)**

**IV.A.6.b).(4).(b).(v) at least five neuromodulation; and, (Detail)**

**IV.A.6.b).(4).(b).(vi) at least five nerve blocks, including a variety of blocks such as intercostal blocks, ilioinguinal blocks, genitofemoral blocks, and lateral femoral cutaneous blocks. (Detail)**

IV.A.6.b).(5) Cancer Pain; (Core)

IV.A.6.b).(5).(a) Cancer pain experience should be a supervised, longitudinal experience in an ambulatory or inpatient population that requires care for cancer pain, and may be integrated with continuity or inpatient experiences. The objectives should include: (Detail)

**IV.A.6.b).(5).(a).(i) The fellow must document longitudinal involvement with a minimum of 20 patients. (Detail)**

IV.A.6.b).(6) Palliative Care Experience; and, (Core)

IV.A.6.b).(6).(a) Palliative care should be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care. It may be integrated with continuity experience or inpatient experience. (Detail)

**IV.A.6.b).(6).(b) To establish this experience, the fellow must document longitudinal involvement with a minimum of 10 patients who require palliative care. (Core)**

IV.A.6.b).(7) Pediatric Experience. (Core)

IV.A.6.b).(7).(a) Experience with the assessment and treatment of pain in children is strongly encouraged. (Detail)

IV.A.5.b) Medical Knowledge

Fellows must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Fellows: (Outcome)

must demonstrate knowledge of the following areas through a formal structured didactic program, including: (Outcome)

IV.A.5.b).(1) assessment of pain; (Outcome)

IV.A.5.b).(1).(a) anatomy, physiology and pharmacology of pain transmission and modulation; (Outcome)

IV.A.5.b).(1).(b) natural history of various musculoskeletal pain disorders; (Outcome)

IV.A.5.b).(1).(c) general principles of pain evaluation and management including neurological exam, musculoskeletal exam, psychological assessment; (Outcome)

IV.A.5.b).(1).(d) indicators and interpretation of electro-diagnostic studies: X-Rays, MRI, CT, and clinical nerve function studies; (Outcome)

IV.A.5.b).(1).(e) pain measurement in humans, both experimental and clinical; (Outcome)

IV.A.5.b).(1).(f) psychosocial aspects of pain, including cultural and cross-cultural considerations; (Outcome)

IV.A.5.b).(1).(g) taxonomy of pain syndromes; (Outcome)

IV.A.5.b).(1).(h) pain of spinal origin, including radicular pain, zygapophysial joint disease, and discogenic pain; (Outcome)

IV.A.5.b).(1).(i) myofascial pain; (Outcome)

IV.A.5.b).(1).(j) neuropathic pain; (Outcome)

IV.A.5.b).(1).(k) headache and orofacial pain; (Outcome)

IV.A.5.b).(1).(l) rheumatological aspects of pain; (Outcome)

IV.A.5.b).(1).(m) complex regional pain syndromes; (Outcome)

IV.A.5.b).(1).(n) visceral pain; (Outcome)

IV.A.5.b).(1).(o) urogenital pain; (Outcome)

IV.A.5.b).(1).(p) cancer pain, including palliative and hospice care; (Outcome)

IV.A.5.b).(1).(q) acute pain; (Outcome)

IV.A.5.b).(1).(r) frequent psychiatric and pain co-morbidities, which include substance-related mood, anxiety, somatoform, factitious, and personality disorders; (Outcome)

IV.A.5.b).(1).(s) the effects of pain medications on mental status; (Outcome)

IV.A.5.b).(1).(t) assessment of pain in special populations, including patients with ongoing substance abuse, the elderly, pediatric patients, pregnant women, the physically disabled, and the cognitively impaired; and, (Outcome)

IV.A.5.b).(1).(u) functional and disability assessment. (Outcome)

IV.A.5.b).(2) treatment of pain; (Outcome)

IV.A.5.b).(2).(a) Drug Treatment I: opioids; (Outcome)

IV.A.5.b).(2).(b) Drug Treatment II: antipyretic analgesics; (Outcome)

IV.A.5.b).(2).(c) Drug Treatment III: antidepressants, anticonvulsants, and miscellaneous drugs; (Outcome)

IV.A.5.b).(2).(d) psychological and psychiatric approaches to treatment, including cognitive-behavioral therapy, psychosocial therapies and treatment of psychiatric illness; (Outcome)

IV.A.5.b).(2).(e) prescription drug detoxification concepts; (Outcome)

IV.A.5.b).(2).(f) functional and vocational rehabilitation; (Outcome)

IV.A.5.b).(2).(g) surgical approaches; (Outcome)

IV.A.5.b).(2).(h) complementary and alternative treatments in pain management; (Outcome)



IV.A.5.b).(2).(i) treatments that comprise multidisciplinary cancer pain care; (Outcome)

IV.A.5.b).(2).(j) strategies to integrate pain management into the treatment model; (Outcome)

IV.A.5.b).(2).(k) hospice and multidimensional treatments that comprise palliative care; and, (Outcome)

IV.A.5.b).(2).(l) treatment of pain in pediatric patients. (Outcome)

IV.A.5.b).(3) general topics, research, and ethics; including: (Outcome)

IV.A.5.b).(3).(a) epidemiology of pain; (Outcome)

IV.A.5.b).(3).(b) gender issues in pain; (Outcome)

IV.A.5.b).(3).(c) placebo response; (Outcome)

IV.A.5.b).(3).(d) multidisciplinary pain medicine; (Outcome)

IV.A.5.b).(3).(e) organization and management of a pain center; (Outcome)

IV.A.5.b).(3).(f) Continuing Quality Improvement, Utilization Review, and Program Evaluation; (Outcome)

IV.A.5.b).(3).(g) patient and provider safety; (Outcome)

IV.A.5.b).(3).(h) designing, reporting, and interpreting clinical trials of treatment for pain; (Outcome)

IV.A.5.b).(3).(i) ethical standards in pain management and research; and, (Outcome)

IV.A.5.b).(3).(j) animal models of pain, ethics of animal experimentation. (Outcome)

IV.A.5.b).(4) interventional pain treatment, including; (Outcome)

IV.A.5.b).(4).(a) selection criteria for a broad range of interventions and an understanding of the risks and potential advantages of these interventions; (Outcome)

IV.A.5.b).(4).(b) airway management skills; (Outcome)

IV.A.5.b).(4).(c) sedation/analgesia; (Outcome)

IV.A.5.b).(4).(d) fluoroscopic imaging and radiation safety; (Outcome)

IV.A.5.b).(4).(e) pharmacology of local anesthetics and other injectable medications, including radiographic contrast agents and steroid preparations; (Outcome)

IV.A.5.b).(4).(e).(i) This must include treatment of local anesthetic systemic toxicity. (Outcome)

IV.A.5.b).(4).(f) trigger point injections; (Outcome)

IV.A.5.b).(4).(g) peripheral and cranial nerve blocks and ablation; (Outcome)

IV.A.5.b).(4).(h) spinal injections including epidural injections: interlaminar, transforaminal, nerve root sheath

injections, and zygapophysial joint injections; (Outcome)

IV.A.5.b).(4).(i) discography and intradiscal/percutaneous disc treatments; (Outcome)

IV.A.5.b).(4).(j) joint and bursal injections, including sacroiliac, hip, knee, and shoulder joint injections; (Outcome)

IV.A.5.b).(4).(k) sympathetic ganglion blocks; (Outcome)

IV.A.5.b).(4).(l) epidural and intrathecal medication management; (Outcome)

IV.A.5.b).(4).(m) spinal cord stimulation; and, (Outcome)

IV.A.5.b).(4).(n) intrathecal drug administration systems. (Outcome)

#### IV.A.5.c) Practice-based Learning and Improvement

Fellows must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Fellows are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, fellows and other health professionals. (Outcome)

#### IV.A.5.d) Interpersonal and Communication Skills

Fellows must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Fellows are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

#### IV.A.5.e) Professionalism

Fellows must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Fellows are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

#### IV.A.5.f) Systems-based Practice

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.(Outcome)

Fellows are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

Insert the Milestone stones



Beth Israel Deaconess  
Medical Center



A teaching hospital of  
Harvard Medical School

ARNOLD-WARFIELD PAIN MANAGEMENT CENTER

As part of our ongoing effort to improve the care delivered at the Arnold Pain Management Center, we want to ask your honest opinion about the doctor you saw today. The doctor is currently a Pain Medicine Fellow in our practice, and we routinely seek feedback from patients about how our fellows are doing.

**INSTRUCTIONS:** Please answer the following six questions about the fellow’s performance during your visit today. The fellow’s picture is below. All answers to these questions will **remain** anonymous – your name is not required on this form. **Kindly complete this form during checkout.**

Physician Name/Picture:

Date of Visit:

QUESTION	POOR	FAIR	GOOD	OUTSTANDING
1. How is the fellow at greeting you and being courteous and respectful during your visit?				
2. How is the fellow at listening to your concerns and addressing them?				
3. How is the fellow at informing you of what they will do during your visit?				
4. How is the fellow at explaining your health condition, the next steps and any prescribed medications in an understandable way?				
5. How is the fellow at encouraging you to ask questions and answering them?				

Would you recommend this physician to a friend and/or family member?

YES

NO

**Beth Israel Deaconess Medical Center**  
**Department of Anesthesia, Critical Care, and Pain Medicine**

## Interventional Pain

### Goals

The ACGME recognizes that interventional pain medicine is an evolving discipline. Programs shall not be required to offer all techniques to their trainees. However, the program director of an ACGME-accredited Pain Medicine Training Program must demonstrate that fellows are exposed to a didactic curriculum that includes topics in Interventional Pain Treatment (see Medical Knowledge), and that fellows receive direct, hands-on experience with a range of interventional pain treatment techniques. At the conclusion of the training period, the program director must prepare a final report for each fellow that clearly documents the specific interventional techniques with which fellows demonstrate competence.

To establish this experience, the fellow must document involvement with a minimum of 60 patients who undergo interventional procedures in the following categories:

- at least 25 image-guided spinal intervention
- at least 10 trigger point injection
- at least 10 neuroablative procedures
- at least five joint and bursa injections
- at least five neuromodulation
- at least five nerve blocks, including a variety of blocks such as intercostal , ilioinguinal blocks, genitofemoral blocks, and lateral femoral cutaneous blocks.

### Objectives by Core Competency

#### ***Patient Care***

- Exposure to a wide variety of clinical pain problems amenable to interventional pain techniques.
- Become familiar with theory, benefits, indications, and practical applications of the following procedures and techniques:
  1. A broad range of spinal and peripheral nerve block procedures
  2. Joint and bursal sac injections
  3. Cryoneurolysis
  4. Epidural, subarachnoid, or peripheral neurolysis

5. Electrical stimulation techniques (Spinal and Peripheral)
6. Vertebral Augmentation procedure
7. Implanted epidural and intrathecal catheters, ports, and infusion pumps
8. Discography and pressure controlled disc stimulation
9. Botox Chemodenervation of muscles and nerves in the periphery
10. Trigeminal ganglion blockade
11. Peripheral neurolysis, via chemical and radiofrequency thermal destruction
12. Sympathectomy techniques (celiac, lumbar, hypogastric, impar)
13. How to avoid, manage and diagnose procedural and device related complications
14. Prevention, recognition and management and resuscitation
15. Recognition and management of therapies, side effects and complications of pharmacologic agents used in pain management with special attention to intrathecal agents.

### ***Medical Knowledge***

- Gain a solid understanding of the following topics, lectures and readings pertaining to interventional pain medicine
  1. Anatomy and physiology of the pain projection and modulation systems where interventions can be focused
  2. Pharmacology of injectates: contrast, local anesthetics, depo-steroids
  3. Pharmacology of intrathecal agents: opioids, baclofen, clonidine, bupivacaine, ziconotide and investigational drugs
  4. Mechanisms of neural destruction and modulation and clinical application
  5. Measurement and assessment of pain and function as could be impacted by interventional pain management
  6. Familiarity with equipment for interventional pain
  7. Principles of diagnostic neural blockade including false positives and limitations of these techniques.
  8. Understanding of treatment algorithms for complex pain syndromes such as post-laminectomy pain and complex regional pain syndromes.
  9. Knowing the differential diagnosis of chronic low back pain including sacroiliac, facet, and disc so as to be able to apply interventional techniques
  10. Principles and techniques of acute pain management
  11. Principles and techniques of cancer pain management so as to appropriately select patients for neurolytic techniques, and implantable therapies
  12. Application of interventional pain to chronic neck pain and headache syndromes
  13. An in depth understanding of theory and application of cryoanalgesia and radiofrequency techniques in chronic pain medicine
  14. Latest developments and applications of spinal cord stimulation technology
  15. Basic surgical skills and implantable techniques
  16. Lectures on fluoroscopy and MRI interpretation
  17. Ultrasound

### ***Practice-based Learning and Improvement***

- Participate regularly in morbidity and mortality conferences, journal reviews, and research seminars.

### ***Interpersonal and Communication Skills***

- Explain pain conditions, formulate a diagnosis and list therapeutic options to other physicians and healthcare providers.
- Communicate effectively with physicians, nurses, and other healthcare professionals, as well as health related agencies.
- Work effectively as a member or leader of a health care team or other professional group.
- Act in a consultative role to other physicians and health professionals.
- Maintain comprehensive, timely, and legible medical records.

### ***Professionalism***

- Demonstrate a commitment to carrying out professional responsibilities and adherence to ethical principles.
- Show compassion, integrity, and respect for others.
- Demonstrate responsiveness to patient needs that supersedes self-interest.
- Maintain respect for patient autonomy and privacy.
- Demonstrate accountability to patients, society and the pain profession.
- Show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

### ***Systems-based Practice***

- Demonstrate awareness of and responsiveness to the larger context and system of healthcare, as well as the ability to call effectively on other resources in the system to provide optimal health care.
- Able to identify patients for appropriate interventions as well as refer for other diagnostic tests prior to these interventions.
- Ensure appropriate less invasive therapies have been tried or are not indicated prior to pursuing advanced pain modalities.



- Prepare prior authorization letters to third party payers which detail the need for a particular therapy. This involvement with insurance providers necessitates fellows to have a detailed understanding of a given patient's medical condition as well as the indication for the requested procedure

# **Clinical Uses of Spinal Cord & Peripheral Nerve Stimulation with Review of the Literature on Lead Placement**

**Thomas Simopoulos MD**

## **1. COMPLEX REGIONAL PAIN SYNDROMES 1 & 2**

### **CLINICAL PRESENTATION**

Complex regional pain syndrome (CRPS) is a regional posttraumatic neuropathic pain syndrome typically affecting a distal extremity (hand or foot) but not uncommonly spreads up the affected extremity. Ipsilateral as well as contralateral spread is a common clinical observation as well. CRPS 1 previously known as reflex sympathetic dystrophy (RSD) is a painful syndrome that usually develops after a traumatic event, most often an injury or surgery. Excruciating, burning pain and functional impairment are the usual disabling characteristics of the syndrome. Other signs and symptoms are summarized:

- Cold or warm extremity
- Edema
- Increased hair or nail growth
- Abnormal skin color
- Allodynia or hyperalgesia
- Hyperhidrosis
- Trophic changes and motor dysfunction

CRPS Type 2 (previously known as causalgia) occurs after injury to a specific nerve and usually exhibits the same symptoms as CRPS 1. Complex regional pain syndromes are associated with a high level of impairment where by only one in five patient's returns to a normal level of functioning with conventional medical therapies. Because of the profound level of pain and decline in activities of daily living, significant depression and anxiety frequently ensues. A careful psychological evaluation and treatment of underlying psychopathology is often necessary before proceeding to a trial of SCS. One prospective randomized controlled trial and retrospective studies support the application of SCS as an effective therapy for complex regional pain syndromes.

#### Lead position:

1. Foot and leg: general from T-10/T-12.
2. For foot only as described below
3. For upper extremity from C-3/C-5.

Intense pain that is felt on the top of the foot or bottom of the foot is not uncommonly difficult to provide reliable strong paresthesia coverage with anterograde lead placement. This problem can be improved with retrograde leads placed parallel to the L-5, SI nerve root but not out the nerve root sleeve. The retrograde approach may be used for other painful peripheral neuropathies as well.

## References

Kemler MA, Barendse GAM, Van Kleef M, et al. N J Med 2000;343(9): 618-624.  
Bennett DS, Alo K, Oakley J, Feler CA. Neuromodulation 1999;2(3):202-210. Kumar K, Nam RK, Cory T. Neurosurgery 1997;40(3):503-509.

## **2. POST LAMIECTOMY SYNDROME (Failed Back Surgery Syndrome)**

### **CLINICAL PRESENTATION**

Post laminectomy syndrome or failed back surgery syndrome (FBSS) refers to the clinical scenario in which patients continue to experience chronic back and/or leg pain despite corrective spine surgery. The careful evaluation of such patients is critical for positive outcomes with SCS, and simple categorization as a FBSS patient does little to guide patient selection. Furthermore the most common reason for FBSS is poor patient selection with little regard or insight for significant psychological, social, and or behavioral issues. Overlooking areas in these domains will lead to poor outcome with SCS as well Thus factors outside of the biological realm significantly influence the reporting and outcome from medical interventions. Some common psychosocial disorders in patients with FBSS and other chronic pain disorders that can profoundly influence outcome are:

- Depression
- Anxiety
- Somatization
- Personality disorders
- Motivational and secondary gain issues

The history, physical examination, and review of imaging and nerve conduction studies should lend strong evidence to support that a significant component of FBSS is neuropathic in origin before SCS is contemplated. Pain in the low back that is constant in nature with burning, sharp and throbbing qualities is strongly suspicious for nerve injury in origin. Potential etiologies of this include:

- Irreversible preoperative nerve injury
- Epidural Fibrosis
- Arachnoiditis

It is important to identify and treat other common etiologies of FBSS that are not neuropathic. These common causes are as follows:

- Foraminal stenosis
- Discogenic pain
- Recurrent disc herniation
- Pseudoarthrosis
- Facetogenic pain
- Sacroiliac syndrome

**Lead Position:** The patient with FBSS not uncommonly presents with bilateral axial and radicular pain components that necessitate paresthesia coverage for SCS to be a fully effective therapy. One lead is preferably dedicated to each side of the back pain to ensure optimal chance for coverage in the low back and lower extremities that can be sustained over time. Traditionally, the T9/10 level has been the preferred position for lead placement that has provided long-term stimulation of back fibers in association with a minor degree of segmental radicular stimulation. Simple caudal migration to T11 results in loss of back coverage. Present current fractionalization and steering technology allows for leads to be placed as high as the T7/T8 level with greater stimulation of the low back fibers compared to segmental roots. The higher level of lead insertion will still allow for back recapture even with some caudal migration. Similarly, high cervical leads placed to the C2/3 level allow for paresthesias to be felt more consistently in the neck and will still provide upper extremity coverage even with some future caudal migration. The placement of cervical leads more lateral (that is nerve root stimulation) can be used to limit stimulation into the lower extremities that is not uncommon when the dorsal columns are stimulated in the cervical region. While there are numerous studies documenting the effectiveness of SCS for FBSS, there remains substantial heterogeneity in study design, quality, setting and duration and thus there is "moderate" evidence to support the efficacy of SCS in the setting of post laminectomy syndrome.

#### References

- North RB, Campbell JN, et al. Neurosurg 1991;28:685-691.  
Barolat G, Neuromodulation 1999;2(3): 179-183.  
Alo K, et al. Neuromodulation 2002;5(2):79-88.  
Sharan A, Cameron T, Barolat G. Neuromodulation 2002;5(3): 167-179.  
Taylor RS, Van Buyten IP, Bucher E. Spine 2005;30(1):152-160.

### **3. OCCIPITAL NEURALGIA**

#### **CLINICAL INDICATIONS**

Occipital Neuralgia is characterized by deep and aching pain occurring within territory of the greater and or lesser occipital nerves. The pain typically begins in the sub-occipital region and radiates over the posterior scalp. Though known causes include closed head injury, direct occipital nerve trauma, degenerative spine disease, and tumors, most patients have no demonstrable lesion. A greater and or lesser nerve block that affords excellent but temporary relief may suggest a favorable outcome from occipital nerve stimulation.

**Lead Position:** A subcutaneous electrode is placed transversely at the level of C1 across the base of the affected greater and or lesser occipital nerves within the muscular fascia. Less commonly, leads may be placed epidurally to the nerve root levels of C2 and C3 lateral to the dens over the atlantoaxial joint. Presently, small prospective case series support the use of occipital nerve stimulation via the subcutaneous approach.

## References

Weiner RJL, Reed KL. Neuromodulation 1999;2(3):217-221.  
Kapural L, Mekhail N, et al. Anesth Analg 101:171-4.

## **4. ANGINA PECTORIS**

### **CLINICAL INDICATIONS**

During physical activity, oxygen supply to the heart has to increase proportionally to the increase in metabolic demand. However certain conditions such as obstructive atherosclerosis plaques in one or more of the coronary arteries or the microvasculature can prevent the heart from meeting this required demand during physical exertion. Myocardial ischemia usually occurs when the myocardial oxygen supply becomes out of balance with the increase in oxygen demands and provokes chest pain, resulting in angina pectoris. Angina pectoris is described as refractory when there is reversible myocardial ischemia that does not respond adequately to anti-anginal medications and revascularization procedures. Patients in this category suffer from coronary artery disease of the small vessels (Syndrome X) and are often not candidates for revascularization. The lack of response to or candidacy for conventional therapy in patients suffering from angina due to Syndrome X qualifies them for SCS therapy. The potential benefits of SCS therapy may include:

- . Improvement in pain control
- Enhancement in quality of life
- Does not totally abolish pain perception and therefore preserves warning of a future myocardial infarction
- Reduction in nitrate use
- Improvement in exercise capacity
- Does not generate arrhythmias

Lead Position: The leads are placed midline to slightly left so as to stimulate the nerve roots by taking advantage of the thickness of the dorsal CSF. The lead tip is placed to the level of T1 to T2. But as with all lead placements, the final position of the lead is determined by the patient's sensation of paresthesias. Pulse widths are typically set to 210 microseconds and frequency is range of 85 hertz. Patients are instructed to use stimulation for 1 hour three times a day and on an as needed basis as well for anginal symptoms. The optimal amount of stimulation per day has yet to be established. In addition, the placebo effect in this population is significant and the amount of benefit SCS has over placebo has yet to be determined.

### References

Hautvast RWM, DeJongste MJL, Staal MJ. Am Heart J 1998;136(6):1114-1120.  
DeJongsteMJL. Neuromodulation 1999;2(3):188-192.  
Latif OA, Nedeljkovic SS, Stevenson LW. Clin Cardiol 2001;24:533-541.

## **5. PERIPHERAL VASCULAR DISEASE**

### **CLINICAL INDICATIONS**

The prevalence of PAD (peripheral arterial disease) in the USA will continue to escalate as our population ages. Vascular reconstruction remains the treatment of choice for patients with severe PAD. There remains however a substantial number of patients who are not candidates for surgery and have not responded well to medical therapy. In Europe these patients are often offered SCS therapy and subsequently show significant improvement in pain, microcirculatory blood flow and functional capacity. The exact mechanism of action remains uncertain. The ability of SCS to promote limb salvage continues to evolve as prospective trials suggest that patients with intermediate impairment of microcirculation may have the strongest potential in avoiding future amputation. The incidence of phantom or stump pain in patients who have an existing SCS system who later have an amputation has not been studied.

Lead Position: There has been variable paresthesia coverage of the painful lower extremity in studies involving PAD. In general the lead is placed antegrade at T11 -L1 level. The upper extremity can be easily covered with lead placement at C4/5 but an ischemic syndrome is far less common in the hand.

### References

Tiede JM, Huntoon MA. Neuromodulation 2004;7(3):168-175.  
Ubbink DT, Spincemaille GH, Prins MH. J Vase Surg 1999;30:236-244.

## **6. POST HERPETIC NEURALGIA**

### **CLINICAL INDICATIONS**

Post-herpetic neuralgia is the most common neurological complication of acute herpes zoster (shingles). Herpes zoster is caused by the reactivation of the latent varicella zoster virus, the causative agent of chicken pox. The virus remains dormant in the dorsal root

ganglion following the resolution of an episode of the chicken pox. In response to waning cell-mediated immunity, most commonly due to advancing age, the virus spreads within the dorsal root ganglion, dorsal horn and peripheral nerve causing an intense neuritis. There is a characteristic dermatomal (a discrete band) rash with vesicles on an erythematous base. In most patients, the rash and pain resolve over the ensuing several months with antiviral therapy and analgesics. However, nearly 50% of patients over the age of 70 continue to experience significant pain and debilitation for well over a year after experiencing their first attack of the shingles. Post herpetic neuralgia is defined as pain persisting at three months after the rash onset. Many elderly patients do not tolerate the adjuvant analgesic therapies that are well known to reduce the pain of post herpetic neuralgia.

Post herpetic neuralgia especially in severe cases is a form of nerve injury that is complex; it involves multiple mechanisms and pathologic changes in the dorsal horn, dorsal root ganglia, and peripheral nerves. There is a spectrum of sensory abnormalities that accompany this condition. Patients may have a partial or complete sensory deficit to heat, cold, and pinprick stimuli. They may have evoked pain induced by light touch (allodynia). Patients complain of three types of pain:

- Spontaneous constant pain - burning, aching, throbbing.
- Spontaneous episodic pain- lancinations, stabbing shooting.
- Stimulus evoked pain- allodynia.
- Unpleasant sensations- neuropathic itching, pins and needles, numbness.

In general, there is a wide range of success rates reported in series when SCS is applied to post herpetic neuralgia because of the variation in the degree of nerve damage and deafferentation. The success of SCS is highly dependent on the integrity of the large fiber functions and is more effective against steady pain than episodic lancinations. Patients with severe post herpetic neuralgia may suffer from extensive damage to the large fibers and have a deafferented clinical exam coupled with episodic lancinations. Thus minimal sensory loss and perhaps temporary positive response to sympathetic blocks may enhance the chances of successful selection for SCS.

The most common sites of post herpetic neuralgia amenable to SCS are in the thoracic, cervical, lumbar followed by sacrum. The pain is usually localized to the T-3 to T-6 area and is most often unilateral in its manifestation. In case series, SCS has been shown to be an effective treatment for post herpetic neuralgia in some patients.

Lead Position: Most cases involve the chest and therefore the lead is placed to the required level usually T2-T7. Due to the thickness of the dorsal CSF layer, the nerve roots are stimulated in order to cover pain in the chest. SCS or stimulation of the nerve roots may be used for pain in the cervical regions. Most commonly, stimulation of the dorsal columns in the lower thoracic spine is used to cover zoster related pain in the lumbar areas.

#### References

Harke H, Gretenkort P, Ladleif HU, et al. *Anesth Analg* 2002;94:694-700.

Kumar K, Nath R, Wyant GM. J Neurosurg 1991;75:402-407.

## 7. CHRONIC POSTAMPUTATION PAIN SYNDROMES

### CLINICAL INDICATIONS

Chronic pain following amputation is composed of two possible neuropathic syndromes. The first is pain in the stump which is related to neuroma formation following the sectioning of the sciatic nerve. The second pain is felt in the amputated extremity and is therefore termed phantom pain. Phantom limb pain is a consummate deafferentation neuropathic pain syndrome and is thought to be a result of neuroplastic changes at the level of the cortex. Therefore like post herpetic neuralgia, it may be difficult to produce paresthesias that cover the entire area of phantom pain limb, or paresthesias are felt but pain relief is only modest. The reason for variable response to stimulation is because of extensive degeneration of the corresponding dorsal columns. As with postherpetic neuralgia, there is a significant variation in outcomes to SCS for phantom limb pain syndromes. SCS does remain a first line invasive option for pain control in stump pain as well as phantom limb pain.

Lead Position: Varies depending on which limb and how much of the limb.

### References

Krainick J, Thoden U, Riechert T. J Neurosurg 1980;52:346-350. Lazorthes Y, Siegfried J, Verdier JC, et al. Neurochirurgie 1995;41:73-88.

## 8. DLIO-INGUINAL HERNIA PAIN

### CLINICAL INDICATIONS

One of the most common neuropathic pain syndromes of the lower abdominal wall arises from repair of an inguinal hernia. This problem might be caused by formation of scar tissue affecting neural tissue or direct injury to nerves in the region after a successful repair of a hernia. The common potential nerves that may be affected include:

- Iliinguinal nerve
- Iliohypogastric nerve
- Genitofemoral nerve

The patient often characterizes this condition as a pain which is dull and aching with causalgia elements as well as allodynia sensitivity. The location of the pain is in the groin region and can extend into the thigh and genital areas. Many attempts have been made to isolate this area by placing an SCS lead on the spinal cord. However this may result in unwanted stimulation in the vaginal or penile area which the patient deems as unpleasant

Lead Position: Potential placements have included:

- Retrograde transforaminal at T12-L2 nerve roots
- Anterograde in the dorsolateral epidural space T11-L2
- Subcutaneous placement in the groin area in the following fashion
  - Lead #1 1-2 cm superior and parallel to the scar
  - Lead #2 1-2 cm inferior and parallel to the scar the subcutaneous



approach is felt to be the optimal way to cover the pain related to herniorrhaphy as reported in case series. But with the recent development of independently current controlled electrode contacts, the groin can be covered without stimulating genital areas.

#### Reference

1. Stinson LW, et al. Neuromodulation 2001;4(3):99-104.

## **9. ABDOMINAL WALL AND VISCERAL PAIN SYNDROMES**

### **CLINICAL INDICATIONS**

The potential indications supported by case reports or series include: (1) abdominal wall neuromas (2) multiple abdominal surgeries (3) non-alcoholic induced chronic pancreatitis (4) severe irritable bowel syndrome, and (5) chronic mesenteric ischemia.

Lead Position: A single midline lead or dual leads placed paramedially with the tip(s) placed at the T5/6 level. Paresthesia coverage corresponds to the T6-T10 dermatomes. The thickness of the dorsal CSF layer favors stimulation of the dorsal root fibers at the mid thoracic level. Paramedially placed leads are needed when the pain is unilateral or when the patient experiences stimulation of the dorsal columns.

#### References:

1. Ceballos A, Cabezudo M, et al. Pain 2000;87:99-101.
2. Krames E, Mousad. Neuromodulation 2004;7:82-88.
3. Khan Y et al. Neuromodulation 2005;8(1): 14-27.

## **10. POST THORACOTOMY**

### **CLINICAL INDICATIONS**

The chronic chest wall pain syndromes that may follow thoracotomy and sternotomy may be severe and not adequately respond to conservative measures. The pain is due to injury to at least one intercostals nerve. The pain characteristics are similar to postherpetic neuralgia. There is often less central nervous system damage because this syndrome is due to a peripheral nerve injury. Therefore stimulation can often be very effective.

Lead Position: The leads are typically placed off midline as described for post herpetic neuralgia. More midline placement tends to run the risk of recruiting in some patients the dorsal columns or the chest on the opposite side of the pain.

#### Reference:

1. Segal R, Stacey BR, Rudy TE. Neurological Research 1998;20:391-396.

## **11. INTERSTITIAL CYSTITIS**

### **CLINICAL INDICATIONS**

Interstitial cystitis is a chronic, debilitating disorder of the urinary bladder. More than half of the patients afflicted with this condition report constant daily pain and suffer from urinary frequency. The intractable pain with this condition contributes to a high suicide rate in these patients. Interstitial cystitis is thought to be caused by neurogenic inflammation that sensitizes the bladder. Low bladder volumes of urine (20 ml) can cause some patients to experience severe pain. Clinically, many physicians have noted a striking resemblance between interstitial cystitis and complex regional pain syndromes. The perpetuation of pain in interstitial cystitis by neurological dysfunction has led to the logical application of sacral nerve root stimulation. Induction of paresthesias over painful bladder and perineal regions has resulted in reduced pain, improved voiding symptoms and increased activity as reported in small case series.

Lead Position: A rostro-caudal (retrograde) method of inserting the leads is employed. Typical entry interspaces include L3/4 and L4/5. Specialized epidural access needles may be used to improve lead steering. Less commonly used for lead insertion is the anterograde approach via the sacral caudal canal. The targets are the S2, S3, and S4 nerve roots. Leads are placed on both sides to cover bilateral perineal and bladder areas.

#### Reference

- Feler CA, Whitworth LA, Brookoff, Powell R. Neuromodulation 1999;2(3):211-216.

## Perioperative Care and Orders for Spinal Cord Stimator-Patients

### Preoperative (Phase I)

1. Informed Consent  
Specify Risks\* Bleeding, infection, headache, nerve injury, paralysis (rare), need for revision, patient to initial and authorization for company sales person
2. Antibiotics\* 2grams of Ancef (30 min prior to inc\*\*) or 1gram of vancomycin
- 3. Mark Pocket Site and side (On Phase II)

### Intra Operative management

- Position
- Prone
  - Pillow under abdomen to reduce lordosis
  - 1010 steri drapes around operative site
  - Scrub prep by OR nurse
  - Sterile preparation again with drapes
  - Stand on patients left if right handed
  - Fluoro enters from right side and is draped sterile
  - Identification of level entry and target
  - Enter at most shallow angle possible with Tuohy needle
  - Loss of resistance to PF Saline or air
  - Insertion of guide wire - should pass easily, do not force
  - Advance lead to approximate level (e.g. T9 for lower extremities)
  - Trial stimulation
  - Paresthesias must cover 80% or better painful regions
  - Make an incision (usually 1.5-2 inches in length) and dissect down to suparspinous ligament. (Make sure the needle is free of tissue)
  - Anchor lead with 2.0 Silk, Use either cylinder with butterfly anchor
  - Remove the needle only after placing anchor sutures
  - Infiltrate tunnel site for percutaneous extension
  - Bend the tunneling tool in order to avoid deep puncture and tunnel at least 10 cm from the insertion site.
  - Insert the lead into the extension so that the contact sites cannot be seen. Be sure to place the cuff on prior to lead insertion.
  - Secure the lead into extension with screw drive through silicone covered screws (must hear click sound)

- Place a 2.0 silk tie on protective cuff
- Make a pocket to fit the extra length of lead
- Close the skin with 2.0 vicryl interrupted
- Staple skin (If doing a phase I)
- Apply gauze and tegaderm after washing off the betadine prep

### PostOp

1. Write an order to D/C the patient home
2. #60 Percocet (carefully review other Tylenol containing meds)
3. NSAIDS (or COX-II) if no contraindications

### Phase II

#### PreOp

1. Ensure spinal cord stimulator provides > 50% pain relief
2. Mark IPG site
  - a. Buttock
    1. above the ischium
    2. below the beltline
  - b. Abdomen
    1. above the groin
    2. below the rib
3. Informed consent
  - bleeding, infection, need for revision, company representative
4. Antibiotic similar to phase I

#### Intraoperative

- Prepare all areas in a similar fashion to phase I
- An incision of 5 cm is often needed to place the IPG
- Use blunt dissection and good hemostasis with electrocautery
- Place a 2.0 anchor suture of silk in the fascia
- Open the prior suture where the lead was inserted. Note, staples and drapes should be off prior to preparation.
- Also tegaderm the lead extension to avoid pulling into the wound
- Unscrew the extension and cut off the thick end of it. Have the circulator remove the percutaneous extension.
- After infiltration of local in the skin, tunnel the lead to the pocket.
- Connect the IPG to the lead or extension. Test the connections.
- Irrigate all wounds and close with absorbable sutures.
- Dress all wounds as described above.

Postoperative Care

1. Plan for 24-hour admission unless tdlld otherwise.
2. PCA for pain control
3. PC pain meds on discharge
4. Resume oral medications
5. Consider toradol 10-15 mg q6 for 24 hours if no contraindications.

Note- All patients require operative reports and discharge summaries if admitted.

## **SAMPLE Letter of Medical Necessity for Spinal Cord**

Stimulation Therapy  
Date:

Inside Address  
Patient: Policy

Holder: ID/Social

Security #:

Dear

This letter is to request a predetermination of coverage/prior authorization for the implantation of a \_\_\_\_\_ System for the treatment of chronic pain. Spinal cord neurostimulation electrically stimulates the spinal cord to superimpose paresthesia (tingling) over the area of pain. The neurostimulation system consists of a lead implanted near the level of the spinal cord corresponding to the areas of pain and connected, via an extension, to a neurostimulator (power source that produces electrical pulses).

Unlike other spinal surgeries, the benefit of this therapy to the specific patient can be assessed prior to the system implant, and the spinal cord and nerves are not damaged or altered. During the screening test, a temporary lead is implanted at the spinal level corresponding to the areas of pain and attached to an external power source to validate therapy effectiveness. The test allows patients to temporarily experience neurostimulation and the effect it has on controlling their pain, and to make an informed choice about pursuing the therapy. Neurostimulation therapy has been widely used since the 1970s to manage chronic pain. I have enclosed further information about this therapy and summaries of clinical studies.

Based on my review, I believe that my patient, \_\_\_\_\_, is an excellent candidate for this therapy.

(Personalize the letter for the specific patient using the information outline that follows. You may require one or more paragraphs for each of the headings listed.)

*Address each of the following points in [the body of the letter or in an attached report:*

**Document Current Findings/Status** Describe the patient's current status including diagnosis, complaints, and level of impairment. Detail functional impairments and state how quality of life, activities of daily living, caregiver (if applicable), employment, etc. are affected.

**Document Chronological History** Document the patient's history of interventional efforts noting procedures, medications and/or therapies that have been previously rendered. Note the outcome of each. A timeline may be useful.

**Recommend Spinal Cord Stimulation**

(Capabilities for two leads, etc.) State how this therapy is an appropriate intervention at this point in the patient's care. Note therapeutic goals. Anticipated outcome, risks of performing the procedure, risks of not performing the procedure, and possible complications.

**Describe the Implant Procedure** Describe the surgery itself, listing anticipated procedure codes (CPT). Note the follow-up care associated with the therapy. This could be an attachment rather than in the body of the letter itself.

As \_\_\_\_\_ fits the patient profile for this treatment modality and has not responded to other measures, I recommend a neurostimulation screening test. The decision to implant the (name of system) System will be based on the patient's positive response to the screening test as indicated by a significant decrease in pain and an improvement in function.

I request confirmation that this therapy is a covered benefit based on medical necessity, and that associated professional fees for the surgery and follow-up will be covered. I request authorization for all charges associated with the screening test, and possible subsequent implant procedure including physician professional fees, device and facility fees. The charge for the device is routinely included with the facility charges. The screening test has been

scheduled at (name of the facility) on (date) and the implant procedure has been tentatively scheduled at (name of the facility) on (date),

Thank you for your review of this information, and for your coverage consideration. If you have any questions, please contact me at (phone).

Sincerely,

*Summarize why you propose this option*

*Summarize your request for prior authorization*

Enclosures:

- Summary of relevant clinical articles
- Implant procedure overview
- Commonly billed codes

Letter

ARNOLD PAIN MANAGEMENT CENTER  
330 Brookline Avenue Boston, MA 02215  
Phone (617) 667-3334 Fax (617) 667-8065

February 1, 2005

RE:

To Whom It May Concern:

This letter is written to request prior authorization for surgical implantation of a spinal cord stimulator to treat Beth White's chronic regional pain syndrome/reflex sympathetic dystrophy of the right upper and lower extremity.

The name of the attending physician is Dr. Thomas Simopoulos. Beth white is a 37-year-old female with a history of chronic regional pain syndrome/reflex sympathetic dystrophy of the right upper and lower extremity. She reports poor relief from multiple medications. The pain is described as constant and tingling and mostly is located in the right hand and right foot. She describes it as a sharp shooting pain.

Her current medications include Topamax 25 mg q.h.s., Ultram 50 mg 2 tablets t.i.d., and Xanax 0.5 mg p.r.n. During her last visit, we had decided to change her Xanax to Klonopin 0.5 to 1 mg p.o. q.h.s. We also added Zonegran 25 mg q.h.s.

On physical exam testing, she has sweating in both the foot as well as the hand. She also has temperature changes, mainly cold sensations to touch of the right hand and foot. She notes lancinations and continuous numbness, tingling and aching. She also has twitching and mottled brittle nails as well as swelling and allodynia. She has similar symptoms in the right foot and the right hand.

Medications that she has tried in the past without success include:



1. Ultram.
2. Darvocet.
3. Topamax.
4. Lidoderm patch.
5. Zanaflex.
6. IV lidocaine infusion.
7. Neurontin.
8. Mexiletine.
9. Doxepin cream.
10. Clonidine patch.
11. Nortriptyline.

Mrs. White has also undergone multiple procedures, none of which have been successful. Procedures performed include.

1. Stellate ganglion block: Only transient relief.
2. Axillary block: No relief.
3. IV regional blocks: No relief.
4. Steroid injections: No relief.
5. Physical therapy: No relief.

Mrs. White reports difficulty in sleeping secondary to the pain. She has seen our pain psychologist Dr. Wootton who recommends that we proceed with a spinal cord stimulator. He believes that the patient is an excellent candidate for this procedure.

As mentioned above, multiple medications as well as procedures including those listed above, several stellate ganglion blocks, numerous IV regional blocks, and 2IV lidocaine infusions were not helpful in relieving her pain. The patient has a severe case of complex regional pain syndrome (reflex sympathetic dystrophy). At this point, we believe the patient is an excellent candidate for spinal cord stimulator trial. Multiple medications and procedures have failed to offer any relief for the patient and we believe she is an excellent candidate for the dorsal column stimulator. We believe that it would be a disservice to deny approval for this procedure.

This letter is to request a predetermination of coverage/prior authorization for the implantation of a dorsal columns spinal cord stimulator. This system is further treatment of cough, chronic lumbar radiculopathy, reflex sympathetic dystrophy, and other spinal painful disorders. Spinal cord neurostimulation electrically stimulates the spinal cord to superimpose paresthesia (tingling) over the area of pain. The neurostimulation system consists of a lead implanted near the level of the spinal cord corresponding to the area of pain and connected via an extension to a neurostimulator (power source that produces electrical pulses). Unlike other spinal surgeries, the benefit of this therapy to this specific patient can be assessed prior to the system implant and the spinal cord and nerves are not damaged or altered. During the screening test, a

temporary lead is implanted at the spinal level corresponding to the area of pain and attached to an external power source to validate the therapy effectiveness. The test allows the patient to temporarily experience neurostimulation and the effect it has on controlling the pain and to make an informed choice about pursuing the therapy. Neurostimulation therapy has been widely used since the 1970s to manage chronic pain. Further information about this therapy is well as a summary of clinical studies can be provided upon request.

As I have mentioned above, the relief that she has received from prior interventions has been very minimal and only temporary. Hence, we strongly recommend a trial for spinal cord stimulation. Spinal cord stimulation has been shown to be very effective in patients with reflex sympathetic dystrophy, nonrefractory to conventional interventions, and medications. There have been numerous studies, publications, chapters, and texts explaining the benefits of this procedure. They have shown marked improvement in patient's symptoms and function in many cases. The implantation of the peripheral nerve stimulator will be done in 2 phases, the first phase is a trial phase in which the leads are placed subcutaneously with fluoroscopic guidance in the operating room and paresthesias are obtained in the area of the pain with the help of stimulation. It is made sure that the painful area was adequately covered by stimulation of the leads inside the region. In phase 2, which is undertaken after the success of phase 1, a permanent placement of an implantable pulse generator will be performed and this may require 23 hours of observation. At this point, we think this patient is an excellent candidate for the dorsal column stimulator. She is a nonsurgical candidate and has a diagnosis of reflex sympathetic dystrophy. She has been seen at the Arnold Pain Management Center since 08/2004 and has had numerous interventional pain procedures as well as being tried on multiple medications as listed above.

So far she has been unable to sleep affectively, perform activities of daily living without pain, or enjoy her life. Her quality of life has been extensively compromised secondary to the pain.

I can assure you that we have exhausted all forms of treatment modalities for this patient and a spinal cord stimulator is our last hope.

We have discussed our plan with Beth White and she has agreed and wants to proceed. It is our recommendation that this patient be approved for a trial spinal cord stimulation for relief of the pain, which she suffers from chronic regional pain syndrome/reflex sympathetic dystrophy of the right upper and lower extremity.

If you have any further questions, please contact Dr. Thomas Simopoulos, as she is the primary pain physician at the Arnold Pain Management Center.

Sincerely,

Dr. KHURAM A. SIAL MD

eScripton document: 1-7340903

Cosigned by THOMAS T. SIMOPOULOS, MD on 03/10/05

**OPERATIVE REPORT  
DICTATION REFERENCE CARD**

1. Name of Dictator (spell name)
2. Patient's Name (spell name)
3. Date of Operation
4. Patient Unit Number
5. Date of Birth and Sex of Patient
6. Service
7. Surgeon (spell name)
8. First Assistant (spell name)
9. Preoperative Diagnosis
10. Postoperative Diagnosis
11. Name, of Operation
12. Indications
13. Preparation
14. Incision
- 15. Findings**
16. Technique
17. Sponge Count
18. Estimated Blood Loss
19. Specimen to Pathology
20. Date of Dictation

**DISCHARGE SUMMARY  
DICTATION REFERENCE CARD**

1. Name of Dictator (spell name)
2. Name of Attending (spell name)
3. Patient's Name (spell name)
4. Service
5. Patient Unit Number
6. Date of Birth and Sex of Patient
7. Date of Admission
6. Date of Discharge
9. Present Illness
10. Physical Examination
11. Pertinent Lab, X-ray, EKG, other tests'
12. Procedures Performed
13. **CONCISE** Summary of Hospital Course
14. Condition at Discharge
15. Discharge Status
16. Discharge Diagnosis (spell out entirely)
17. Discharge Medications
18. Follow-up Plans
19. If work type 0 (stat transfer summary)  
state facility which should receive copy  
(spell name).

BIDMC – Health Information Management Dept.  
To dictate from any hospital extension, call 7-4503  
To dictate from outside the hospital dial a toll free # 877-517-0462

- Listen for greeting
- Enter your 5-digit ID number followed by the # sign.
  - House officers user beeper #
- Enter the work type followed by the # sign.
  - #10 Stat Discharge Summary
  - 1# Operative Report
  - 2# Discharge Summary
  - 3# D/S summary addendum
  - 6# Stat Cardiac & Psych Reports
  - 7# Psych Discharge Summary (Routine 24 hours)
- Enter 7-digit medical record number followed by the # sign. You may begin dictating at the tone.
- Multiple Reports: Press 5 to separate reports
- Press 9 at the end of last report before hanging up.
- #15 – AO= Addendum to OP Note

## Beth Israel Deaconess Medical Center

### Department of Anesthesia, Critical Care, and Pain Medicine

#### Psych Rotation

##### Goals

- To encourage the development of a performative understanding of the psychosocial background and risk factors influencing the development and maintenance of chronic pain.
- To acquire the skills to conduct effective and compassionate behavioral and psychiatric evaluations and develop multidisciplinary plans of treatment, demonstrated on a minimum of five supervised and directly observed patient interviews.
- To acquire the skills to complete a comprehensive patient anamnesis (history) with special attention to psychiatric and pain comorbidities.
- To become familiar with conducting a complete mental status examination, demonstrated on a minimum of 15 patients.
- To become conversant with the process of explaining psychosocial interventions and therapies to patients and making referrals to allied providers when indicated.

##### Objectives by Core Competency

###### *Patient Care*

- Observe and conduct supervised psychiatric interviews with patients.
- Evaluate patients to assess the influence of psychosocial risk factors in the setting of chronic pain.
- Facilitate the development of multidisciplinary plans of treatment, including appropriate behavioral and psychiatric interventions.

###### *Medical Knowledge*

- Develop an understanding of the flow of a psychiatric interview, including the following sections:
  - A full psychosocial anamnesis
    - Presenting patient complaint
    - History of presenting pain complaint
    - Current level of functioning
    - Current identifiable stressors
    - Psychiatric history
    - Substance Abuse history
    - Medical history
    - Developmental and social history

- A mental status examination – formal, informal, and/or psychometric
- A dynamic formulation of the patient’s situation, identifying pertinent psychosocial risk factors
  - Review and discussion – with the patient, where appropriate, of psychological testing results
- A multidisciplinary treatment plan with appropriate recommendations to the primary pain physician
  - Review with the patient of the patient’s questions and self-reported goals for treatment
- Develop knowledge of and sensitivity toward the psychosocial risk factors affecting chronic pain
- Demonstrate mastery of the psychology curriculum
- Promulgate full written and monitored reports on a minimum of five patient interviews for the Online Medical Record (OMR), co-signed by the pain psychologist

### ***Practice-based Learning and Improvement***

- Participate in monthly multidisciplinary rounds, presenting and/or discussing patients with a focus on outlining the psychosocial risk factors influencing the patient’s pain, reviewing the comparative success and failure of medical, psychological, and complementary interventions to date, and revising the treatment plan to address more effectively the risk factors affecting ongoing care.
- Attend and contribute to psychology curriculum presentations as part of the Pain Medicine didactic lecture series.

### ***Interpersonal and Communication Skills***

- Nurturing the ability to generate a good working alliance with the patient, facilitating the anamnesis and receptivity to recommendations.
- Applying flexibly the sections of the interview in response to the rhythms of the patient’s presentation.
- Taking into account and sensitively addressing the patient’s current stage of readiness for change, according to the transtheoretical model.

### ***Professionalism***

- Being punctual.
- Making timely responses to staff needs, including pages and messages from patients.
- Demonstrating respect for patients and co-workers, including sensitivity toward differences of culture, age, gender, gender and sexual orientation, and disability.
- Communicating with referring providers and learning to anticipate the needs of other health care professionals.

## ***Systems-based Practice***

- Demonstrating knowledge of multiple socio-economic and service aspects of outpatient health care systems, including cost control, billing, and reimbursement.
- Becoming an advocate for quality patient care and assisting patients in negotiating the system's complexities—encouraging, educating, and mediating, where appropriate.

**Beth Israel Deaconess Medical Center**  
**Department of Anesthesia, Critical Care, and Pain Medicine**  
**Rotation: Physical Medicine and Rehabilitation**

**Goals**

- Gain an understanding of the natural history of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities.
- Learn the performance of a musculoskeletal exam.
- Emphasize both structure and function as it applies to diagnosing acute and chronic pain problems.
- performing a comprehensive musculoskeletal and appropriate neuromuscular history and examination with emphasis on both structure and function as it applies to diagnosing acute and chronic pain
- Fellows must gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients
- developing rehabilitation programs to include assessments of static and dynamic flexibility, strength, coordination, and agility for peripheral joint, spinal, and soft tissue pain conditions; and
- Fellows must demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients
- integrating therapeutic modalities and surgical intervention in the treatment algorithm.

**Objectives by Core Competency**

***Patient Care***

- Review patient's history contained in the Online Medical Record ahead of time.
- Elicit a directed musculoskeletal history.
- Perform a detailed musculoskeletal examination of the myotomes, dermatomes, reflexes, pain behaviors and kinesiophobia, and problem-specific physical exam maneuvers.
- Develop comprehensive rehabilitation plans for 5 patients.

***Medical Knowledge***

- Emphasize both structure and function as it applies to diagnosing acute and chronic pain problems and also understand the inconsistent relationship between imaging and signs or symptoms.
- Understand the natural history and statistics of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities.



### ***Practice-based Learning and Improvement***

- Attend didactic curriculum sessions on basics of musculoskeletal evaluation and diagnosis, pathophysiology and management of various musculoskeletal pain syndromes.
- Attend case based conferences focusing on complex musculoskeletal pain syndromes pain issues.
- Review algorithms for the medical management of musculoskeletal pain syndromes.

### ***Interpersonal and Communication Skills***

- Effectively communicate with the patient and interact with members of the team and with referring physicians.
- Explain the pain conditions and therapeutic options to other physicians and headache providers.
- Work effectively as a member or leader of a health care team or other professional group
- Act in a consultative role to other physicians and health care professionals.
- Maintain comprehensive, timely, and legible medical records, if applicable.

### ***Professionalism***

- Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
- Demonstrate compassion, integrity, and respect for others
- Demonstrate responsiveness to patient needs that supersedes self-interest
- Demonstrate respect for patient privacy and autonomy
- Demonstrate accountability to patients, society and the profession.
- Show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation.

### ***Systems-based Practice***

- Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system of health care to provide optimal health care.
- Order appropriate medications keeping in mind the best formulary option for the patient.

**Beth Israel Deaconess Medical Center**  
**Department of Anesthesia, Critical Care, and Pain Medicine**

**Rotation: Headache Center**

**Goals**

- Learn diagnostic criteria for the most common types of headaches, as well as some more unusual varieties.
- Review a basic neurologic examination, and discuss differentials, indications for imaging and other work-up and treatment plans.
- Decide on best treatment options through discussions of medications and integrative therapies.

**Objectives by Core Competency**

***Patient Care***

- Observe attending neurological examinations.
- Discuss differentials, indications for imaging and other work-up and treatment plans.
- Perform a neurological examination including focusing on headache and pain.

***Medical Knowledge***

- Gain familiarity with anatomy, physiology, and pharmacology of neurologically relevant pain conditions.
- Understand principles and indications for diagnostic testing including MRI, CT and electrodiagnostic testing.
- Observe and gain exposure to behavioral, cognitive and supportive psychotherapeutic treatment principles including rehabilitation and the role of team management including psychiatric, psychological, and social services.

***Practice-based Learning and Improvement***

- Attend at least two of the monthly headache interest group meeting held on Tuesday evenings in the CLS building.

### ***Interpersonal and Communication Skills***

- Interact with members of the team and with referring physicians.
- Explain the pain conditions and therapeutic options to other physicians and headache providers.
- Work effectively as a member or leader of a health care team or other professional group
- Act in a consultative role to other physicians and health care professionals
- Maintain comprehensive, timely, and legible medical records, if applicable.

### ***Professionalism***

- Demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.
- Demonstrate compassion, integrity, and respect for others
- Demonstrate responsiveness to patient needs that supersedes self-interest
- Demonstrate respect for patient privacy and autonomy
- Demonstrate accountability to patients, society and the profession.
- Show sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities and sexual orientation.

### ***Systems-based Practice***

- Able to refer patients for the appropriate neurodiagnostic and/or radio imaging studies.
- Provide quality health care that is cost-effective and advocates for patients within the health system.

**Beth Israel Deaconess Medical Center**  
**Department of Anesthesia, Critical Care, and Pain Medicine**

**Rotation: Pediatric Pain – Boston Children’s Hospital**

**Goals**

- Provide in-depth exposure to management of acute and chronic pain in the pediatric population.
- Enhance fellow knowledge on pharmacological, interventional, psychological, and physical medicine treatments for pediatric patients with pain.
- Participate in multidisciplinary evaluations and development of the patient’s treatment plan.
- Attain skills and knowledge requisite for routine office care of children with pain from infancy through adolescence, with emphasis on identification and diagnosis of pain and documentation of the impact of pain on normal versus abnormal patterns of development, behavior, and health in the pediatric population.

**Objectives by Core Competency**

***Patient Care***

- Become experienced in the physical exam of children and adolescents with pain with a ready capacity to identify pathology through general and directed examination.
- Gain competence and skill to assess and treat acute and chronic pain.
- Gain facility in obtaining and interpreting pain with appropriate measurements and pain scales.
- Attain skill and sophistication in the management of common behavior concerns related to a pain diagnosis such as colic, discipline, sleep troubles, toilet training, tantrums, bedwetting, exercise, diet, etc.
- Completion of a comprehensive pediatric medical history and physical exam while addressing a complete pain care history including: patient’s medical diagnosis, goals of care, psycho-social, coping, functional assessment, and quality of life.

***Medical Knowledge***

- Know the recommended guidelines for acute and chronic pain management in the pediatric population.
- Demonstrate an understanding of the common diagnostic tests and imaging studies used in the inpatient and outpatient setting for patients with pain.
- Explain the rationale for each study ordered to evaluate pain and interpret the results in the context of the specific patient.

- Generate a differential diagnosis for a child with acute or chronic pain.
- Demonstrate a commitment to acquiring the base of knowledge needed for the care of children with acute and chronic pain.
- Completion of a comprehensive pediatric medical history and physical exam while addressing a complete pain care history including: Patient's medical diagnosis, goals of care, psycho-social

### ***Practice-based Learning and Improvement***

- Ability to access medical information efficiently, evaluate it critically, and apply it to outpatient care appropriate.
- Demonstrate knowledge, skills and attitudes needed for continuous self-assessment.
- Participate actively in the pediatric pain conference series, which includes completing the assigned readings, participating in the discussions, and leading the conference when assigned.
- Use practice-based methods and evidence to investigate, evaluate, and improve one's pediatric pain management practice in the outpatient setting.

### ***Interpersonal and Communication Skills***

- Discuss language, cultural and other social barriers to provision of health supervision and care and describe strategies to overcome these for specific families.
- Communicate effectively utilizing a medical interpreter.
- Demonstrate a variety of interview techniques that can facilitate a dialogue.
- Understand the effect of one's own emotions on the clinical encounter.

### ***Professionalism***

- Develop a positive working environment for more effective delivery of health supervision care with: patients and families, office staff and primary care team, consultants and referral sources.
- Demonstrate strategies that allow provision of comprehensive and efficient provision of pain management services (develop and use structure records, computerized information, websites, questionnaires, patient education handouts, books, videos; office policies for consent and confidentiality, request for school information).
- Maintain punctuality in keeping appointments with supervisors, peers, and patients, and manage time productively with attention to patient flow, nursing demands, staffing shortages, etc.

## ***Systems-based Practice***

- Demonstrate knowledge in clearance for referrals and pre-authorizations.
- Develop skill in obtaining informed consent and an awareness of circumstances that require consent prior to transfer of information or medical procedure.
- Develop a basic knowledge of regional statutes in the provision of care for those with questions of competence, mature minors, and emancipated minors.
- Use knowledge of the pediatric health care system in development of the appropriate plan of care for the patient and family.
- Utilize the interdisciplinary team resources to create smooth transitions across health care settings for patients and families.
- Learn to advocate for patients and families across settings.
- Avoid delays in completing documentation, and complete documentation in thorough and concise fashion to afford other health care providers ready comprehension of patients' medical issues and concerns.
- Maintain responsibility for patient care and secure alternative care for patients when you are not available
- Be receptive to accepting and providing criticism and feedback to peers, staff, and Supervisors alike



**Beth Israel Deaconess Medical Center**  
**Department of Anesthesia, Critical Care, and Pain Medicine**

**Rotation: Palliative Care**

**Goals**

- Palliative care should be a supervised longitudinal experience in an ambulatory or inpatient population that requires palliative care. It may be integrated with continuity experience or inpatient experience.
- To establish this experience, the fellow must document longitudinal involvement with a **minimum of 10 patients who require palliative care.**
- Obtain knowledge and skill in the management of terminally ill patients in accordance with the Palliative Care Precepts put forth by the American Academy of Hospice and Palliative Medicine.
- Understand how a life-threatening illness can alter the presentation of pain and its assessment and management.
- Learn the tenets of communicating with patients about their goals of care.
- Appreciate how terminal illness affects the home life of patients and their families.
- Recognize the impact of psychosocial issues in assessing palliative care patients.

**Objectives by Core Competency**

***Patient Care***

- Develop an understanding of a clinical approach to the multidimensional treatments that comprise palliative care, and an understanding of strategies to integrate pain management into this multi-dimensional treatment model.
- Gain an understanding of advanced directives and the concept of healthcare proxy.
- Gain an understanding of terminal sedation and hydration.
- Gain an understanding of pain management and comfort measures at the end of life.

***Medical Knowledge***

- Learn epidemiology, natural history, and treatment options for patients of all ages with common chronic, serious, and life-threatening conditions.
- Perform age-appropriate comprehensive assessment including physical, cognitive, functional, social, psychological, and spiritual domains using data gathered from history, examination, appropriate laboratory studies, and assessment of suffering and quality of life.



- Understand common co-morbidities and complications in patients with life-threatening illness.
- Understand management neuro-psychiatric co-morbidities in patients with life-threatening illnesses.
- Overcome discomfort of being present in the room of an actively dying patient and his/her family.
- Anticipate common questions from family members.
- Identify physical signs of imminent death (respiratory patterns, cool extremities)
- Manage common symptoms: secretions, delirium, tachypnea/dyspnea.
- Address emotional and spiritual concerns of family members (your “other patient”).

### ***Practice-based Learning and Improvement***

- Demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.
- Make an appropriate hospice referral.
- Understand the different levels of care available within hospice and elicit relevant information regarding patient values and family/social settings so that you can recommend an appropriate hospice setting.
- Understand the benefits and limits of hospice.

### ***Interpersonal and Communication Skills***

- Communicate effectively and compassionately with families
- Understand grief and bereavement and interact in a professional fashion with grieving families
- Communicate effectively and professionally with other members of the care team.

### ***Professionalism***

- Demonstrate compassion, integrity, and respect for others
- Demonstrate responsiveness to patient needs that supersedes self-interest
- Demonstrate respect for patient privacy and autonomy
- Demonstrate accountability to patients, society and the profession
- Demonstrate sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

### ***Systems-based Practice***

- Effectively access/utilize outside resources
- Use systematic approaches to reduce errors and patient care
- Enthusiastically assist in developing improvement



## **A Guide to Palliative Care Consultation**

### **What is a palliative care consultation service?**

A palliative care consultation service generally consists of physicians and nurse practitioners who work in collaboration with social workers & chaplains to provide a multi-disciplinary approach to caring for the physical, emotional and spiritual suffering of patients living with chronic and serious illnesses. The aim is to enhance quality of life, to optimize function, to relieve symptoms, and to support decision-making.

Whereas hospice care is for people coping with the last stage of life, palliative care can be offered at any time in the course of a patient's illness and can be simultaneously delivered with any curative therapies.

### **Why do patients need palliative care?**

Patient's with life-threatening illness have expressed the following wishes (Singer et al JAMA 1999)

- To receive adequate pain and symptom management
- To avoid inappropriate prolongation of dying
- To achieve a sense of control
- To not be a burden
- To strengthen relationships with loved ones

Palliative care helps patients fulfill these wishes.

### **Why do physicians consult the palliative care service?**

Physicians consult palliative care services for a number of reasons. Below are a few of the most common reasons:

1. To address goals of care
2. To help with pain/symptom management
3. To assist with psycho-social issues
4. To discuss poor prognosis & end-of-life issues, aid in coping
5. To transition to hospice
6. To help with spiritual issues

### **What is unique about palliative care consultations?**

(From Handbook of Palliative Care in Cancer by Waller & Caroline, 2<sup>nd</sup> ed.)

Palliative care consultations often occur during times of profound loss and vulnerability for patients and families. The job of the palliative care team is to complement not supplant the work of the primary team for the patient. Given the intensity of the experience, the palliative care team may find that it is caring not only for the patient and family, but also for the primary team as they grapple with feelings of grief and discomfort while caring for a suffering patient.

## **How to approach palliative care consultation?**

(Adapted from *Handbook of Palliative Care in Cancer* by Waller & Caroline, 2<sup>nd</sup> ed.)

**I. “How can we be of help?”:** First, and most importantly, clarify the specific reason for the consult. Consider contacting the patient’s primary outpatient physician, or, in the case of a cancer patient, consider contacting the primary oncologist to better understand how you can be of service. Also, establish the urgency of the consult.

**II. Review the patient’s underlying conditions,** through talking with the primary team and review of the medical record. Get a sense of the nature and extent of the patient’s underlying illnesses. This will help you develop a general prognosis that can guide your approach to the patient.

**III. How to approach the patient:** As with any consulting service, introduce yourself as a member of the palliative care team. Describing what the palliative care team is and what it does can be challenging. For more information about how to describe what palliative care is, please read J. Andrew Billings essay, “*What is Palliative Care?*”—link on Wiki. Here is a sample introduction to palliative care given by a palliative care physician on her first meeting with the patient/family:

*“I am a member of the palliative care team. I have been asked by your primary doctor(s) to see you regarding [fill in the blank, if there is a specific reason for the consult, ie, pain management]. Have you heard of palliative care before?...[give chance for pt/family to respond & get a sense of their impression/conception of palliative care]... Palliative care doctors/teams focus on relief of pain and other symptoms, helping patients and families cope with illness, and providing support and advocacy as patients and families face decisions about their care.”*

**IV. Listen to the patient** (as well as the family): It is essential to hear the patient’s “story” from his/her perspective in order to discover how you can best be of service. The family may also be able to add important details that may aid in better understanding the patient and the situation.

1. **Ask about symptoms.** Patients will likely have multiple symptoms. It is estimated that chronically ill patients will have anywhere from 7 to 11 symptoms, according to multiple studies.

- **Ask the patient to describe every symptom**, no matter how trivial the symptom seems. Many patients do not wish to “bother the doctor” with symptoms that have not reached unbearable proportions. The patient needs to be assured that it is important to hear about every symptom, since sx’s can often be dealt with more effectively if they are recognized early, before they become terribly distressing.

- **Assign priorities to the patient’s problems/symptoms** according to the patient’s preferences. This should govern the treatment plan.

- **Explore the significance that each symptom has for the patient.** The patient who reports forgetting things may be wondering, “Am I losing my mind?” The patient who says he noticed streaks of blood in his sputum is apt to be thinking, “will I bleed to death?” It will be difficult, if not impossible, to relieve the distress that a symptom causes without addressing the meanings that the patient has ascribed to it.

**2. Perform the Palliative Care Review of Systems:** (Questions adapted from Block, Lo, Quill, Tulsky, & Chochinov)

**Pain:** *“What does your pain feel like? (sharp, shooting, aching, cramping)”, “How many kinds of pain do you experience?”, “Where do you feel it?”, “What makes it better?”, “What makes it worse?”, “On a scale of 0-10 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain now?”, “How would you rate it at its worst? And at its best?”*

**Non-Pain Review of Symptoms:** *“Are you experiencing difficulty with...”*

- Appetite
- Sleep
- Fatigue
- Dyspnea
- Nausea/vomiting
- Constipation
- Concentration/thought processes
- Anxiety
- Depression

**Psychosocial Assessment:** (From the *Harvard Palliative Care Fellowship “Palliative Care Syllabus.”*)

**Meaning of illness:** *“What is your understanding of your illness?”, “How have you made sense of why this happening to you?”, “What do you think lies ahead?”*

**Support system:** *“Who are the important people in your life now?”, “Whom are the people you depend on & confide in?”, “How are the important people in you life coping with your illness?”*

**Coping style/Methods of coping:** *“How have you coped with hard times in the past?”, “How are you coping with what is happening to you?”, “What inner strengths help you cope with your illness?”, “How do you like to make decisions? For example, do you like to know every detail or do you prefer to know only the big picture issues?”, “Are there things that help you take your mind away from your illness & bring you comfort?”*

**Stressors:** *“What are the biggest stressors you are dealing with right now?”, “How much of a concern are financial issues for you?” “How concerned are people who depend on you (children, spouse, elderly dependents) right now?”*

**Spiritual Resources:** *“What role does faith or spirituality play in your life?” “What role has your faith or spirituality played in facing hard times in the past?”, “Do you participate in organized religion?” and “In what ways could we be helpful in supporting your spirituality right now?”*

**Patient goals:** *“What are your hopes for the future?”, “As you think about the future, what matters most to you?”, “What do you still want to accomplish in you life?”*

**Health care proxy:** *“In the case that you could not make decisions for yourself, whom would you like to makes decisions for you?”, “what have you told them about your wishes for your care?”*

**Advance directives:** *“Have you discussed your wishes with your physician about what care you would desire if despite all of our efforts, you were to die (or get more sick)?”, “Would you like more information about this?”*

**Wishes for end-of-life care:** *“What would be your wishes about your care as time gets shorter?”, “Where would you like to be cared for?”*

**Note:** You may not be able to or may not need to address all of the above issues with each new consultation; however, these are the issues central to palliative care consultation.

## **V. Develop a treatment plan:**

- 1. Make a diagnosis before treating.** Palliative medicine is a medical discipline and follows the method of discipline: history-taking, physical examination, laboratory investigation where necessary, formation of a diagnosis, and then treatment. If the discipline of Medicine is neglected in palliative care, the enterprise will fail. Reflex prescription of an anti-emetic to every patient with nausea & vomiting, for example, will not benefit the patient who is vomiting because of fecal impaction or because of hypercalcemia. In palliative care, as elsewhere in Medicine, choosing the most appropriate treatment depends on identifying the underlying pathophysiology.
- 2. Explain the treatment to the patient and family.** Explanation of the plan is part of the treatment. Mystery spawns anxiety: patients and families who do not understand what is happening often operate on the basis of the worst case scenario. Open communication about the patient’s condition and treatment plan may engender trust between the patient/family & consulting team.

Most of the principles that govern palliative care are simply matters of good clinical practice.

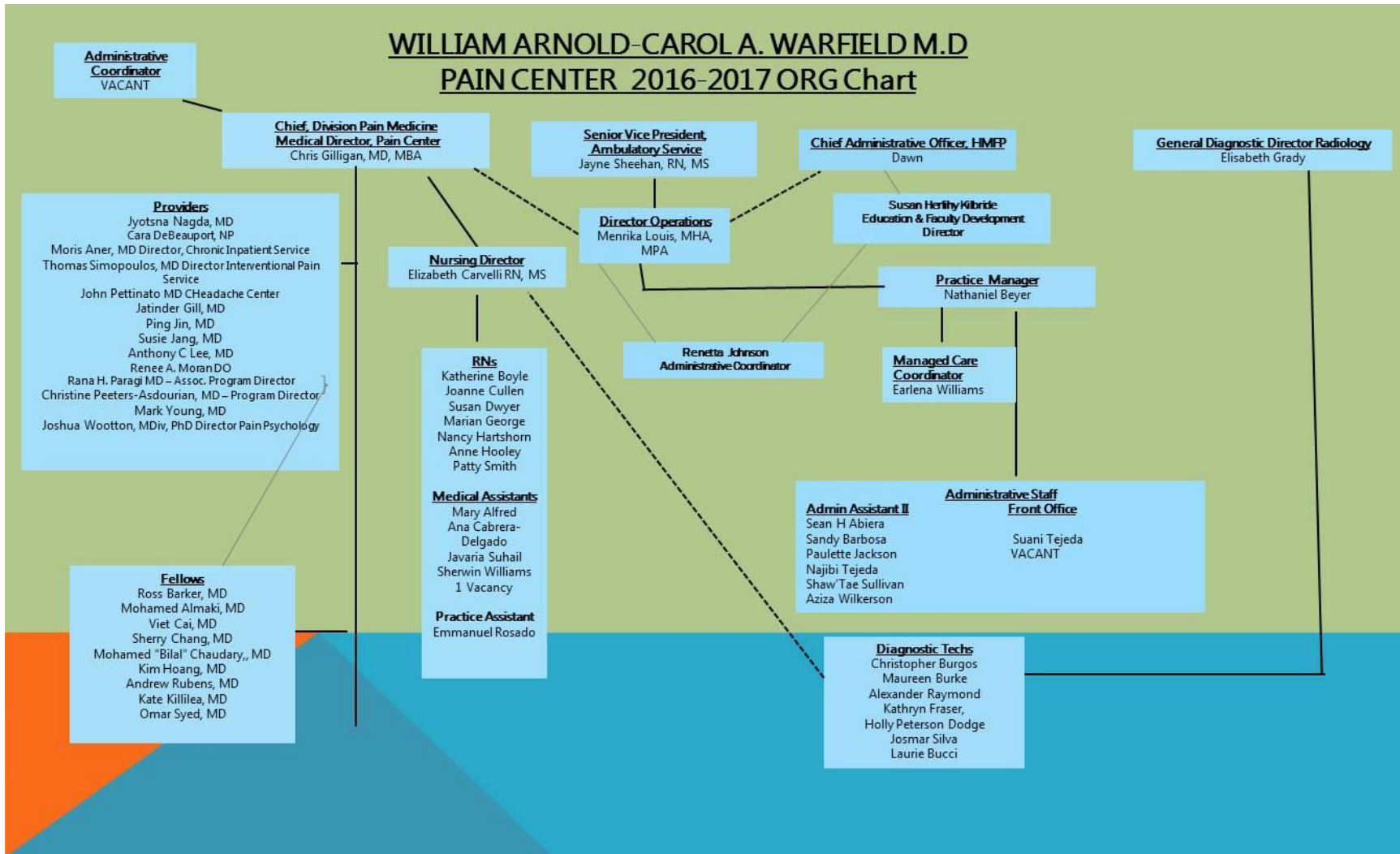
**Remember:** The phrase, “There is nothing more that can be done,” does not exist in the lexicon of palliative care. **There is always something that can be done**, even if it is to sit beside the patient and hold her hand and offer a few words of comfort & solidarity.

## **References**

Waller, A, Caroline, NL. Handbook of Palliative Care in Cancer. Butterworth Heinemann. 2<sup>nd</sup> ed., 2000.

*Harvard Palliative Care Fellowship “Palliative Care Syllabus: Approach to Palliative Care Consultation”*

## WILLIAM ARNOLD-CAROL A. WARFIELD M.D. PAIN CENTER 2016-2017 ORG Chart





**Division of Ambulatory/Emergency Services  
Unit Structure Standards/Scope of Service FY 2016**

**Name of Unit:** William Arnold-Carol A. Warfield, MD Pain Center

**Location:** 1 Brookline Place, Suite 105, Brookline, MA 02445

**List of Cost Center Numbers:** 8842,

**Person(s) Filling Out Report:** Nathaniel Beyer, Menrika Louis

**Title:** Practice Manager; Director, Ambulatory Operations

**Description of Setting** – The Arnold-Warfield Pain Center at Beth Israel Deaconess Medical Center is an ambulatory outpatient clinical practice where patients are scheduled for an appointment to see a provider. The providers associated with the service include twelve Anesthesiologists/Pain Management Specialists, a Psychiatrist and a Psychologist. The multi-disciplinary service provides comprehensive, patient centered care for chronic and acute pain conditions. The mission of the Center is to provide convenient and timely care with ease of access that is both comprehensive and personalized. The staff is committed to helping patients obtain relief from pain and achieve the highest level of independence and physical function. The MD staff typically has a Pain Fellow, or an Anesthesiology Resident supporting them during the clinic sessions. Furthermore, there are Pain Fellows from Children’s Hospital and Brigham and Women’s Hospital who rotate through the service. We also have fellows from the Pain Clinic precept at the Spine Center to see patients when the Pain Attendings are in the Spine Center.

The layout of the service is as follows: The reception area has seating for 12. The reception area has a front desk with space for two Practice Representatives who check in and check out patients and make follow-up and injection appointments. Across from the front reception desk there is a private phone for patients to contact Registration.

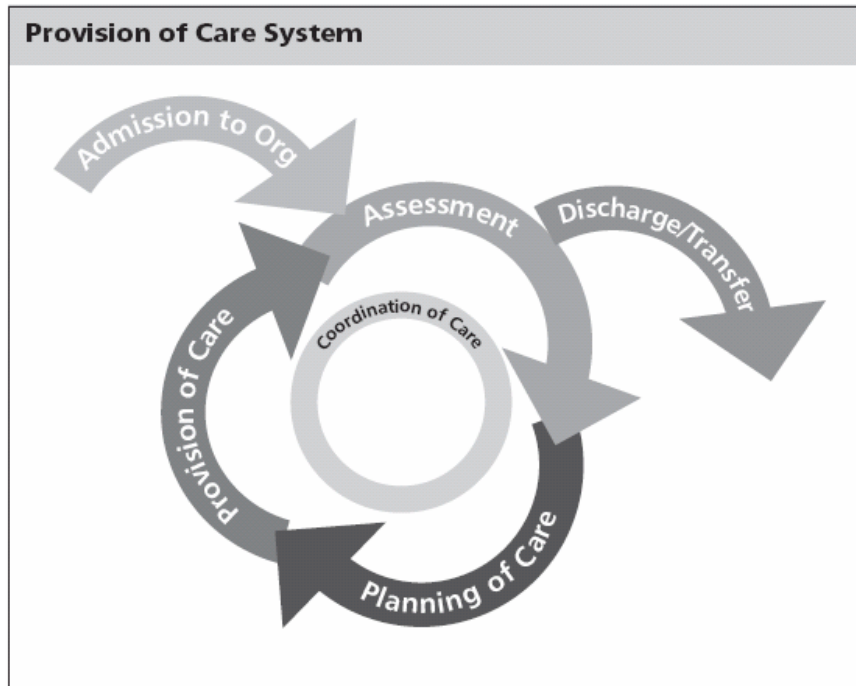
There are four exam rooms in the suite, and three procedure rooms with fluoroscopy. We have a recovery bay with space for six patients. There is one conference room with six workstations and phones for the fellows/ residents. We are scheduled to expand to a different suite on the 4<sup>th</sup> floor and expand the amount of procedural room on the first floor. After the Construction, we will have 5 Procedural rooms and two exam rooms on the first floor. We will have three exam rooms on the 4<sup>th</sup> floor.

Patient calls are responded by the Administrative Assistants in the Pain Center Call Center located in the Suite. There is one access number 617 278-8000 that all patients and referring physicians may use to schedule an appointment. Physicians may also call the provider’s Administrative Assistant directly for appointment scheduling. Another option for referring physicians is to complete an on-line referral

form located in the medical centers web OMR (on line medical record) system. The referral form upon completion is automatically generated and faxed to a central location whereby the Administrative Assistants are responsible for immediate triage.

The patient population treated at the Pain Center consists of male and female adults ranging in the age from 15 through over 75 years of age.

**The Joint Commission Schematic for describing the cycle of care**



**Entry to Care:**

Patients are referred to the Pain Center either by their PCP, or other medical specialist. Some patients are self referred. Patients are referred to the service for evaluation and treatment of acute and chronic pain. Inpatient services are also provided for acute and chronic pain patients.

We offer a number of services, including but not limited to: consults, evaluations, many types of injections, infusion pumps, spinal cord stimulators, discography, Kyphoplasty, IV infusions.

We use an automated reminder call and reminder letter system for all patient appointments.

A health status questionnaire is filled out by the patient at the first appointment.

Additionally, patients who have been evaluated through the collaborative arrangement at the Spine Center are referred to the Pain clinic if an injection has been determined to be the appropriate treatment plan. Many of the Pain MD's are providing evaluation and

consultation at other sites, including Boston Spine, Chelsea Spine, Chestnut Hill, Lexington Spine and Needham and more recently we also have a practice at BIDMC-Milton.

### **Scope of Initial Assessment:**

For BIDMC patients referred to the service, information from the medical center's online OMR – online medical record system is obtained and prepared for the physician and other members of the team assigned to perform the patient evaluation. Information may include physician notes, OR reports, radiology reports, pathology reports, lab tests, physician therapy notes and general health information. If a patient is from outside of the BIDMC system, we request the patient to bring a copy of their most recent radiologic reports/films and any pertinent medical records.

An initial assessment would include a review of systems with the patient and examination with specific objective measurements that relate to the patient's primary problem. Additionally, the physician reviews the health status questionnaire provided to the patient prior to the appointment. The examination, in addition to the review of other related medical documentation plus any recent CT's or MRI's, is used to identify potential abnormalities and impairments, develop a diagnosis and is the basis for developing a plan of care with the patient. The plan of care outlines the recommended treatment options. The physician documents the initial assessment and records data via dictation which is then upon physician review and sign off is directly uploaded to the OMR system.

### **Time Frame for Assessment**

Predominantly general patient referrals are booked by our Administrative Assistants. They follow a triage algorithm which was created by our medical leaders. Referrals are generally considered urgent or routine. The triage algorithm provides the Administrative Assistants with information to help them book appointments appropriately. Another group of referrals come to the service through established relationships with the referring physician network at BIDMC and other health care entities. Individual administrative assistants respond to these requests following the same guidelines.

### **Process to Develop /Execute the Plan of Care**

The initial assessment is completed at the first visit as well as the treatment/care plan. The initial assessment is dictated by the end of the business day and typically is reviewed and signed within 48 hours. The correspondence is sent to the Primary Care Physician, and/or to the referring Specialist.

If the treatment plan recommends a pain injection, the patient is advised upon check out to book the appointment with the practice representatives at the Front Desk who will schedule the injection appointment. The injection appointment may be booked in the Pain Center or in the BID Needham campus. Internally, many insurances require a prior authorization for many

of the spine interventions, so our Managed Care Team would work to obtain the PA if a spinal injection is warranted.

Patients maybe referred for additional diagnostic radiology testing such as CAT scan or MRI. The order is entered into the OMR system and the patient is given a number to call. Patients maybe referred to physical therapy. Outpatient services are available throughout the BIDMC network in Lexington, Chelsea and Bowdoin Street. If those locations are not convenient the physician provides the patient with the physician referral form and gives them a recommendation. Patients may also be referred to another medical specialty such as neurology, rheumatology, oncology, or surgical specialty.

### **Provision of Care**

Patients are scheduled for follow up visits as determined by the physician's assessment and plan of care. Typically if additional diagnostic testing is needed, the radiology tests will be scheduled and thereafter, allowing time for the formal report the outpatient appointment is scheduled.

### **Patient Education Approaches**

Patient education or caregiver education is an essential component to the treatment intervention. During the assessment the physician is making decisions about additional information the patient would benefit from receiving. Patient educational material is a priority for the service. Physicians may easily access the BIDMC.org web site. We currently have animated patient education on the various procedures we perform at the Pain Center. We have revised our own fact sheets for specific procedural interventions, and these are kept at the nurses' station and in the exam/procedural rooms. by the physicians at the time of the patient visit. The fact sheets are also the BIDMC Portal as well.

For non-English speaking patients, a member of the medical center's interpreter services is available on our video conferencing monitor or telephone conference.

### **Triggers for Reassessment/Usual Reassessment Periods/Use of Consultative Services**

Reassessment is completed after as needed typically after a treatment intervention or diagnostic test. Reassessment is performed if the patient's medical status or functional abilities change. The physician makes an assessment of the patient's status, progress toward goals and updates the plan of care, making changes to the treatment intervention as needed.

Patients are discharged from the Pain Center when they have been assessed by the physician and it is determined that they no longer need care because of they have achieved their goal, Surgery was identified as the only option or the patient has demonstrated to be unwilling or unable to participate in the treatment program.

**Visit Types:**

- Botox ( 20 min)
- New ( 40 minutes)
- Procedure Cervical
- Procedure non-fluoroscopy ( 20 & 40 min)
- Procedure RF ( Radiofrequency)
- Procedure with Fluoro & Sedation (30 or 60 min)
- Procedure with Fluoro (30 or 60 min)
- Return (20 & 40 min)
- Special Procedure - includes discography, spinal cord stimulator trial in clinic (User defined time)
- Synvisc (20 min)

B. Please identify any access issues and are quality improvement efforts in place to address these issues with results to date.

We have two additional pain specialists and are in the process of recruiting for another Physiatrist to provide non-interventional options for our patients and referring physicians. We are working on the inpatient coverage and ensuring that our providers could see patients. We run the first available and third appointment available report for each provider in the Pain Center at the beginning of every month. Our physicians are very committed to promoting the vision of the service, a hallmark of providing timely and easy access to care. The physicians allow for double booking and urgent care requests to be accommodated and also provide additional clinic sessions as needed.

**Administration/Organization of Unit**

A. Unit Level Committees/Meetings/Staff Meetings (list types/frequency/who attends/existence and purpose of the group)

-Journal Club – once per month attended by physicians

-Combined Indications Conference – every other Friday, a CME accredited conference with PMR, Neuroradiology, Anesthesia, Pain Clinic, Neuro Surgery and Orthopaedic Spine Surgery attendings, fellows, residents and PA's attend. It is an evidence based case conference. One topic per session is covered in discussion/talk format.

Fellows and residents attend daily didactic meetings taught by Attending Staff as well as guest speakers.

-Physicians attend regular departmental faculty meetings within their academic department, twice per month.

-Physicians attend quarterly HMFP faculty meeting

-Physicians attend Grand Rounds affiliated with their academic department

-Weekly meeting with Administrative Director and Practice Manager, Nursing Director & Medical Director

-Support staff & Clinical staff have bi-monthly meeting includes Nurses, Medical Assistants, practice representatives, administrative assistant, Managed care coordinator, and the Practice Manager. Guest speakers are invited based on training needs.

-Quarterly administrative meeting that includes administrative managers from the Spine Center, Department of Orthopaedics, Department of Neurosurgery, and Call Center

-Administrative Director and Operations Manager attend monthly BIDC leadership meeting, Ambulatory Operations Meeting, and JCAHO preparation meeting.

### **Hours of Operation**

1. Regular Hours: Monday through Friday 7:30 am to 5:00 pm, Wednesday 8:30 am to 5:00 pm.

2. Evening Hours/Saturday Hours: N/A

3. Frequency of Add-on Sessions: As needed based on access.

4. Overtime: typically not needed

### **Evacuation Plan**

In the event of fire, or other hazards, if evacuation is deemed necessary by the Brookline Fire Department, all staff will assist in patient evacuation from the clinic to outside of the building to a specified area (grassy section by Rte 9/Brookline Ave intersection). Fire exits are located by the front reception area, as well as in the rear by the kitchen and conference room. As soon as the alarm is given, all procedures must stop, and patients will be escorted from the area by any available nursing staff, fellow, resident or other m.d.

All other staff not mentioned should help facilitate any patients in the area requiring help. Please receive direction from the Floor Marshal (Resource Nurse Designee) or the Floor Administrator (Practice Manager: Nate Beyer and Director of Operations- Menrika Louis).

# Trainee<sup>2</sup> Moonlighting Policy

## Department of Anesthesia, Critical Care and Pain Medicine

(See GME-16 Trainee Moonlighting Policy<sup>i</sup>)

### External Moonlighting

BIDMC anesthesia trainees<sup>2</sup> are not permitted to moonlight at external institutions during their employment as a trainee in the Department of Anesthesia, Critical Care and Pain Medicine.

In the event that a trainee moonlights at an outside institution they may be subject to dismissal from their training program.

### Internal Moonlighting

Trainees (CA4 or higher) in ACGME programs (Critical Care, Cardiac Anesthesia Obstetric Anesthesia and Pain Management) and Non-ACGME programs (Vascular Anesthesia) can moonlight internally one (1) weekend per month and one (1) late call per week with the permission of the fellowship program director.

Trainees wishing to moonlight must have successfully completed the ABA Part 1 (written) board examination and received approval from their Fellowship Director and the Vice Chair for Education.

Trainees who wish to moonlight (either on a limited or a full medical license) must accomplish both the following items after obtaining Program Director approval.

1. Trainees will need to arrange to shadow a current fellow (if the fellow is a former BIDMC resident (critical care/cardiac/ob/pain) and/or a senior resident for one (1) east call and one (1) west call
2. Trainees will request feedback on their call from their preceptor (fellow/resident) and the attending on call. The trainee must forward this information to Joanne Grzybinski and the Anesthesia education office.).

### **For all Trainees:**

#### Weekday Call

Trainees will be limited to one (1) paid weekday late call per week (maximum of four (4) per month); any additional call taken will be considered as normal call and not reimbursed. Program Directors may choose to limit weekday late call scheduling for their fellows.

#### Weekend Call

Trainees are permitted weekend call, but must remain in compliance with current duty hour standards. Current duty hour requirements limit a trainee to working 80 hours per week and require trainees have 1 day off in 7 (note: pager call does NOT count as a day off, even if the trainee was not called in).

#### Ad Hoc Call

Once fellowship duties are completed for the day, Trainees may contact the east/west campus

floor managers to inquire if any assistance is needed in the operating rooms (Ad Hoc Call) once per week. Trainees will need to have permission from their supervising attending and have program director approval on file for moonlighting to leave for an Ad Hoc call. If Ad Hoc call is accomplished, trainees will need to inform the education office and Joanne Grzybinski for duty hour compliance and payment.

### Junior Attending Moonlighting

The Department's policy of Junior Attending Moonlighting for 2013-2014 trainees and incoming 2014-2015 trainees will officially end on June 30, 2015.

### Ongoing Responsibilities

#### PGY4/CA3 Residents

PGY3/CA3a are eligible to moonlight in the operating rooms at BIDMC on the weekends, subject to approval by the Program Director and the Director of the Clinical Competence Committee.

Trainee educational and professional requirements (case logs, duty hours, grand rounds and M&M conference attendance, lecture attendance, evaluations, feedback and or milestones) must be current at all times in order to moonlight. Trainees who do not remain current in their educational and professional requirements will have their moonlighting privileges suspended and/or terminated. Reinstatement of moonlighting privileges will be based on the recommendation of the Program Director and the Chair of the Clinical Competency Committee.

Trainee fellowship educational and professional requirements (procedure logs, duty hours, grand rounds and M&M conference attendance, evaluations, feedback, combined fellowship lectures, and /or milestones) must be current at all times in order to moonlight. Trainees who do not remain current in their educational and professional requirements will have their moonlighting privileges suspended and/or terminated. Reinstatement of moonlighting privileges will be based on the recommendation of the Fellowship Program Director and the Vice Chair of Education.

### Duty Hours

Internal moonlighting hours count towards duty hours for all trainees. In addition to limiting work hours to 80 hours per week, each trainee must have one (1) day in seven (7) free of all clinical responsibilities (including pager call) and must have at a minimum eight (8) hours off between shifts (10 hours is preferred).

Trainees will be assigned to a moonlighting shift/weekend at the same time as the call schedule is published.

Weekend moonlighting is **voluntary** – no trainee should feel it is an expectation of the program. Assignments will be made on a first come, first served basis and depending upon availability.

If you wish to review a copy of the GME-16 Trainee Moonlighting Policy, please contact the Manager, Anesthesia Graduate Medical Education Programs.

Date Created: Jun 2006

Review Date: Jan 2016

Review Due: Jan 2017



# **Trainee<sup>1</sup> Supervision Policy - Anesthesiology**

## **Department of Anesthesia, Critical Care and Pain Medicine**

The Accreditation Council on Graduate Medical Education, Federal Medicare regulations, and the Professional By-Laws of the Beth Israel Deaconess Medical Center require that all trainees be supervised. The following policy governing progressive supervision of trainees in any program within the Department of Anesthesia, Critical Care and Pain Medicine has been adopted and is in effect July 31, 2011.

### **Supervision in Operating Room and Procedural Areas**

Regardless of the “year” of the training period, up to and including ACGME and Non-ACGME fellows, Trainees should receive direct supervision for critical portions of cases in the operating suites and procedural units, and indirect supervision for remaining elements by staff who are immediately available (defined as within 5 minutes) within the hospital or clinic where care is being provided.

### **Overall Principle**

- I. The attending anesthesiologist has the ultimate responsibility for all decisions regarding care for patients.
- II. The attending anesthesiologist is responsible for providing supervision or oversight of all care provided by trainees.
- III. Attending anesthesiologists are expected to behave in a professional manner at all times in regard to trainee supervision, and are expected to encourage each trainee to seek guidance from the attending at any time the trainee believes it to be helpful in the care of the patient. The attending anesthesiologist is to make clear to each trainee that failure to seek guidance is unacceptable.
- IV. All faculty members are expected to be able to recognize the signs and consequences of fatigue and sleep deprivation and provide appropriate relief of trainees if these signs are manifest.
- V. Faculty are expected to provide graded authority and responsibility for residents as outlined below:

### **Graduated Responsibilities**

The program director and attending anesthesiologist are responsible to ascertain the level of training of a trainee. In general it is the responsibility of the attending to supervise all intubations, extubations, and central line placements performed by trainees in anesthetizing locations. As part of graduated resident responsibility, it is reasonable to allow a resident to extubate without direct supervision. This must be explicitly communicated between the resident and attending EACH time it is to occur, and the attending must know when it is occurring so he/she can be immediately available to respond to problems. This should occur only rarely with a CA-1 resident, but may occur with increasing frequency as the resident progresses.

Some procedures may require particular vigilance and prolonged direct attending participation in order to maximize patient safety, despite an advanced level of resident training. In these instances,

the actual participation of the attending while present in these situations may vary according to the skill and level of training of the resident or fellow.

Examples of more complicated or “demanding” situations include:

- Induction of:
  - Patients with significant cardiac morbidity
  - Patients requiring a double-lumen endotracheal tube
  - Rigid bronchoscopy and other procedures without an established airway
  - Patients with a known or suspected difficult intubation
- Emergence and extubation of:
  - Morbidly obese patients
  - Patients with known difficult intubation
  - Patients who have received a large volume of intra-operative IV fluids that could lead to airway compromise
  - Patients with significant cardiac morbidity
  - Patients who have undergone a prolonged procedure in the prone or Trendelenburg position
- Transportation of critically ill patients

The guiding principle of advancement of resident responsibility will be a progressive increase in the degree of autonomous decision making and management by progressively more experienced and senior trainee. CA-1 residents thus will have higher proportions of each case requiring direct supervision with significant attending input into planning, whereas more senior residents will require less attending guidance and physical presence outside of induction and emergence.

### **Students**

Resident and faculty members have responsibility for teaching and supervising medical students on the service. Medical students without direct supervision by a resident or attending anesthesiologist perform no clinical work.

### **Interns (PGY1 Residents)**

Resident and faculty members have responsibility for teaching and supervising Interns on the service. Interns will be directly supervised by a resident or attending anesthesiologist during intraoperative care of the anesthetized patient, but may be indirectly supervised during basic pre- and postoperative tasks, such as IV placement.

### **CA1 residents (PGY2)**

#### **Clinical**

CA1 residents work under the supervision of an anesthesiology attending. They are expected to be able to set up anesthetizing locations, perform basic anesthesia procedures under direct supervision such as basic airway management, intubation, LMA insertion, and intravenous and peripheral arterial line placement. During the rotation on labor and delivery the resident will be instructed on the placement of lumbar epidural and spinal anesthetics under direct supervision;

the epidural procedure may be conducted under indirect supervision by an on-ward attending physician following verification of procedural competency.

During the first year the CA1 resident may be expected to perform more advanced procedures under direct supervision such as thoracic epidural placement, regional blockade, central line and swan ganz catheter insertion with assistance from the attending anesthesiologist who is directly supervising the procedure.

CA1 residents are expected to be able to discuss the preoperative evaluation and formulate a basic anesthetic plan. It is expected they will be able to fully formulate and carry out the anesthetic plan for most ASA 1 and 2 patients with minimal assistance from staff by the end of the year; nonetheless, staff will be present to directly supervise induction, emergence, and critical portions of the procedure.

In the second half of the first year, CA1 resident will be exposed to more complex cases during vascular, neurosurgery, and cardiac rotations. During these rotations CA1 residents will be closely supervised by the attending.

CA1 residents take overnight and late call once they have demonstrated competence in patient assessment and implementation of a basic anesthetic as judged by the supervising faculty and program director after the first month of residency training. In general, after the first month of residency training, the attending anesthesiologist must be able to supervise the junior resident and another operating room during the maintenance phase. The attending must personally participate in induction, emergence, and other critical portions of the anesthetic and be immediately available during other times.

### **Supervision**

An attending anesthesiologist will directly supervise all CA1 residents for induction, emergence, transport of critically ill patients and during the bulk of any non-routine procedure. Indirect supervision will be conducted by the attending during maintenance of anesthesia during non-critical portions of the procedure. In addition, during the day the Anesthesia floor manager is immediately available to provide assistance to the resident or attending if needed. During nights and weekends the CA1 resident will be on overnight call with a CA2 or CA3 resident and an attending in the ORs or on L&D.

### **CA2 residents (PGY3)**

#### **Clinical**

During their second year of training the CA2 resident will rotate through the anesthesia subspecialties in cardiac, thoracic, neurosurgery, vascular, pain management, intensive care and pediatrics at Boston Children's Hospital. These rotations involve more complex cases. Each resident is supervised by an attending. In addition to basic anesthesia skills, CA2 residents are expected to acquire more advanced skills such as fiberoptic intubation, thoracic epidural placement, nerve blocks, and advanced cardiovascular monitoring with pulmonary artery catheters.

#### **Supervision**

An attending anesthesiologist will supervise all CA2 residents for induction, emergence, and key portions of the procedure and collaboratively develop and implement the perioperative care of the patient. Supervision during maintenance of anesthesia is primarily indirect except for direct supervision for critical portions of the case such as invasive line placement, acute changes in patient condition, or unexpected surgical events. In addition, during the day the Anesthesia floor

manager is immediately available to provide assistance to the resident if needed. Periods required for direct supervision are less than those for CA-1 residents, and the degree of attending input into planning and execution of routine anesthetics progressively decreases. Staff involvement in subspecialty rotations remains high, but the relative amount of direct supervision decreases with resident experience and comfort as assessed by staff during direct contact and in discussion with the resident and program director.

During nights and weekends the CA2 resident will be on overnight call with a CA1 resident and an attending in the ORs or on L&D. Senior residents also take overnight subspecialty pager call in cardiac, transplant and pain management. Residents rotating through the intensive care and pain management will follow policies and procedures as dictated by the ICU and pain staff.

### **CA3 residents (PGY4)**

#### **Clinical**

During their third year of training the CA3 residents rotate through a variety of advanced rotations in the operating room, L&D, and the anesthesia subspecialties in cardiac, thoracic, neurosurgery, vascular, pain management, intensive care and pediatrics at Boston Children's Hospital. The CA3 resident requests their rotations in consultation with the Program Director to best meet the resident's learning goals and career objectives, and to fill knowledge gaps.

It is expected that the CA3 resident is able to manage basic ASA 1&2 cases independently including performing the preoperative evaluation, executing the anesthetic plan and initiating postoperative pain management. Staff will be present to supervise during induction, emergence, and critical portions of the procedure. They are expected to make progressively less adjustments in the planning and execution of the anesthetic, primarily provide indirect supervision, and be immediately available to discuss all aspects of the case.

During the CA3 year, it is expected that the resident will be able to manage most complex cases, perform advanced techniques such as central line placement and nerve blocks independently but under direct supervision by an attending physician (e.g. attending present to observe, but not intervene unless necessary for patient safety).

In addition the CA3 resident is expected to function as a consultant to other services providing information to surgeons and obstetricians regarding preoperative work-ups, anticipated anesthetic difficulties and postoperative management as relevant. In this consultant role, the resident will be indirectly supervised by an attending anesthesiologist who is immediately available in the clinical care area.

#### **Supervision**

CA-3 residents will be supervised by an attending anesthesiologist. In addition during the day the Anesthesia floor manager is immediately available to provide assistance to the resident if needed. It is expected that the degree of planning input and physical assistance by the directly present staff will decline over time in order to facilitate the resident's transition to successful independent practice following graduation. The role of staff will in these later stages of training become that of a consultant to stimulate educational discussion and ensure safe conduct of patient care by the resident.

During nights and weekends the CA3 resident will be on overnight call with a CA1 resident and an attending in the ORs or on L&D. Senior residents also take subspecialty pager call in cardiac,

transplant and pain management. Residents rotating through the intensive care and pain management will follow policies and procedures as dictated by the ICU and pain staff.

#### **CA4 Fellow (PGY5/6/7)**

##### **Clinical**

During their fellowship year of training it is expected that the fellow is able to manage all their cases independently including performing the preoperative evaluation, executing the anesthetic plan and initiating postoperative pain management. Staff will be present to supervise during induction, emergence, and critical portions of the procedure (if needed). Staff are expected to make progressively less adjustments in the planning and execution of the anesthetic, and primarily provide indirect supervision and be immediately available to discuss all aspects of the case.

During the fellowship year, it is expected that the fellow will manage complex cases, perform advanced techniques such as central line placement and nerve blocks independently but under direct supervision by an attending physician (e.g. attending present to observe, but not intervene unless necessary for patient safety).

In addition the fellow is expected to function as a consultant to other services providing information to surgeons and obstetricians regarding preoperative work-ups, anticipated anesthetic difficulties and postoperative management as relevant. In this consultant role, the fellow will be indirectly supervised by an attending anesthesiologist who is immediately available in the clinical care area.

##### **Supervision**

Fellows will be supervised by an attending anesthesiologist. In addition depending on the fellowship specialty attendings are available via telephone/pager and in person (overnight coverage). It is expected that the degree of planning input and physical assistance by the directly present staff will decline over time in order to facilitate the fellow's transition to successful independent practice following graduation. The role of staff will in these later stages of training become that of a consultant to stimulate educational discussion and ensure safe conduct of patient care by the trainee.

During nights and weekends the fellow will be on overnight call with a CA1/CA2 or CA3 residents and an attending in the ORs, APS/CPS service, ICU/SICU/TICU/MICU or on L&D. Fellows take subspecialty call in cardiac, transplant, obstetric and pain management.

##### **Requirements for Notification of Attendings**

An attending anesthesiologist must cover all cases for which an anesthetic is provided. The attending may personally perform a case, or supervise a CRNA or resident or fellow.

It is expected that the resident or CRNA will notify an attending anesthesiologist of any major changes in the patient's condition or case plan. This list provides examples of instances when the attending should be notified (if they are not already present in the anesthetizing location).

- A. Acute and/or persistent adverse change in hemodynamic status
- B. Persistent decrease in oxygen saturation
- C. Change in anesthetic type e.g. conversion of a regional or MAC anesthetic to a general anesthetic

In addition certain demanding situations may require more prolonged attending presence. Examples are noted above under "Graduated Responsibilities" above.

## **Schedules and coverage**

On call schedules for attendings provide 24-hour on-premises supervision 7 days per week. These schedules are posted on the anesthesia intranet and are listed with the BIDMC page operator. There is thus never a time when a trainee will be left unsupervised in the conduct of patient care.

## **Evaluations**

Attendings are expected to evaluate residents on a regular basis and provide feedback to the program director and the resident regarding performance during the period of supervision.

Residents must also complete confidential online faculty and rotation evaluations.

## **Definitions**

### **Levels of Supervision**

- **Direct supervision:**  
The supervising physician is physically present with the trainee and patient. The supervising faculty is credentialed for the procedure/activity that is occurring and present for its entirety.
- **Indirect Supervision:**  
The supervising physician is immediately available – the supervising physician is physically within the hospital or other sites of patient care and is immediately available to provide direct supervision

Or

The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide or refer to another faculty member to provide Direct Supervision.

- **Oversight:**  
The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (ACGME definition)

PGY1: First year of training (Intern)

PGY 2/CA1: First year anesthesia resident

PGY 3/CA2: Second year anesthesia resident

PGY 4/CA3: Third year anesthesia resident

Fellow—Trainee that has completed an anesthesia residency or other specialty training and is pursuing advanced training in a focused anesthesia discipline (e.g. ACGME: Adult Cardiothoracic Anesthesia, Critical Care, Obstetric Anesthesia, Pain Medicine, or non-ACGME: Advanced Anesthesia, Vascular Anesthesia)

Date Created: Aug 2011  
Review Date: Dec 2015  
Review Due: Dec 2016

### Department of Anesthesia, Critical Care and Pain Medicine

Our program seeks to minimize the number of transitions in inpatient care and assure safe, high quality handoffs of care. This is accomplished through the following mechanisms:

#### **Reduction in number of handoffs required in the Operating Room:**

1. Case assignments are made by the Vice Chair for Clinical Operations or his designee. Note is made of trainees<sup>1</sup> and faculty on late call assignments and efforts are made to place these individuals into cases which are anticipated to run past 5:00 pm.
2. Non-call trainees are relieved by staff by 4:30 pm on Mondays, Tuesdays and Thursdays for attendance of didactic programs. Relief should be by the staff covering the case whenever possible to reduce the number of handoffs and transitions of care. If the attending staff is still covering two locations, efforts are made to allocate call team resources to relieve the daytime trainee as expediently as possible and with the minimum number of handoffs.
3. If a case is near completion and is complex in nature, the daytime care provider(s) may elect to stay with the patient to facilitate care and reduce the number of transitions.

#### **Assurance of Appropriate Communication:**

1. The Anesthesia team caring for the patient is listed on PIMS, our electronic perioperative information management system, and is available to all health care team members. This listing is updated in real time to reflect changes in coverage and identifies anesthesia residents, fellow (trainees), CRNAs, and attending staff responsible for the care of the patient.
2. Trainees receive training and feedback on communication skills Crisis Resource Management at the Center for Medical Simulation, weekly simulation sessions on campus, and daily feedback comments from faculty. These processes ensure that trainees are competent communicators.
3. Trainees receive formal evaluation of their communication skills at least twice yearly during performance evaluations with the Residency Program Director or Assistant Residency Program Director(s). Fellows meet with their respective Program Directors for a formal evaluation of their communication skills at least twice during their fellowship performance evaluations.
3. Faculty members receive training on providing feedback on communication skills via a live or web based training module.
4. Handoffs of care in the Post Anesthesia Care Unit are conducted by structured oral and written report which is taught to trainees during their orientation period.
5. Handoffs in the Intensive Care Units and Obstetrics are conducted by a detailed structured oral and written report. Residents (trainees) receive instruction on this approach during their Advanced, Cardiac and Obstetric months. Fellows are oriented to this process at the beginning of their fellowships in Critical Care, Adult Cardiothoracic and Obstetric Anesthesia. Nursing, the Intensive Care, and Obstetric staff participate in the handoff to ensure that all appropriate information is transferred.
6. Intraoperative handoffs are conducted via oral report and review of the anesthetic preoperative assessment, intraoperative record, and plans for patient disposition. The surgical and nursing staff

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<sup>1</sup> Trainee = Interns/Residents/Fellows (ACGME - Critical Care; Adult Cardiothoracic; Obstetric; Pain Management and non-ACGME - Vascular)

are made aware when these transitions are occurring so that they may be involved in the reporting process as appropriate. The staff or trainee assuming care signs in to the anesthetic record following report to indicate the transfer of care.

**Assurance of Quality and Safety of Care:**

1. If a provider is fatigued, relief will be made available expeditiously per the sleep and fatigue policy.
2. PACU or ICU residents, fellows (trainees) and staff should be involved in the handoff of all complex or unstable patients to ensure physician to physician communication as part of the handoff process.
3. A pilot project to evaluate and further standardize PACU handoffs is currently in the design phase within one of the department's faculty hour project groups and will include an audit of communication quality and efficiency.

Date Created: April 2012

Review Date: April 2015

Review Due: April 2016

<sup>1</sup> Trainee = Interns/Residents/Fellows (ACGME - Critical Care; Adult Cardiothoracic; Obstetric; Pain Management and non-ACGME - Vascular



# Trainee<sup>1</sup> Abstract Submission Policy

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## Department of Anesthesia, Critical Care and Pain Medicine

1. Attendance will be generally limited to one (1) non-local major meeting per year (e.g. AAPM, APS, ASIPP, ASA, IARS, NANS, SOAP, SAMBA, SCA, SCCM, or ASRA). Exceptions will be made on an individual basis for those with other roles at a meeting (e.g. committee member, delegate, etc.). Exceptions may also be granted for those presenting original research not already presented at another meeting.

In order for any non-local major meeting to be approved, trainees must plan on submitting their presentation for publication as well as participate in all of the following local presentation opportunities: NEARC, Harvard Anesthesia Night, BIDMC resident research day and, the Silverman Symposium.

2. International Conferences: Trainees wishing to attend a scientific conference outside of the United States must have approval of their training program director and identify a faculty mentor prior to abstract submission.

- i. Trainees wishing to submit/present at meetings outside of the United States may use their existing educational funds to defray expenses. Departmental support is not available for international meetings.

3. All abstracts, following review by the faculty mentor, must be reviewed by one of the following: Department Chair, Vice Chair for Education and Faculty Development, Program Director (Residency/Fellowship), or Associate Program Directors prior to submission. Abstract must be received for review at a minimum **one** month prior to the submission deadline.
4. Abstract acceptance does not guarantee meeting attendance. In the event attendance at a given meeting is limited, research abstracts have priority over case reports.
5. Time off must be requested and coordinated with the Chief Resident in charge of the vacation schedule and their program director **before or at the time of submission**.
6. The presenting trainee must participate significantly in the writing of the abstract. He/she is expected to be present for all required poster sessions, available for questions and be professionally attired.
7. Only **one** author per abstract will receive departmental travel reimbursement.
8. When at all possible, two residents attending the same meeting should share a hotel room. When not feasible (gender, traveling with significant other), please choose hotels in a reasonable price range, i.e. equivalent in price to sharing a room at the meeting headquarters hotel. You are free to pay the difference if you would prefer to stay in more expensive accommodations. In addition, please be mindful of airfare when booking tickets. If you have any questions regarding travel costs, ask your program director prior to booking.

### **Travel Reimbursement**

9. In order to qualify for travel reimbursement, presented **case reports** must also be submitted as a letter or case report to an appropriate journal (e.g. Anesthesiology, A&A Case Reports, Journal of Cardiovascular and Thoracic Anesthesia, etc.). Reimbursement is not contingent upon publication, but sufficient effort should be put into the manuscript to make acceptance a possibility.
10. The general departmental policy for meeting days is the presentation day plus one travel day on either side. If your plans exceed this, and you are approved for the time off, you can pay the difference from your educational fund.
11. The department will pay for meeting registration, airfare, hotel, food (reasonable), taxi to/from airport, with copies of receipts must be submitted. Workshops and other extra fees may be paid for from your

education fund. As a reminder you must submit your reimbursement to the anesthesia education office within thirty (30) days of your meeting attendance.

12. Acceptance letters and final abstracts should be forwarded to the program director/associate program director the anesthesia education office for placement into residency/fellowship training records. Expense reports must be signed by Susan Herlihy Kilbride, Education and Faculty Development Director.

Date Created: May 2008

Review Date: May 2016

**Review Due: May 2017**

<sup>1</sup>Trainee = Interns/Residents/Fellows (ACGME - Critical Care; Adult Cardiothoracic; Obstetric; Pain Management. Non-ACGME- Vascular)

## **Department of Anesthesia, Critical Care and Pain Medicine**

**(See MS-13 policy Principles Guiding Medical Education)**

Our department fully supports and stands by the Medical Center Policy # MS-13 **Principles Guiding Medical Education at BIDMC** which stated purpose reads:

*The Beth Israel Deaconess Medical Center recognizes medical education as central to its mission. This statement outlines the principles supported by the BIDMC community to support and strengthen “a culture of education” at this medical center.*

The Anesthesia Department has a long history of providing quality medical education to all trainees<sup>1</sup>. All members of the department full participate in a positive learning environment for all trainees while providing patient care.

Date Created: January 2013

Review Date: January 2016

Review Due: January 2017

<sup>1</sup> Trainee = Medical Student/Interns/Residents/Fellows (ACGME - Critical Care; Adult Cardiothoracic; Obstetric; Pain Management and non-ACGME – Vascular)

Beth Israel Deaconess Medical Center  
Pain Medicine Fellowship Program

**Pain Fellow Time Off Policy**

**General**

- Pain Medicine Fellows receive **20 days off** during the 2016-2017 academic year.
  - This is UNASSIGNED time meaning that **ALL VACATION, SICK AND JOB INTERVIEW TIME IS DEDUCTED FROM THIS ALLOTMENT**
- If you call out sick, your available days for vacation will be appropriately reduced.
- **FELLOWS MAY NOT CARRY MORE THAN FIVE DAYS OF UNALLOCATED TIME INTO THE FINAL QUARTER OF THE ACADEMIC YEAR (APRIL 1<sup>ST</sup> THROUGH JUNE 30<sup>TH</sup>).**

**Vacation Requests**

- Fellows vacation requests have been processed and assigned
  - Only one fellow will be scheduled for vacation at a time.
  - Accommodations for multiple fellow time off requests may be made around major holidays.
- Requests are considered **on a first come, first serve basis**.

**Sick Calls**

- Fellows unable to report to work due to illness, **must email Susan Kilbride, Nate Bever, Dr. Peeters Asdourian, Dr. Rana and the attending whom you are working with that day.**
- Fellows assigned to one of the following outside rotations **MUST EMAIL Susan Kilbride, Dr. Peeters Asdourian, and the contact at the affiliated institution listed below.**

New England Baptist Hospital:  
Children's Hospital:

Ellen Quartone  
Marybeth Sweeney

[equartar@nebh.org](mailto:equartar@nebh.org)  
[Marybeth.Sweeney@childrens.harvard.edu](mailto:Marybeth.Sweeney@childrens.harvard.edu)

**Job Interviews**

- Fellows must email Dr. Peeters Asdourian, Susan Kilbride
- Please give at least 3-4 weeks notice if possible
- Job interview days are taken out of your 20 day total time off allotment.

Beth Israel Deaconess Medical Center  
Pain Medicine Fellowship Program

**Grand Rounds and Didactic Session Attendance Policy**

*Grand Rounds and Mortality and Morbidity Conferences*

1. **ATTENDANCE IS REQUIRED AT THE WEEKLY ANESTHESIA GRAND ROUNDS AND MORTALITY AND MORDBIDITY CONFERENCES.**
2. Conferences are held at 7:00am on the East Campus in Sherman Auditorium.
3. Fellows **must attend at least 70% of these conferences.** A separate sign-in sheet is passed for each conference. Fellows **must sign BOTH SHEETS** to receive credit.

*Morning Didactic Sessions*

1. Daily sessions are held in the Arnold Pain Management Center Conference Room at 7:00am unless otherwise noted on the didactic schedule.
  - The next month's didactic schedule is emailed approximately one week before the 1<sup>st</sup> of the month.
2. Fellow attendance is REQUIRED EVEN IF your assignment is to the Spine Center, New England Baptist Hospital or on the CPS Rotation.
3. The only excusable absences are when a fellow is:
  - Sick
  - Attending a Meeting
  - On Vacation
  - On Rotation at Children's Hospital

*Attendance Tracking*

1. Fellows are required to sign the attendance log located in the Pain Center conference room. **All attendance must be logged within 24 hours of the didactic session.**
  - a. No accommodations will be made for fellows failing to log their attendance.

*Attendance Monitoring*

- Dr. Peeters Asdourian will review your Grand Rounds and didactic attendance as part of the fellow quarterly evaluation meetings.



Beth Israel Deaconess  
Medical Center



A teaching hospital of  
Harvard Medical School

### *BIDMC IT Support Sheet*

Department of Anesthesia, Critical Care and Pain Medicine

#### **Hospital WiFi Setup**

The private network is not broadcasted, which means that you cannot see it, if you look for available networks.

The private wifi is ALWAYS on and allows you uninterrupted access.

Under wifi settings, got to add WI-FI network.

- The network is SSID “CGWD1”.
- Security is “802.xEAP” (android) or “WPA Enterprise” (iphone).
- Username/identity: “its/XXX” where XXX is your bidmc username. **Please note the backslash, not forwardslash.**
- Enter your password, click ok and you are done.

#### **Citrix Setup – BEST OPTION**

Allows you to work remotely and eval patients live on your phone/tablet/remote computer. To type in the program, you have to pull up the keyboard in the menu (for android folks that use Swype, you have to disable and use a normal keyboard before entering Citrix). For your Children’s rotations, Children’s Hospital has a network too.

- Download “Citrix Receiver” to your device smartphone/tablet: go to your AppStore and search Citrix Receiver computer:  
<http://www.citrix.com/English/ps2/products/product.asp?contentID=1689163>
- Server: <https://citrixweb.caregroup.org>
- User name: XXXXX
- Password
- Domain: ITS
- Description: Whtaever you want i.e. “Harvard”

#### **BIDMC Email Setup**

You might have to call the BIDMC Help Desk at 4-8080 to allow access to email on your smartphone. Unfortunately, they have been moving to more stringent settings.

**IPhone Users:** There is a handout available at

[https://portal.bidmc.org/Intranets/Clinical/Radiology/~/\\_media/Files/Intranets/Radiology/Resources/IphoneInstruction.ashx](https://portal.bidmc.org/Intranets/Clinical/Radiology/~/_media/Files/Intranets/Radiology/Resources/IphoneInstruction.ashx)

INSERT DESCRIPTION/DICATIONS FOR PAIN FELLOWS

NEW EVALUATION

Dr. John Smith  
123 Main Street  
Boston, MA 02215

RE: Kermit The Frog (fi000 00 oOo)

Dear Dr. Smith:

Date:

Thank you for referring Mr. Frog to the Arnold Pain Management Center. *At*; you recall, he is a 56-year old male with low back pain radiating to the left lower extremity for one year.

DESCRIBE THE PAJN:

The patient reported having dull aching pain in the lower back associated with numbness of the left foot.

PREVIOUS TREATMENT:

The patient has tried physical therapy, NSAID, etc. with limited relief.

PHYSICAL E:x:AMJ:NIATION:

(The most important systems are the CNS and MS. Report positive findings of other systems **if** any. Apart from mild weakness of the lower extremity, the patient had normal reflexes, motor and sensory examination).

RADIOLOGICAL STUDIES:

(Summarize MRJ report)

IMPRESSION:

The patient suffers from Lumbar Radlculopathy and possible Facet Arthropathy Syndrome.

PLAN:

The plan of treatment is as follows:

- 1) The patient will be started on medication XYZ
- 2) The patient will be scheduled for a series of Lumbar Edipural Steroid Injections
- 3) The patient's symptoms could be consistent with Facet Arthropathy Syndrome. This patient might benefit from Facet Joint Injection in the future **if** no improvement of his symptoms is achieved with our initial plan\_

Thank you again for the opportunity to consult on this patient. Should you have arty questions regarding the care of this patient, please feel free to contact Dr. XYZ (attending) who is the primal)' pain doctor following your patient

Sincerely yours,

John A. Smith, MD (fellow)  
Dr. Christine Peeters-Asdourian (attending)



FOLLOW UP/PROCEDURE

(THIS IS A LETTER NOT AN OPERATIVE REPORT!!- COMMUNICATE YOUR PLAN!!  
DO NOT DETAIL PROCEDURE)

Dr. John Smith  
123 Main Street  
Boston, MA 02215

RE: Kermit The Frog (IID00 00 000)

Dear Dr. Smith:

Date:

We had the pleasure of seeing Mr. Frog at the Arnold Pain Management center today. As you recall, he is a gentleman with (PROBLEM LIST-LISTED IN CHRONICAL ORDER)

INTERIM HISTORY:

Mr. Frog's history and physical examination have been reviewed and the findings remain unchanged (or new findings are as follows: or...his presenting symptoms of ...remain the same (this is to justify the need for injection, including result of previous injection).

PROCEDURE NOTE:

The procedure performed was a L4/5 Epidural Steroid Injection at U-L5 (under fluoroscopic guidance if done so). Be sure to indicate the following:

- 1) complication during the procedure (vaso-vagal, reaction to contrast)
- 2) ambulation after the procedure
- 3) response to the procedure (report anesthetic phase (THIS IS VERY IMPORTANT!!!))

PLAN:

We will plan to schedule the patient for a repeat LESI in X weeks. Or  
We will plan to schedule the patient for a follow up visit in 4 weeks for a medication renewal. Or  
We will plan to schedule the patient for a follow up in X weeks to determine the effectiveness of this procedure and or to review his medication.

Thank you again for the opportunity to consult on this patient. Should you have any questions regarding the care of this patient, please feel free to contact Dr. XYZ (attending) who is the primary pain doctor following your patient

Sincerely yours,

John A. Smith, MD (fellow)  
Dr. Christine Peeters-Asdourian (attending)

## eScript General Guidelines for Dictation



1. Use your own code when you dictate, even if you are dictating for someone else. The system is tailored carefully to each speaker's voice, so it needs to know who is speaking.
2. Say your full name at the beginning of each dictation. It is not necessary to spell your name or say the address of your clinic. The system already has this information.
3. Restrict each dictation to a single encounter with a single patient. Please use the number 5 key on your telephone keypad to indicate that you are moving on to another dictation. You may also hang up if you are finished dictating.
4. Use verbal punctuations. Especially "comma" and "period".
5. Say section headings. For example, "Medications" or "History+Physical".
6. Say important formatting directives. For example, "New Paragraph".
7. Say "number" when enumerating lists. For example, "Number One" or "Next Number".
8. Dictate reports sections in the order they are to be typed.
9. When you pause, press the "pause" key or remain silent.
10. It's best to use the same telephone channel (handset and phone line) for all dictations. Using a cell phone is prohibited because of *voice* clarity and call drop-out.

## Guidelines for Dictating with Speech Recognition

1. Use your own code when you dictate, even if you are dictating for someone else. The system is tailored carefully to each speaker's voice, so it needs to know who is speaking.
2. Say your and the patient's full name at the beginning of each dictation. It is not necessary to spell your own name or say the address of your clinic. The system already has this information.
3. Confine each dictation to a single encounter for a single patient. If your system has a key to indicate that you are moving on to another dictation, you may use it. Otherwise, please hang up after each dictation.
4. Use verbal punctuations. Especially "comma" and "period".
5. Say section headings. For example, "Medications" or "History and Physical".
6. Say important formatting directives. For example, "New paragraph".
7. Say "number" when enumerating lists. For example, "Number one" or "Next number".
8. Dictate report sections in the order they are to be typed.
9. When you pause, press the "pause" key or remain silent.
10. No cell phones.

## *Frequently Asked Questions* **Clinicians**

- 1) Where is my dictation?
- 2) What are the eScription System phone numbers?
- 3) Can I dictate under another clinician number?
- 4) Can I send a dictation back to eScription to be fixed?
- 5) What's the process from the eScription system to OMR?
- 6) How do I create an addendum?
- 7) Why is my dictation in the wrong format?
- 8) Whom do I contact for quality issues?
- 9) How do I update my dictation to STAT?

- 1) Where is my dictation?

**Answer:**

Please contact your Practice Administrator via email. Please include the Medical Record Number (MRN) and Service Date of the dictation in question.

- 2) What are the eScription System phone numbers?

**Answer:**

General Internal: 120  
External: (617) 754-8580

Radiology Department:

Internal: 121  
External: (617) 754-8581  
Listening Line: (617) 754-8583 (only Radiology reports)

- 3) Can I dictate under another clinician number?

**Answer:**

No, and for two reasons. One is that the dictations will not be sent to your 'signing queue' box in OMR. The second is that this will ruin the physician's voice profile.

- 4) Can I send a dictation back to eScription to be fixed?

**Answer:**

No, once a dictation is in your 'in box' in OMR there's no way to send the file back to the eScription system. The eScription system is simply a 'holding bin' to manage dictations prior to sending them to the clinician's 'signing queue'. The communication of data between eScription and OMR flows only in one direction.

- 5) What's the process from the eScription system to OMR?

**Answer:**

The important thing to remember is that the data flows in one direction. The first step is the clinician dictates into the phone. The next step in the process is that the dictation is sent out to the transcription service, who in turn either types up the note or edits the note for completion. The last step is the note will either be sent directly to

the Clinician's 'sign queue' or sent to your administrator for an issue that might have arisen. (See above question 10 in the Administrators section for reasons a note might be pended to your administrator.) Please note that once a dictation is in your queue you are not able to send it back for editing. If an issue does arise with your dictation that needs to be addressed, please email your administrator.

6) How to do I create an addendum?

**Answer:**

There are a few options. The first option is recommended by the BIDMC eScription Support team, which is the clinician adds the addendum to the note via OMR. The next option is to dictate the addendum via the eScription system. You'll need to state that this dictation is an addendum to the patient visit in question after you 'punch' in the patient's MRN and Service Date. This second option will create two notes in OMR which will require the clinician to copy and paste the addendum into the original note in OMR. The last option is in conjunction with the second one. For this option we'll work with your administrator and transcription company to pend all addendums to your practice. This will allow your administrator to cut and paste the addendum to the original dictation via the eScription tool. If you have any questions about these options please email support at: [esupport@bidmc.harvard.edu](mailto:esupport@bidmc.harvard.edu).

7) Why is my dictation in the wrong format?

**Answer:**

There could be a few reasons why your dictations are not in the correct format. When these issues arise, please email your administrator the MRN and Service Date of the dictation in question. He/She will then forward these issues to the Transcription Company and resolve the issue for future dictations.

8) Whom do I contact for quality issues?

**Answer:**

Please email your administrator and reference the dictation with the MRN and Service Date of the dictation in question.

9) How do I update my dictation to STAT?

**Answer:**

If time permits please notify your administrator and reference the dictation with the MRN and Service Date. If not, please email support directly at: [esupport@bidmc.harvard.edu](mailto:esupport@bidmc.harvard.edu). After normal business hours, please page BIDMC eScription Support at pager #31446.

**Blackberry Users:** You should follow the rules for Android phones. The alternative is Enterprise, which usually has a monthly fee.

**Android Phone Users:** Recent changes in the ITS department have required that they get remote access to your phone in order to wipe the device in case it gets stolen. Therefore, having BIDMC email on your Android phone requires that you let the hospital administrator access.

- Got to “My Account” and click Corporate Sync.
- Username: “its.caregroup.org\XXXXX”...please note the backslash NOT forwardslash
- Enter password
- Email address [XXXX@bidmc.harvard.edu](mailto:XXXX@bidmc.harvard.edu)
- Server: “mail.caregroup.org”.
- Account name can be whatever i.e. “Harvard”.

### **Access to Anesthesia Record in OMR**

- Computers (Mac/PC/Smartphone/Tablet) not on the hospital network cannot open the Anesthesia Record PDF in OMR.
- Option #1: Go through the citrix system version of OMR/portal (see below)
- Option #2: Add Remote Access to your portal apps. This will take you to a secure version of BIDMC. Under bookmarks is “portal home” which if you go through OMR this way allows you to view anesthesia records. Also there is a link for citrix.

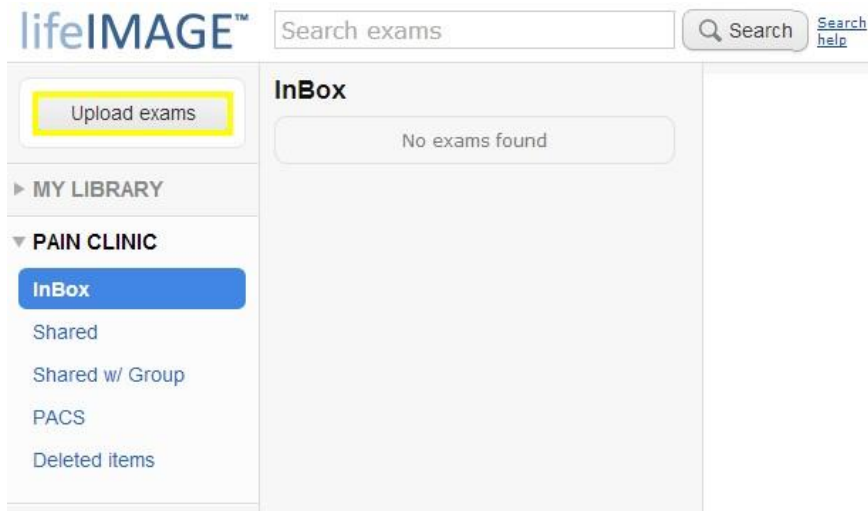
### Uploading to Life Image

1. Log in using ITS username and password



The image shows the login interface for LifeIMAGE. At the top, the logo reads "lifeIMAGE™" with the tagline "the picture of health" below it. The login form consists of two input fields: "Username:" and "Password:". Below these fields is a dark grey button labeled "Log in".

2. Insert CD
3. In top left corner, click **Upload Exams**



The image shows a screenshot of the LifeIMAGE dashboard. At the top left is the "lifeIMAGE™" logo. To its right is a search bar labeled "Search exams" with a magnifying glass icon and a "Search" button. Further right is a "Search help" link. Below the search bar is a navigation menu. The "Upload exams" button is highlighted with a yellow border. Underneath, there are sections for "MY LIBRARY" and "PAIN CLINIC". The "PAIN CLINIC" section is expanded, showing "InBox" (highlighted in blue), "Shared", "Shared w/ Group", "PACS", and "Deleted items". To the right of the navigation menu is the "InBox" area, which currently displays "No exams found".

# LifImage\_CD\_Upload\_Procedure\_Pain\_Clinic\_V3.docx

4. Click **Find Exams on CD/DVD** or **Browse for exams**

## Upload Exams

1 Select exams      2 Confirm exams      3 Upload exams

Place a CD/DVD in your computer's drive and click to detect exams

or

Specify the location of your exams by selecting a drive or folder

**Find exams on CD/DVD**      **Browse for exams**

5. The exam descriptions are now shown on the screen. You can choose to select individual or all exams on the disk.
6. Click on **Continue** in the bottom right

1 Select exams        2 Confirm exams    3 Upload exams

The following patient and exams were located on your selected media.

**Patient**  
FROG^KERMIT TCH (F)  
DOB: Feb 1, 1972

**Exams**

<input checked="" type="checkbox"/>	Modality	Description	Date
<input checked="" type="checkbox"/>	CR		Jun 26, 2013
<input checked="" type="checkbox"/>	DX	FEMU...ND.LAT).RIGHT.	Jun 6, 2013

If this information is incorrect      If this information is correct

**Go back**      **Continue**

7. In the **MRN box**, enter the patient's B.I. MRN
8. At the **"Upload Exams to"** tab, choose "Pain Clinic" or "My library"
9. Click **"Upload Exams"**

1 Select exams        2 Confirm exams        3 Upload exams

**Patient**  
FROG^KERMIT TCH (F)  
DOB: Feb 1, 1972

**Exams**  
2 exams are available for upload  
[Show details >](#)

7. MRN:

8. \* Upload exams to:   
Pain Clinic  
My Library  
Pain Clinic

Quit the upload process      Upload and assign exams

**Cancel upload**      **Upload exams**

9.

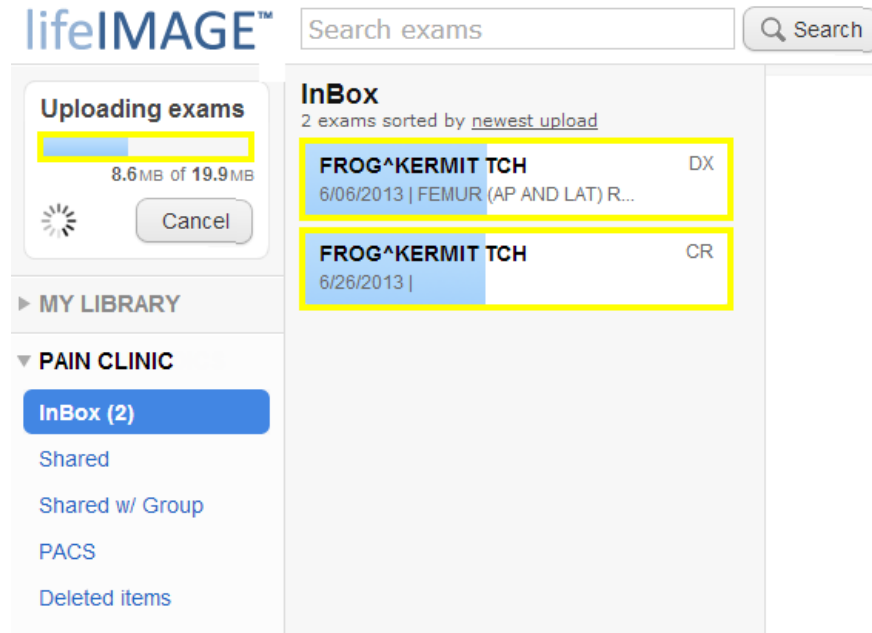
*The exams will begin uploading*

C:\Users\kgranqui\Desktop\LifImage\_CD\_Upload\_Procedure\_Pain\_Clinic\_V3.docx



# LifImage\_CD\_Upload\_Procedure\_Pain\_Clinic\_V3.docx

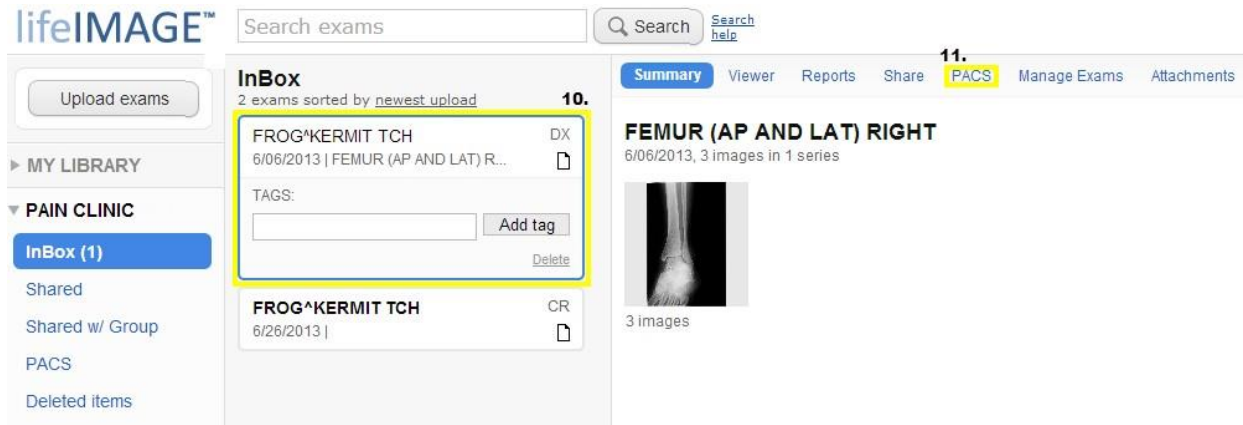
You will see the progress in the bar to the top left. All the exams being uploaded will also have a progress bar



You can click on each exam to see the amount of associated images and relevant info.

10. Once the exams have uploaded, click on one

11. To the right, choose **PACS** from the headings



# LifImage\_CD\_Upload\_Procedure\_Pain\_Clinic\_V3.docx

The fields that need to be completed on this form have a red asterisk next to them

“Requesting Provider” and “Contact Email” are free text fields, so names and/or numbers can be added

12. At the bottom of the form, if there are multiple exams on the disc, select **All from this CD**

13. click **Nominate Exam**

Fields marked with an asterisk \* are required.

\* BIDMC MRN:

D.O.B. MM/DD/YYYY:

\* Requesting Provider:

\* Contact Email:

\* Priority:

## CDs Only: Return or Destroy after 7 days

Modality: DX

External exam description: FEMUR (AP AND LAT) RIGHT

Additional patient history:

12.

\* Apply to:  Only this exam  
 All from this CD ([view exams](#))

13.

**Nominate Exam**

**Beth Israel Deaconess Medical Center**

**BIDMC Manual**

**Title: Industry Representative Code of Conduct (formally named: Vendor Access Policy)**

**Policy #: ADM-02**

**Purpose: To provide clear policies and procedures for Vendor Representatives when visiting Beth Israel Deaconess Medical Center (BIDMC).**

**Policy Statement:**

It is the goal of Beth Israel Deaconess Medical Center to maintain a clearly defined and professional relationship with representatives of the pharmaceutical and medical device and equipment industry (“representatives”). It is the intent of this policy to define the parameters by which representatives may conduct business while ensuring that the delivery of patient care is not interrupted or adversely affected at the Beth Israel Deaconess Medical Center. All departments shall be responsible for developing and publishing guidelines for implementation of this policy. This policy applies to all representatives doing business on hospital premises.

Note:

- Additional guidelines for industry representatives in the perioperative setting are provided in policy [#PSM400-320: Industry Representatives in the Perioperative Setting](#).
- Guidelines for the attendance of trainees and other non-industry visitors who visit BIDMC through graduate medical education programs are provided in policy [#GME-09: Guidelines for Graduate Medical Observation Experience](#). This includes fellowship and residency candidates.

**Procedure(s) for Implementation:**

**A. Responsibility for Implementation:**

Each department is responsible for establishing and documenting check in policies specific to their department’s hours of operations, organizational structure and credentialing requirements. They are also responsible for enforcement of the policy.

**B. Representative Registration:**

All representatives must first complete an on-line registration process, managed through Vendor Credentialing Service, in order to conduct on-site business. Registration can be accessed directly through [www.vcsdatabase.com](http://www.vcsdatabase.com). Representatives will be required to provide contact information and upload documentation as described in the Representative Classification Matrix (Attachment A) to become a “registered representative”.

At a minimum, the following information will be required:

1. Representative's name
2. Company name
3. Telephone number where (s)he may be contacted during normal business hours
4. Vendor's immediate supervisor name.
5. Telephone number where supervisor can be contacted
6. The representative's 24-hour emergency number

**C. Appointments**

All representatives shall have a previously scheduled and confirmed appointment with the individual(s)/department(s) they wish to visit prior to arriving at Beth Israel Deaconess Medical Center. Departments may issue standing invitations to representatives with the approval of the Department Chief or Administrative Director. Representatives are not permitted to roam the corridors.

Representatives may participate in in-service education or training programs upon invitation by authorized hospital department personnel. Representatives may not otherwise be in attendance at any conference, rounds or discussions, formal or informal, where individual patients or any collective patient care matters are being presented or discussed.

**D. Emergency Situations**

In an emergency situation, which shall be defined by the physician responsible for the patient's care, a representative may be called to Beth Israel Deaconess Medical Center without an appointment. It is the responsibility of the department to manually approve the representative's access in accordance with this policy in an expedited manner. Access may be manually overridden by an authorized hospital administrator or user.

**E. Sign in Procedures**

All representatives with approved appointment at Beth Israel Deaconess Medical Center must sign-in through one of the designated sign-in/sign-out kiosks at the following locations:

- East Campus – Feldberg Lobby
- West Campus – West Clinical Center Elevator Bank

While both kiosks are available at all times, the West Campus is the only campus open twenty-four hours a day, seven days per week.

**F. Identification Badges**

Upon signing in (See Section D above) representatives will be issued a badge by the kiosk, which must be prominently displayed at all times while on campus. Company-supplied name badges may also be worn

**G. Consent**

***Vendor representatives may not be present during any patient procedures***

*without obtaining proper consents:*

*Patient Consent is required during all of the following situations:*

1. Observation
2. Technical Support

Prior to the start of the procedure, consent must be obtained (where applicable) from **Patient** and at least one of the following:

1. Physician
2. Anesthesiologist
3. Nurse Manager or Designee

Consent must be documented in the chart. In the case where a chart does not exist, verbal consent may be obtained and recorded in the electronic medical record. In an emergency situation in which the representative has the expertise that would contribute to a positive outcome, the physician must make a note on the chart and inform the family as soon as possible after the procedure. All representatives called in an emergency situation must have been previously “cleared” regarding competency through the basic education offering.

Life-threatening emergencies may constitute an exception to obtaining consent prior to the procedure. In those cases in which the presence of an Industry Representative would contribute to the likelihood of a more positive outcome for the patient, the surgeon will include a note in the patient’s chart.

#### **H. Representative Code of Conduct**

1. Representatives are permitted only in physician offices, procedure rooms, or Perioperative Services with a prior appointment and appropriate consents.
2. Representatives are expected to abide by the Beth Israel Deaconess Medical Center’s Code of Conduct and HIPAA Privacy policy pertaining to access and disclosure.
3. Never shall a vendor, BIDMC staff/employee, and/or physician suggest or offer incentives to anyone to use or promote a product.
4. Under no circumstances will vendors review or read a patient’s chart or other aspect of their medical record. Vendors should avoid all contact with documents containing unique patient identifiers. In an emergency situation, it is the responsibility of the department to obtain the proper consents as soon as the situation is stabilized.
4. Patient Confidentiality is required. All representatives will keep all information about a patient confidential and will not disclose or reproduce such information for any purpose at any time. The representative is bound by this policy at all times during and after his/her visit to Beth Israel Deaconess Medical Center. Failure to do so will result in immediate restriction from the Beth Israel Deaconess premises and potential legal action.
5. Representatives are not allowed to be involved in direct patient care.

## I. Maintaining Credentials

It is the representatives' responsibility for monitoring their ongoing continuing education and health screening requirements, as further described in the Minimum Credential Standards (Exhibit B). Credentials are required to be updated with VCS annually, unless otherwise specified by industry standards or required by department.

## J. Breach of Policy

Any employee who sees a Vendor Representative within the Beth Israel Deaconess Medical Center without a Visitor Identification Badge should report it immediately to the Beth Israel Deaconess Medical Center Office of Compliance and Business Conduct.

### 1. Breach of Policy by Industry Representatives

- a. It is at the discretion of Beth Israel Deaconess Medical Center to determine the appropriate response to a breach of this policy. Responses could include a warning up to and including restriction from Beth Israel Deaconess Medical Center premises.
- b. Breaches of this policy should be reported to the Director of Contracting, who will collaborate with the reporting department and the Office of Compliance and Business Conduct regarding the following actions:
  - i. First Offense: Contracting will counsel the representative and place documentation in the Industry Representatives file.
  - ii. Second Offense: Contracting will restrict access to the Industry Representative and send a letter to his/her immediate supervisor.
  - iii. Third Offense:
    1. A letter will be sent to the Industry Representative and his/her Supervisor, resulting in banning of the Industry Representative for business at BIDMC.
    2. Review of current business at BIDMC will be evaluated to determine further actions with the company.

### 2. Disciplinary Action for Beth Israel Deaconess Medical Center Employee and Medical Staff.

- a. Employees - Disciplinary action in accordance with Medical Center policy.# [PM-04 Corrective Action](#)
- b. Physicians - Reporting to Chief of service and will result in disciplinary action up to and including termination of privileges in accordance with Beth Israel Deaconess Medical Center by-law

## K. Training

Each department will be responsible for communicating this policy to their vendor representatives and employees. On-going training on the use of Vendor Credentialing Service's website may be provided through webinar/webex as

desired by department.

[Attachment A: Vendor Representative Classification](#)

[Attachment B: Minimum Credential Requirements](#)

**Vice President Sponsors:** **Robert Cherry, VP Support Service**

**Approved By:**

**Operations Council: 2/4/13**

**Marsha Maurer  
Interim Chief Operating Officer**

**Medical Executive Committee: 1/23/13**

**Rich Wolfe, MD  
Chair, MEC**

**Requestor Name: Stephen Cashton, Director Purchasing**

**Original Date Approved: 2/4/2013**

**Next Review Date: 2/16**

**Revised:**

**Eliminated:**

**References:**

[Attachment A: Vendor Representative Classification](#)

[Attachment B: Minimum Credential Requirements](#)

[ADM-51 Visiting Industry Scientists - Attendance at Educational Conferences](#)

[www.vcsdatabase.com](http://www.vcsdatabase.com)

[PSM400-320: Industry Representatives in the Perioperative Setting.](#)

[PM-04 Corrective Action](#)

[GME-09: Guidelines for Graduate Medical Observation Experience](#)

**American Council of Surgeons (ACS)**

[http://www.facs.org/fellows\\_info/statements/st-33.html](http://www.facs.org/fellows_info/statements/st-33.html)

**The Association of Peri-Operative Registered Nurses (AORN)**

*The Role of the Health Care Industry Representative in the Perioperative/Invasive Procedure Setting*

<http://www.aorn.org/PracticeResources/AORNPositionStatements/>

**The Joint Commission**

*Health Care Industry/Vendor Representatives*

[http://www.jointcommission.org/mobile/standards\\_information/jcfaqdetails.aspx?StandardsFAQId=92&StandardsFAQChapterId=5](http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=92&StandardsFAQChapterId=5)

**Centers for Disease Control**

*Immunization of Health-Care Workers*

<http://www.cdc.gov/mmwr/preview/mmwrhtml/00050577.htm>



**Title: Personal Gifts, Travel, Meals, and Entertainment**  
**Policy #: ADM-17A**

**Purpose:** The purpose of this policy is to set forth the standards for Beth Israel Deaconess Medical Center (BIDMC) relating to the acceptance of personal gifts. This policy applies to members of the “Workforce,” which means persons working for the benefit of BIDMC, whether or not they are paid by BIDMC. This includes employees, members of the professional staff, volunteers, trainees, and also includes consultants, agents, and members of the Board of Directors when they are acting in a BIDMC capacity.

### **A. Policy Statement**

When personal gifts are made to members of our Workforce, they have the potential to influence, or create the appearance of influencing, how they carry out their BIDMC responsibilities.<sup>2</sup>

Except as provided below, members of the Workforce may not solicit or accept personal gifts, travel, meals, or entertainment, from any patient, or from any pharmaceutical company, medical device company, biotechnology manufacturing/supply company (or their representatives), or any person or entity that provides or is seeking to provide goods or services to BIDMC, or that does business with or is seeking to do business with BIDMC. All solicitations for commercial support for educational fellowships, programs, travel, and events should be coordinated with the BIDMC Office of Development, and follow the guidelines set forth in Policy **ADM-17B, Industry-Supported Speaking, Programs, Fellowships, and Preceptorships**.

A “Gift” means anything of any value that is received by an individual for which the recipient has not paid fair market value. By way of example, this includes token items such as pens, pads of paper, mugs, calendars, entertainment or recreational items of any value. Meals in conjunction with entertainment or recreation, tickets to concerts or events, and vacation trips are not allowed. Payments of any kind, including cash and cash equivalents, gift certificates, equity, royalties, tangible items, and rebates that are prohibited under applicable federal or state fraud and abuse laws or regulations are also not allowed.

An item is not considered a gift if the individual provides fair market value for the item.

When situations are not specifically addressed in this policy, decisions should be guided by the BIDMC [Code of Conduct](#), always keeping in mind that our patients and their welfare come first, and that we are committed to ethical and compliant conduct. When in doubt, please ask for advice from your supervisor, or from the Office of Compliance and Business Conduct (617-667-1897).

### **B. Meals and Travel**

With the exception of certain programs and trainings described in **Policy ADM-17B, BIDMC**

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<sup>2</sup> Free or discounted goods, if tied to the generation of federal healthcare program business, may violate federal or state anti-kickback laws. In addition, the Massachusetts Pharmaceutical / Medical Device Manufacturer Code of Conduct (MGL c. 111N) prohibits gifts from biomedical manufacturers to health care practitioners licensed in Massachusetts.

considers vendor or industry-supplied food, meals, and travel to be prohibited personal gifts that may not be accepted by members of the Workforce, either on-site or off-site.

This policy does not prohibit:

- personal gifts exchanged between members of the Workforce;
- educational brochures provided solely for the use of patients or staff to educate them regarding a disease, condition, drug, device, biological, or medical supply, if the division chief for the area determines in advance that the materials are clinically acceptable, and do not advertise or promote a drug, device, supply, or biologic (materials carrying a corporate name or logo in small font size is acceptable, but no mentions of the company's business lines or products is allowed);
- modest and occasional meals and refreshments made generally available to all participants of a large-scale open-registration meeting or conference or similar large-scale event, or at an event open to the public, where the identities of individuals partaking are not tracked. "Modest meals and refreshments" are food and drinks that, as judged by local standards, are similar to what that individual might purchase when dining at his or her own expense;
- modest and occasional meals and refreshments offered by the organizer at a bona fide educational event (*not* a marketing event), if the meals are not directly provided by a pharmaceutical, medical device, or biotechnology manufacturing company, are offered across the board to all participants out of the event's budget, and are subordinate in time and focus to the bona fide educational purpose of the meeting;
- prizes and awards for scientific or medical achievements from company-supported foundations and organizations if the recipient is chosen through an established, independent process of scientific review; or
- meals, travel, and lodging expenses provided to an individual who is
  - a. an employee of the company; or
  - b. providing services (e.g. speaking, consulting) or
  - c. receiving training and who complies with **BIDMC Policy ADM-17B**, Section C, "Attendance at Industry-Sponsored Events Off-Site."

### **C. Gifts to BIDMC**

For Gifts to BIDMC, the following requirements apply:

- Charitable gifts to BIDMC should be approved by the BIDMC Office of Development (617-667-7330).
- Free or discounted goods offered or provided to patients from BIDMC are governed by BIDMC Policy [ADM-31 Restrictions on Free or Discounted Goods and Services](#).
- Gifts of data, reagents, equipment, or other laboratory materials provided by companies to BIDMC for use in the scope of research should be accepted in compliance with BIDMC Policy [RS-23 Classification and Administration of Research Gifts](#).
- Gifts of product samples, coupons, and vouchers, provided solely and exclusively for use by patients, that have the prior approval of the Pharmacy Department (617-754-3810), should be managed in compliance with BIDMC Policy [CP-11 Drug Sample](#).

**Management.**

- The loan to BIDMC of demonstration or evaluation devices and supplies for a short-term trial period should comply with BIDMC Policy **ADM-15 Supplier Contact and Negotiation.**
- Industry support to BIDMC for educational activities (including trainee fellowships, travel, educational events and programs) may be accepted in compliance with BIDMC Policy **ADM-17B, Industry-Supported Speaking, Programs, Fellowships, and Preceptorships.**

Members of the Workforce who interact with any vendor representatives are expected to be familiar with BIDMC Policies **ADM-02 Industry Representative Code of Conduct (Vendor Access)**, and **ADM-15 Supplier Contact and Negotiation.**

**D. Gifts from Patients**

Gifts can compromise the therapeutic relationship between patient and caregiver. Members of the Workforce should not accept personal Gifts from patients or their family members, unless the Gift meets all of the following requirements:

1. The Gift is meant as a token of gratitude.
2. It is not meant to influence the care given.
3. It has not been solicited.
4. It is not cash or a cash equivalent (gift card, gift certificate, check, money order, or other similar item).
5. It is valued at less than \$50.

In instances where a patient offers a gift valued greater than \$50 for the benefit of an entire unit, the appropriate VP should be consulted for guidance. Patients wishing to give Gifts of cash or cash equivalents should be referred to the BIDMC Office of Development (617-667-7330).

**Vice President Sponsor:**

**Eileen McCarthy, RN, CHC  
Sr. Vice President, Compliance, Audit & Risk**

**Approved By:**

**Medical Executive Committee: 09/09/2015**      **Jonathan Kruskal, MD  
Chair, MEC**

**Operations Council: 09/14/2015**      **Nancy Formella, RN  
Chief Operating Officer**

**Requestor Name:**      **Melissa Anderson, JD  
Director, Conflicts and Industry Interactions**

**Original Date Approved: 03/01/05**

**Revised: 08/03/05, 03/09/09, 03/21/12, 09/14/15**

**Next Review Date: 9/2018**

**Related Policies:**

[ADM-02 Industry Representative Code of Conduct \(Vendor Access Policy\)](#)

[ADM-15 Supplier Contact and Negotiation](#)

[ADM-17B Industry-Supported Speaking, Programs, Fellowships, and Preceptorships](#)

[ADM-18 Conflict of Interest Policy for Institutional Transactions](#)

[ADM-19 Conflict of Interest Policy for Research](#)

[ADM-31 Restrictions on Free or Discounted Goods and Services](#)

[ADM-60 Speaking, Consulting, and Other Outside Activities](#)

[CP-11 Drug Sample Management](#)

[RS-23 Classification and Administration of Research Gifts](#)

[BIDMC Code of Conduct](#)



***Title: Transitions of Care and the Safe Handover of Patients***

***Policy: GME - 27***

***Purpose: The purpose of this GME policy is to enhance patient safety by defining standards for a safe, effective approach to transitions of care across all GME programs, consistent with the ACGME Common Program Requirements.***

***General Background:***

1. Effective communication among team members is an essential team process and a critical component in the delivery of safe quality health care to the patient across the entire spectrum of healthcare providers. Such communication is particularly critical when primary responsibility for a patient is transferred from one physician to another.
2. These transitions of care must be timely, patient-centered, explicitly structured and contribute to safe patient care. The process of “clinical handover” formalizes the transfer of accountability and responsibility of some or all relevant aspects of patient care.
3. The Sponsoring Institution and Clinical Departments are committed to implementing systems that ensure effective, consistent and agreed upon processes to support clinical handover. This ensures timely transitions of care free from significant distractions other than emergent patient interventions, utilizing an appropriate environment and systems to deliver continuous safe quality clinical care.

***Definitions:***

***Transitions of care or clinical handover*** is the communication process that enables the “transfer of clinical responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or healthcare team on a temporary or permanent basis” .<sup>1</sup>

***Policy Rationale:***

The purpose of this GME policy is to enhance patient safety by defining standards for a safe, effective approach to transitions of care across all GME programs, consistent with the ACGME Common Program Requirements.

***Standards:***

1. Programs must design clinical assignments to minimize the number of transitions in patient care.
2. Programs must ensure and monitor effective, structured handover processes to facilitate

both continuity of care and patient safety.

3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
4. Schedules that list the attending physicians and residents currently responsible for each patient's care must be made readily available to all members of the health care team.
5. Individual programs /departments should develop a policy that addresses transitions of care relevant to the clinical specialty. These polices should include standards around the transfer of information, supervision requirements, and documentation of the clinical transfer
6. This policy should be supported by faculty development and resident education related to safe handoffs and transitions in care.
7. The program should ensure sufficient resources are in place to enable effective transitions in care, including staff training in clinical handover.

A review of the department's policy and education related to transitions of care will be reviewed by the GMEC at the mid cycle review.

**Vice President Sponsor: Richard M. Schwartzstein, MD Vice President for Education**

**Approved By:**

**Graduate Medical Education Executive Council**

**Carrie Tibbles, MD, DIO/Director, GME 5/19/2014**

**Medical Executive Committee**

**Rich Wolfe, MD, Chair, MEC 9/2/2014**

**Original Date Approved: 09/26/2011**

**Revisions: 9/2/2014**

**Next Review Date: 09/2016**

**Eliminated:**

***References:***

1. Australian Medical Association, 2006, Safe Handover: Safe Patients, Guidance for Clinical Handover for Clinicians and Managers. (Adapted from the British Medical Associations resource: Safe Handover: Safe Patients)

**Radiation Safety Manual**

**Title: Compliance and Enforcement Policy for Radiation Safety in Non-laboratory Settings**

**RSC Policy: P-01**

**Purpose:**

To promote patient and workplace safety there will be a uniform enforcement standard of radiation safety regulations as overseen by the Radiation Safety Committee (RSC), and compliance with [Federal](#) and [State regulations](#) and licensing requirements, [Joint Commission on Accreditation of Healthcare Organizations \(JCAHO\)](#) standards, and Beth Israel Deaconess Medical Center (BIDMC) Radiation Safety Committee (RSC) manual, policies and procedures. Refer to BIDMC Radiation Safety Manual for policy pertaining to compliance and enforcement for radiation safety in the laboratory setting.

**Policy Statement:**

The BIDMC RSC is empowered by the Medical Executive Committee (MEC) to oversee implementation, interpretation of, and compliance with

- ❑ [Federal](#) and [State regulations](#) and [JCAHO](#) standards for use of all radiation sources.
- ❑ Radioactive material licenses issued to BIDMC by the [Massachusetts Department of Public Health \(DPH\)](#) for both clinical and research applications.
- ❑ Requirements of BIDMC Radiation Safety Manual, and associated RSC policies and procedures.

The elements of the Compliance and Enforcement Code are:

- ❑ Authority to stop unsafe practices, and to suspend non-authorized individual(s).
- ❑ Definition of individuals responsible for compliance under this policy.
- ❑ Documentation that an individual has reviewed the contents of this document.
- ❑ An audit program to monitor compliance. For identified violations (depending on the severity of the finding), the audit enforcement actions are as follows:
  - Suspension of work after three findings in a 12-month period ([Level C](#)).
  - Suspension of work after two findings in a 12-month period ([Level B](#)).
  - Suspension of work after one finding ([Level A](#)).
- ❑ Reinstatement criteria.
- ❑ Appeal process.



### ***Procedure(s) for Implementation:***

#### *Authority to act to stop unsafe practices and suspend non-authorized individual(s)*

The Radiation Safety Officer (RSO) has the authority to immediately stop any operations involving the use of radiation sources in which health and safety may be compromised or may result in non-compliance with DPH licenses and regulations. In those situations when withdrawal of a physician's authorization to use radiation for clinical purposes is involved (e.g. fluoroscopy), the matter will be addressed by the Chair of the RSC, in conjunction with the BIDMC Vice President in charge of Radiation Safety, and, in addition, where radiation in human studies is involved, by the Committee on Clinical Investigations. For non-physicians, [BIDMC Policy PM-04 \(Employee Corrective Action\)](#) will be followed.

#### *Responsibility*

Those individuals responsible for compliance under this policy are defined in the BIDMC Radiation Safety Manual.

#### *Knowledge of policy*

Documentation acknowledging receipt of and understanding of the contents of this policy and BIDMC Personnel Radiation Monitoring Handbook will be placed on file in the Radiation Safety Office for all personnel authorized to use, or be in the vicinity of, radiation sources.

#### *Audit program, action on non-compliance*

To ensure compliance with [federal](#) and [state regulations](#) and [JCAHO](#) standards for use of radiation sources and to ensure that conditions are met in the [DPH](#) radioactive materials use licenses discussed above, the following audits will be conducted:

- Quarterly reporting to RSC of personnel monitoring readings greater than ALARA I criterion.
- Quarterly reporting of statistics on wear and return rates of personnel radiation-monitoring badges.
- Audits of each laboratory using radioisotopes will be made by the RSO at his/her discretion and can encompass a walk through visit, or a comprehensive audit at a frequency to be determined by the RSC.
- Annual reporting to the RSC of patient dose Quality Control (QC)/monitoring for all

medical users of radiation.

- ❑ Annual reporting to the RSC of Quality Assurance (QA)/QC results regarding the various users (e.g. nuclear medicine, radiology, cardiology, radiation oncology, DEXA bone scanning, etc.), equipment (e.g., fluoroscopy equipment, dose calibrators in nuclear medicine, therapy machines, mammography units, CT scanners), monitoring and performance.

The RSO has the authority to stop all operations with radiation sources where a hazard or violation exists. For serious violations, or violations involving potentially serious hazards, the RSO has the authority to stop operations immediately. For less serious occurrences, citations will result. Examples of such violations are described below:

#### *Citation process*

- ❑ *Level A – Suspension of individual after one finding for:*
  - Serious violations, or violations involving potentially serious hazards.
  - Radioactive material not secured against removal.
  - Handling of radioactive material or operation of an ionizing radiation producing source by a non-authorized individual.
  - Failure to deal appropriately with, and report, a major spill.
  
- ❑ Level B – Suspension of individual after two findings in 12 month period for:
  - Failure to deal appropriately with, and report, a *minor* spill.
  - Not wearing appropriate protective clothing.
  
- ❑ *Level C – Suspension of work after three findings in 12 month period for:*
  - Personnel not wearing required personnel radiation monitoring badges or not returning badges promptly for readout.
  - No record of sink disposal of radionuclides.
  - Not performing and/or documenting required surveys.

This action will be documented in a letter to the individual(s), as described below.

#### **NOTICE**

(Level C, first finding)

Upon observation that an infraction under verbal counseling\* has been repeated, the RSO will notify, in writing, both the individual directly responsible for the violation and the violator's supervisor. A NOTICE will contain a description of the infraction and it will set a date by which corrective measures must be completed. The supervisor will then prepare a written counseling letter to the individual responsible for the infraction. In addition, on or before that date, the supervisor and the responsible individual must jointly present the RSO with a description of the action, in writing, that has been taken to bring activities into compliance with BIDMC Radiation Safety rules. Where there is failure to satisfactorily respond to a NOTICE as described above, or if the same individual repeats the same violation within a year of the issuance of a letter of NOTICE, a letter of WARNING will be issued.

*\*Prior to issuing a NOTICE, verbal counseling will have taken place. The Radiation Safety Staff will have notified the individual's supervisor that an infraction has occurred. The supervisor will then discuss this with the individual involved, and notify the radiation safety staff of the corrective action taken.*

## **WARNING**

([Level B](#) first finding, [Level C](#) second finding)

The WARNING will set a date by which corrective steps must be completed and will state that the suspension of work under the responsible individual's supervision will follow if corrective measures are not completed by the specified date. A copy of the WARNING will be sent to the individual responsible for the violation, the violator's supervisor and to the Chief of Service (physicians only) or Department Director (non-physicians). For physicians, a copy of the letter of WARNING will be placed in their departmental credentialing file. If more time is needed to complete the corrective measures, the responsible individual(s) may apply for additional time in advance of the date on which the suspension is to ensue. If the individual receiving the letter fails to satisfactorily respond to the WARNING, as described above, or if he or someone under his/her supervision within a year of the issuance of a letter of WARNING repeats the same violation, a letter of [SUSPENSION](#) will be issued.

## **SUSPENSION**

([Level A](#) first finding, [Level B](#) second finding, [Level C](#) third finding)

A letter of SUSPENSION of work for activities defined above will be sent by the Chair of the RSC to the individual involved, with a copy sent to his/her immediate supervisor; and for physicians to the Office of Professional Staff Affairs and Chief of Service. It will state that authorization to work with or in the vicinity of radiation sources will be suspended, pending a letter of explanation, co-signed by the individual and the Chief of Service (or Department Director for non-physicians). In addition, where the individual receiving the citation is a permit holder for radioactive materials use, all radionuclides possessed by the permit holder may be confiscated and all users listed on the permit may be prohibited from activities involving use of radioactive materials.

In some circumstances, for physicians, a citation may lead to action under applicable Medical Staff By-laws. Similarly, for non-physicians a citation may lead to termination under the

[Employee Corrective Action Policy](#).

## **Reinstatement criteria**

Reinstatement of user activities, and return of confiscated radionuclides, if applicable, will be authorized after the Chair of the RSC determines that an effective corrective action has been proposed and will be implemented in a timely manner. The Chair of the RSC, at his discretion, possesses the additional option of referring the reinstatement decision to the full RSC. It is expected that re-training either for individuals or for an entire group will be considered in formulating a corrective action response.

## Appeal process

If an individual receiving a citation under this policy, together with his/her Department Chair, believes that he/she has been unfairly cited, he/she may appeal the citation to the Chair of the RSC. If not satisfied, a final appeal can be made to the full RSC, with the resultant decision being final and binding. In cases of [suspension of work](#), the repeal of the suspension will not be deemed effective until the appeal process has been completed and a determination in favor of the individual appealing has been made.

### *References*

*(Can be obtained from the Radiation Safety Office)*

Appropriate [federal](#), [state](#) and [JCAHO](#) regulations (e.g. [DPH regulations in 105 CMR 120](#))  
Broad scope and mobile DPH licenses for use of radioactive materials at BIDMC

BIDMC Radiation Safety Manual, policies and procedures  
BIDMC Personnel Radiation Monitoring Handbook  
Agreement acknowledging receipt and understanding of this policy

BIDMC Medical By-laws

### [BIDMC Policy PM-04: Employee Corrective Action](#)

- *NOTICE (this policy) equivalent to Written Counseling (PM-04)*
- *WARNING (this policy) equivalent to Written Warning (PM-04)*
- *SUSPENSION OF WORK (this policy) equivalent to Suspension (PM-04)*

### **Attachments**

[NOTICE letter format](#)

[WARNING letter format](#)

[SUSPENSION OF WORK letter \(physicians\) format](#)

[SUSPENSION OF WORK letter \(non-physicians\) format](#)

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**Radiation Safety Committee** \_\_\_\_\_

**Chair, RSC**

Requestor Name: Joseph Ring, per Radiation Safety Committee approval on 8/13/14

**Date Approved by RSC: 8/13/14**

**Initial review was by MEC 12/17/03**

**Next Review Date: 12/15/15**

**Revised:**

**Eliminated:**

Personal Radiation Handbook Goes Here

**FORMAT FOR NOTICE LETTER**

Date:

To: (Viola/or)  
cc: (Supervisor)

FROM \_\_\_\_\_, Radiation Safety Officer

RE: NOTICE

This is to notify you, in accordance with the provisions of the BIDMC Compliance and Enforcement Code, that you are in violation of BIDMC radiation safety practices. On (dale) the RSO staff identified the following violation:

*(Description of violation)*

In accordance with the provisions of the BIDMC Enforcement Code a written response, co-signed by both you and your supervisor, is due by (dale) and should include the following **corrective actions**:

1. Corrective steps taken and the achieved results.
2. Actions taken to avoid future incidents of non-compliance.
3. The date when full compliance will be achieved.

Although this is only a NOTICE, failure to respond to, or failure to correct this violation could lead to eventual suspension of your work using radiation sources. This practice must not be allowed to jeopardize the BIDMC regulatory compliance program.

Sincerely,

\_\_\_\_\_  
Radiation Safety Officer

Cc: (Supervisor)  
(Department Manager)

Attachment: BIDMC Compliance and Enforcement Policy for Radiation Safety in Non-laboratory Settings

## FORMAT FOR WARNING LETTER

*(Date)*

*(Violator)*

*(Address)*

Re: WARNING

Dear *(Violator)*,

This is to notify you, in accordance with the provisions of the BIDMC Compliance and Enforcement Code, that you continue in violation of BIDMC radiation safety practices. Specifically:

### *(Description of violation and previous response)*

In accordance with the provisions of the BIDMC Enforcement Code and the Compliance and Enforcement Policy for Radiation Safety in Non-laboratory Settings, a written response, co-signed by both you and your supervisor, is due by *(date)* and should include the following **corrective actions**:

1. Corrective steps taken and the achieved results.
2. Actions taken to avoid future incidents of non-compliance.
3. The date when full compliance will be achieved.

Failure to respond to, or failure to correct this violation in a timely manner will lead to suspension of your work using radiation sources. This practice must not be allowed to jeopardize BIDMC compliance programs.

Sincerely,

Radiation Safety Officer

cc: *(Individual involved)*

*(Supervisor)*

*(Chief of Services or Department Director)*

*(Chairman, Radiation Safety Committee)*

Attachment: BIDMC Compliance and Enforcement Policy for Radiation Safety in Non-laboratory Settings

## FORMAT FOR SUSPENSION LETTER FOR PHYSICIANS

*(Date)*

*(Violator)*

*(Address)*

Re: SUSPENSION

Dear *(Violator)*,

This is to notify you, in accordance with the provisions of the BIDMC Enforcement Code, that you continue in violation of BIDMC radiation safety practices, resulting in the suspension of your work using radiation sources. Specifically:

*(Description of violation history)*

In accordance with the provisions of the BIDMC Enforcement Code (enclosed), you must stop all work involving use of radiation sources. A written response to this notice is required to reinstate your ability to work using radiation sources. Your response must be submitted by *(date)* and must include the following:

- I. Corrective steps taken and the achieved results.
2. Actions taken to avoid future incidents of non-compliance.

Please be advised that failure to correct this violation of BIDMC radiation safety practices could result in additional action under the Medical Center By-laws, including disciplinary action reportable to the Board of Registration in Medicine (see Registration Renewal Form question 18\*).

Sincerely,

Gerald M. Kolodny, M.D.  
Chairman Radiation Safety Committee

cc: (Supervisor)  
(Office of Professional Staff Affairs)  
*(Chief of Services)*  
Kenneth F. Sands, M.D., MPH  
Rosemary Kennedy, Radiation Safety Officer

Attachment: BIDMC Enforcement Code and Compliance and Enforcement Policy for  
Radiation Safety in Non-laboratory Settings

\* Board of Registration in Medicine, Registration Renewal Form question 1118 states: *Have you been charged or disciplined for any violation of laws, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or*

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