HENRY FORD HEALTH

HENRY FORD WARREN GRADUATE MEDICAL EDUCATION INTERNATIONAL OBSERVERSHIP POLICY

I. **PURPOSE**: To insure observers, as defined as international medical students or graduates, trying to obtain hospital experience, are appropriately identified, approved and supervised to observe patient care for educational purposes.

II. **SCOPE**: This policy will apply to Henry Ford Warren Hospital Graduate Medical Education Department, individuals seeking observerships at any Henry Ford Warren clinical site, GME training programs, and all faculty sponsors of the observer.

III. **POLICY**: Observerships may be granted on a case-by-case basis and require a two-week notice. The availability of an observership is at the discretion of each GME training program director based on that department's availability of resources. The existence of this policy creates no obligation on the part of a training program or any clinical department at Henry Ford Warren Hospital to provide such an experience. No observer may participate in direct patient contact. They are permitted to observe the interaction of the team with their patients and each other. Observers may participate in discussions and didactic sessions. Please Note: This policy does not apply to resident applicants who return to the hospital for a "second look" day.

IV. **IMPLEMENTATION**: It is the responsibility of all attendings and faculty associates and/or department chairs who sponsor individual observers to implement this policy.

A. Types of Observers:

1. Shadow a resident team at Henry Ford Warren Hospital: Must be accepted by the program director, however, this is a departmental decision. Once accepted, the observer must register with the GME office and complete required paperwork.
2. Shadow an employed physician in their office: Must be accepted by a Henry Ford Warren Hospital Physician Sponsor. This is a departmental decision. Once accepted, the observer must register with the GME office and complete required paperwork.
3. Shadow a private physician in their private office: this is a private matter. The observer may not, under any circumstances, follow the physician to the hospital for patient care activities nor claim to have done an observership at Henry Ford Warren Hospital despite the private physician being on staff.

V. **PROCEDURE**:

A. All individuals who desire to be an observer at Henry Ford Warren and Hospital must be sponsored by a Henry Ford Warren Hospital Program Director, or Faculty member who will be responsible for insuring that the observer is approved through the GME office at Henry Ford Warren Hospital.
B. The sponsoring program director and program coordinator shall be responsible for insuring the observer is appropriately identified as an observer only.
C. All observers must wear an Henry Ford Warren Hospital ID badge, issued by the Security Department, any time they are in Henry Ford Warren Hospital facilities.
D. At the conclusion of the observership, the program coordinator must retrieve the observer's ID badge.
E. Observers must adhere to the Henry Ford Warren Hospital Dress Code Policy, appearing professional at all times. (No open-toed shoes, tank tops, blue jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry, in-tongue/in- face piercings. Scrubs and lab coats are to be worn only when required by a specific department and must be removed when leaving).
F. Observers will not be compensated in any way.
G. Applicants may not apply for more than one (1) 1-week observership.
H. Observers in Radiology and Nuclear Medicine must be issued and wear radiation badges.
I. Observers will not gain entry to the operating room.
J. Observers are expected to bear all costs and expenses including parking, meals, and health screens.

VI. **APPLICATION PROCESS**: Before you begin the application process, all observers must have a pre-arranged attending or faculty sponsor.

A. Observer applicant completes application form and gets required approvals.
B. Completed application is submitted to the GME office.
C. Observer must have an Henry Ford Warren Hospital ID badge issued by the Security Department. The ID badge must designate Observer.
D. If the observer's information is not sent to the Security Department, no ID badge will be issued and the observer will be referred to the GME Office.
E. The GME office will provide updates as needed.

Henry Ford Warren HOSPITAL
GRADUATE MEDICAL EDUCATION

INTERNATIONAL EDUCATIONAL OBSERVATION PROGRAM CHECKLIST

Henry Ford Warren Hospital ("Hospital") is pleased to provide interested international medical students and qualifying medical practitioners an educational experience through observation of patient care, while ensuring patients receive quality care, treatment, and services. To further this endeavor, applicants are required to complete an application, acquire a hospital sponsor, adhere to all health screening requirements, and show proof of healthcare coverage. Applicants may apply for no more than one 1-week observership.

PROGRAM QUALIFICATIONS:

- Applicants must be at least 18 years of age and students or medical practitioners in good standing and have completed at least one year of clinical rotations at the home country's medical school by the application deadline.
- Applicants must be fluent in English to be able to take advantage of this educational opportunity.
- Applicants must be able to obtain a visa on his/her own. Hospital will not sponsor any type of visa for observations.
- Observation opportunities in the NICU are limited and must be approved by the manager in that area.
- Observers in Radiology and Nuclear Medicine must be issued and wear radiation badges.

APPLICATION PROCESS:

All applicants must have the following completed before being allowing to observe. There are no exceptions. We only accept complete application packets. Use this as your checklist:

- ☐ Application form (Attachment A) signed by: the applicant, the sponsor, the department chair or program director, the director of medical education (and the manager, if required). It is the observer's responsibility to secure a sponsor, confirm all dates and requirements and obtain all necessary signatures on the form.
- ☐ Consent for Participation in Observation Program and Confidentiality Agreement (Attachment B); signed by the applicant.
- ☐ Proof of a negative tuberculin test (two TB test within one year). If prior history of a positive tuberculin test: present documentation of testing, chest x-ray results and treatment plan. Each situation will be assessed on an individual basis.
- ☐ Proof of current influenza vaccination for any applicants applying for an observership any time from October through April.

- ☐ Proof of healthcare coverage effective for medical care in the United States, which includes coverage for care at Hospital and/or its affiliates for the duration of the observership. A photocopy of documentation of current coverage is required.

- ☐ A letter of good standing from the Dean of your medical school or the Chief of Staff of your medical facility (Attachment C), stating that you are enrolled/have privileges and have approval for the observership(s), with dates for each, as requested by you.

- ☐ For students/medical practitioners who are not native English speakers:
    - Documentation of a minimum total score of 89, with a minimum section score of 24 for speaking, in the Test of English as a Foreign Language (TOEFL) iBT (internet-based test). For information on TOEFL in your country, please visit their website: www.toefl.org Verification (by the Dean of the medical school or Chief of Staff) of English as the primary language of medical school instruction or primary language of medical practice is also acceptable. (See Attachment C).

- ☐ A Curriculum Vita, in English, with a statement of your long-term plans in the medical profession.

- ☐ Photocopy of a photo ID; this can include a valid driver's license, state ID, school ID, or passport presented on or prior to the first day of observership to Henry Ford Warren Hospital (HFWH) Security Department to secure a pictured ID badge.

- ☐ Submit completed application packet to:

    Michelle Markewicz or Kara Ramos
    mmarkie1@hfhs.org
    kramos2@hfhs.org

RESPONSIBILITIES OF OBSERVERS:

All observers are expected to bear all costs and expenses incurred by the observer, including parking and meals, and health screenings.

All observers are expected to adhere to the dress code: no open-toed shoes, tank tops, blue jeans, exposed midriffs, heavy perfume or cologne, dangling jewelry or in-tongue or in-face piercings. Scrubs and/or lab coats are to be worn only when required by a specific department and must be removed when leaving. All observers are expected to comply with all Hospital policies and procedures.

APPROVAL OF OBSERVER VISIT AND ADDITIONAL HOSPITAL RIGHTS:

By participating in this program, observers gain no rights or authority with respect to Hospital or its patients. In addition to all other rights, which are explicitly reserved by Hospital, Hospital reserves the right, in its sole and absolute discretion to:

1. Approve or disapprove of any observer or requested observation, for any legally permissible reason whatsoever.
2. Discontinue the observational program for any reason whatsoever.
3. Remove an observer from the observational program and/or Hospital facilities, for any legally permissible reason whatsoever.

ATTACHMENT A

HENRY FORD WARREN HOSPITAL

GRADUATE MEDICAL EDUCATION

OBSERVATION APPLICATION

TO BE COMPLETED BY THE OBSERVER:

PERSONAL INFORMATION			
Name:			Date of Birth:
Home Address:	City, State:		Zip Code:
Home Phone:	Cell Phone:	Email:	
Emergency Contact Name:	Home Phone:	Cell Phone:	Work Phone:

HOSPITAL DEPARTMENT INFORMATION			
Department:	Start Date:	End Date:	# of hrs/wk requested:
Please describe why you are interested in doing an observation in this area:			

I certify that the statements made in this Observation Application are true and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release the hospital from any liability whatsoever for supplying such information.

_____ _____

Applicant Signature Date

TO BE COMPLETED BY THE SPONSOR:

Department:	Phone:
Attending Physician Sponsor:	Phone:
Contact Person Observer Reports to at Hospital:	Phone:
Location:	

I will follow the Hospital's Observation Policy and will ensure the above individual is supervised while they are on the Hospital campus. Also, in accordance with this policy, I will ensure the individual completes all procedures and paperwork prior to beginning the observation.

Attending Physician Sponsor	Date

Approved by:

Manager (if required)	Date
Residency Program Director or Department Chair	Date
Director, Medical Education	Date

ATTACHMENT A

HENRY FORD WARREN HOSPITAL
GRADUATE MEDICAL EDUCATION

CONSENT FOR PARTICIPATION IN OBSERVATION PROGRAM AND CONFIDENTIALITY AGREEMENT

I understand that I/my child will be participating in the Educational Observation Program (the "Program") at Henry Ford Warren Hospital ("Hospital"). I understand that, in participating in the Program, I/my child will be exposed to the normal risks of any hospital visitor, as well as possible additional risks that arise because I/my child will be in patient care areas and observing patient care.

I understand that I/my child will at no time be allowed to give patient care, touch patients or instruments, or make entries into the patient chart or any other hospital document. I understand my/my child's role is simply to observe patient care and/or procedure(s), and at no time may I/my child participate in any patient care or procedure(s) observed. I understand that I/my child may experience physical and emotional reactions to the observation experience, which could cause me/my child to experience physical/or emotional injury. I hereby agree to release, indemnify and hold harmless Hospital, its medical staff members, employees, and agents from all liability related to my/my child's observation experience.

I understand and agree that I waive, for myself, my child, and any heirs and/or assigns, any and all claims, including any negligence claims which I or my child might have against the Hospital, or its agents or representatives, in any way arising from or relating to the Program, except for claims arising out of gross negligence or reckless or willful misconduct of Hospital or its agents, or representatives. I hereby agree that I will not sue Hospital from any claims I/my child, may have against it except for gross negligence or reckless or willful misconduct on the part of Hospital, its trustees, officers, agents, and employees. I also hereby agree that I will, for myself, my child, and any heirs and/or assigns, indemnify and hold hospital harmless against any and all claims or liabilities, including any negligence claims, for damages that I or my child cause to Patients and/or the Hospital, or its agents or representatives, in any way arising from or relating to the Program.

In the event of exposure to blood or other bodily fluids from a patient who is a carrier of a contagious or infectious disease or a patient who is, in the judgment of Hospital, at risk of carrying a contagious or infectious disease, Hospital shall, with my consent, administer immediate precautionary treatment to me/my child that is consistent with current medical practice without any further consent from me. I shall pay for the initial screening tests or prophylactic medical treatments should the need arise. Hospital shall have no responsibility for any further diagnosis, medication or treatment and I acknowledge and assume the risk of me/my child observing or being in the immediate presence of patents at risk of carrying a contagious or infectious disease. I/my child hereby forever release and discharge all claims and causes of action whatsoever, present and future, against Hospital, its directors, officers, employees and agents, related to or arising out of any illness, disease or health condition I/ my child may contract, develop or come into contact with while on the premises of Hospital.

I certify that I/my child has no known physical or mental illness or condition, including any contagious disease, which could be detrimental to the welfare or interfere with the care of any of Hospital's patients or staff. I certify that I/my child am/is currently covered by health care insurance or Medicare/Medicaid and that it shall remain in effect through the end of my/my child's participation in the Program.

I understand that Hospital does not view this observational experience as subject to the Family Educational Rights and Privacy Act ("FERPA") and I/my child will be given no confidentiality consideration under FERPA.

I/my child will wear appropriate attire for this Program. Participants may not wear open toe shoes, sleeveless shirts, blue jeans, tank tops, exposed midriffs, heavy perfume or cologne, dangling jewelry or jewelry in-tongue or in-face piercings. I/my child will not be permitted to remain at Hospital unless dressed appropriately. I/my child will obtain and wear appropriate hospital badging pursuant to facility requirements, returning such badge and any other hospital property at the termination of the observation period.

I/my child agree to conform to all Hospital policies and procedures including those relating to safety, patient care and non-discrimination. These policies and procedures include all standards covered by the Hospital Code of Conduct, the Joint Commission, infection control standards, safety standards, confidentiality standards, and Occupational Safety and Health Administration (OSHA) requirements.

In addition to the above matters, I/my child also understand the following:

> Confidential means that something is to be kept private or secret and it is not to be repeated to anyone or given to anyone.
>
> Confidential Information means any and all information that I may learn about the Hospital or a patient at Hospital. This information is automatically private or secret and is not to be repeated to anyone or given to anyone. Confidential information about a patient includes: name, address, diagnosis, medical information, medical notes, resumes, pictures, and medical records including x-rays and medicines, as well as any descriptive that could cause any person to become aware of the identity of a patient. Confidential information also includes the name of any person at Hospital who is not Hospital employee or volunteer.
>
> Disclosure means sharing or telling someone something I know about someone that is private or confidential.
>
> Nondisclosure means not sharing or telling someone something. It means not to write, speak, or gossip about any patient I see or talk to at Hospital.
>
> As an observer, I am governed by the same code of ethics that applies to physicians, nurses, and all other hospital employees. Patients expect the hospital to keep their charts, medical information, and even the fact that they are in the hospital confidential. This understanding between the patient and Hospital is an implied contractual agreement and is legally enforceable through HIPAA (the Health Insurance Portability and Accountability Act of 1996) and the Health Information Technology for Economic and Clinical Health (HITECH) act.

I understand that while I am observing at Hospital, I may obtain Confidential Information about Hospital's patients. I understand that Program participants are to maintain in strict confidence all information and data relating to Hospital's patients, and shall not disclose such information to any third party, including any family member or friend, under any circumstances. Additionally, confidential information is not to be removed from Hospital. I understand that patient confidentiality is of such significant importance that it is never to be disclosed to anyone outside of Hospital no matter how long after participating in the Program.

I understand that I will not be permitted to engage in patient care. I agree that in the presence of a patient or in any patient care areas, I will not be asked or allowed to answer questions about a patient's care or treatment, or otherwise provide medical or professional opinions. I agree to follow the directives of the physician sponsor wile in patient care areas. I understand that I am on Hospital property at my own risk and insurance coverage, and that I will not be indemnified/insured by Hospital. I understand that for any reason in Hospital's sole discretion, I am to act as an observer and may be withdrawn and I may be asked to leave immediately. I understand that I have no implied rights of employees, contractors or facility medical staff.

By signing this form, I agree that I have read, understand, and agree to the terms in every page of this consent form and confidentiality agreement. I give my full consent to my participation in the Educational Observation Program at Henry Ford Warren Hospital.

Observer:

Print Name	Signature of Applicant
Name of School (if applicable)	Date

ATTACHMENT C

Henry Ford Warren Hospital Graduate Medical Education

DEAN/CHIEF OF STAFF LETTER

TO BE COMPLETED BY THE DEAN, REGISTRAR OF MEDICAL SCHOOL OR CHIEF OF STAFF OF MEDICAL FACILITY:

I confirm that _____ is a full-time medical student or medical practitioner in good standing at the school/facility listed below and has permission to be an observer at Henry Ford Warren Hospital FROM _____ (Start Date) TO _____ (End Date).

I hereby certify that this medical student/medical practitioner has completed at least one year of clinical rotations.

Medical School/Facility:_____

Address of Medical School/Facility:_____

_____ _____

Signature Date

_____ _____

Printed Name Contact Phone Number

_____

Title

English is the primary language of medical school instruction/medical practice? ☐ YES ☐ NO

[Affix School or Medical Facility Seal]

Please submit this form directly from the Medical School/Facility to Henry Ford Warren Hospital, Graduate Medical Education Department. It must not be submitted by the student/practitioner. Email directly to:

Michelle Markewicz or Kara Ramos
Henry Ford Warren Hospital

EMAIL: mmarkie1@hfhs.org and
kramos2@hfhs.org