



THE UNIVERSITY
of TEXAS

MEDICAL SCHOOL
AT HOUSTON

*A part of The University of Texas
Health Science Center at Houston*

**Internal Medicine
Residency Training Program
Policies and Procedures Manual
2010-2011**

Effective July 1, 2010

Section I: General Information about the Internal Medicine Residency Program

- A. Definitions and Descriptions**
- B. Program Overview**
- C. Program Leadership**
- D. Program Staff**
- E. Affiliated Institutions**
- F. Level of Training**

Section II: Internal Medicine Policies and Procedures

- A. Appointment and Reappointment**
- B. Professional Attire and Etiquette**
- C. Structure of Program**
- D. Educational Aspects of the Program**
- E. Schedules**
- F. Evaluation and Advancement**
- G. Educational Meetings/Conferences**
- H. Inpatient Services**
- I. Hospital Admissions**
- J. Medical Records and Clinical Documentation**
- K. Moonlighting**
- L. Duty Hours**
- M. Grievances**
- N. Corrective and/or Adverse Actions**
- O. Conditions of Separation**
- P. General Information**
- Q. Exposure to Infectious Diseases**
- R. Departmental Conference**
- S. Attendance**
- T. Procedures and Skills**
- U. Teaching Functions of the Residents**

Section I: General Information about the Internal Medicine Residency Program

A. Definitions and Descriptions

B. Program Overview

C. Program Leadership

D. Program Staff

E. Affiliated Institutions

F. Level of Training

A. DEFINITIONS AND DESCRIPTIONS

Resident: The term “Resident” encompasses all Internal Medicine Residency and Internal Medicine Pediatrics Program trainees from PGY1 to PGY 4.

Intern: The term “Intern” refers to trainees who are going into or are currently in their first year of training as a PGY1.

Upper Level: The term “Upper Level” refers to trainees in their second year of training to their 3rd year for Categorical’s and 4th year for Internal Medicine Pediatrics Residents.

B. PROGRAM OVERVIEW

The mission of the University of Texas Houston Internal Medicine Program is to prepare each trainee for a successful career as a Physician. We strive to provide an excellent foundation for each trainee so that no matter which career path is chosen, he/she will have the ability to excel. Training encompasses the development of a high level of clinical skills, as well as a strong fund of knowledge of the pathophysiology, manifestations, and principles of treatment of diseases generally seen by internists.

One of the fundamental principles of Internal Medicine training is the progressively increasing degrees of responsibility that Residents are given for the care of patients. The principles of patient care demand that the attending physician retain ultimate responsibility for the welfare of his or her patients, however, this rule allows delegation of authority to the Residents for management of patients on a day to day basis. Attending physicians will delegate progressively more and more authority to the house officer as he or she progresses through the training program. Acceptance of this responsibility requires that the Housestaff have time to assess the patient, to develop a reasonable formulation of the patient’s problems, and to propose a plan of management. With the concurrence of the attending physician, the plan of management may then be undertaken by the Resident. Additionally, the attending physician has an obligation to teach general and/or subspecialty internal medicine to the Residents. This teaching is best carried out in the context of the immediate clinical situation. The attending physician and Residents should work together for the benefit of the patient.

Throughout their training, the Residents are exposed to several different kinds of clinical experiences. At Memorial Hermann Hospital, M.D. Anderson Cancer Center and Lyndon B. Johnson General Hospital, there are inpatient services staffed by full time faculty. At Memorial Hermann and St. Luke’s Episcopal hospitals, there are also patients under the care of voluntary faculties of the University of Texas Medical School and Baylor College of Medicine respectively. There are rotations through general and subspecialty inpatient services and outpatient clinics, medical intensive care, coronary care units and emergency rooms. All categorical Housestaff attend a weekly continuity clinic.

The first year resident serves as an intern on inpatient services, outpatient clinics, emergency departments and critical care units. The upper level schedule consists of a

combination of inpatient services and critical care units, emergency departments, outpatient clinics, and subspecialty consultation services. The consultation services allow the resident to develop in-depth knowledge about specific areas of internal medicine and permit close personal interactions with members of the faculty. Furthermore, residents can participate in some specialized technical procedures during their subspecialty rotations. There is also the opportunity to rotate through general internal medicine consultations, during which the resident acts as a consultant to other departments.

In scheduling rotations, we consider four factors. First and most important is educational value. Over the three years, the resident should rotate through most or all of the major medical subspecialties. The second is the requirement of the American Board of Internal Medicine that there be at least twenty-four months of “meaningful patient responsibility” in the three year residency. The third factor is the requirement for staffing of our inpatient and subspecialty consultation services. The fourth is the preference of the resident for particular subspecialties. We try to arrange for each resident a reasonable mixture of the various experiences available in this training program.

C. PROGRAM LEADERSHIP

Our faculty strives to be distinguished for its scientific, clinical and teaching excellence in all major disciplines within the broad field of internal medicine. Attainment of this goal requires the operation of an excellent Resident training program. Therefore, the residency program is of the highest departmental priority. All physicians on the faculty are expected to teach and make contributions to the Residency training program. The ultimate responsibility for administration of the training program rests with the Vice Chair of Medicine for Education and Program Director for Internal Medicine, Dr. Philip Orlander, who is aided with the administration of the program by the Associate Program Directors and the Assistant Chiefs of Service (also known as the Chief Medical Residents). The Programs overriding consideration for decisions of policy is the education of the Residents.

The faculty and the departmental administration are fully aware of the many sacrifices made by house officers for their training. We also understand that personal or professional problems may distract a Housestaff officer from his or her training. We therefore urge that any such problems be brought to the attention of the Program Directors or Chief Medical Residents. We will work with whatever means possible towards the satisfactory resolution of any problem, in strictest confidence.

We encourage the Residents to take full advantage of the knowledge and enthusiasm of the faculty, by seeking them out. We expect the faculty to encourage this type of interaction and dialogue.

DEPARTMENT LEADERSHIP

David D. McPherson, M.D.
Chair, Department of Internal Medicine
Director, Division of Cardiovascular Medicine
Medical Director, Heart and Vascular Institute, Memorial Hermann Hospital – TMC
Executive Director, Center for Clinical and Translational Sciences
Professor of Medicine

PROGRAM LEADERSHIP

Philip R. Orlander, M.D.
Assistant Dean for Educational Programs
Vice-Chair of Medicine for Education
Program Director, Internal Medicine Residency Program
Director, Division of Endocrinology, Diabetes and Metabolism
Professor of Medicine

Mark A. Farnie, M.D.
Program Director, Medicine/Pediatrics Residency Program
Associate Professor of Medicine
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Senior Associate Program Director, Internal Medicine Residency Program
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Assistant Professor of Medicine

Brett Stephens, M.D.
Associate Program Director, Internal Medicine Residency Program
Assistant Professor of Medicine

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Associate Program Director, Internal Medicine Residency Program
Assistant Professor of Medicine

LEADERSHIP AT OUTSIDE HOSPITALS

Robert A. Wolff, M.D.
Director of Educational Programs, MD Anderson Cancer Center
Professor, GI Medical Oncology

Herbert L. DuPont, M.D.
Vice Chair, Department of Medicine, Baylor College of Medicine
Chief, Internal Medicine Service, St. Luke's Episcopal Hospital
Clinical Professor of Medicine

Barry J. Zeluff, M.D.
Assoc Chief and Director, Education, Internal Medicine Service, St. Luke's Episcopal Hospital
Associate Director, Medicine Residency Program, Baylor College of Medicine
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D. PROGRAM STAFF

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Residency Program Office Contact Information

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Department of Internal Medicine
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Houston, TX 77030
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E. Affiliated Institutions

The Internal Medicine Residency Program is housed in the University of Texas Medical School Building (MSB) located at 6431 Fannin, Ste 1.134, Houston, TX 77030. Housestaff rotate through Hospitals inside and outside of the Medical Center.

Hospitals

Hospitals affiliated with The University of Texas Health Science Center at Houston ("UTHSC-H") for the purpose of the Residency Training Programs include:

- a. Memorial Hermann Hospital-TMC
- b. Memorial Hermann-TIRR
- c. Lyndon B. Johnson General Hospital (Harris County Hospital District)
- d. The University of Texas M.D. Anderson Cancer Center
- e. St. Luke's Episcopal Hospital

Clinics

Clinics/Ambulatory Settings affiliated with The University of Texas Health Science Center at Houston (“UTHSC-H”) for the purpose of the Residency Training Programs include:

- a. University of Texas Professional Building (UT Physicians)
- b. UT Health Center (West Loop Clinic)
- c. Thomas Street Clinic (Harris County Hospital District)

F. Level of Training

Progressive levels of training in the Program are designated as Post Graduate Year (“PGY”) 1 through 3 for Internal Medicine Categorical and 1-4 for Internal Medicine/Pediatrics, e.g. PGY-1 is the first year of post-M.D. clinical training. A physician more than one year out of medical school may nevertheless be appointed to a PGY-1 position. After the PGY-1 appointment term, the PGY level to which a Resident is appointed will be determined by the Program Director, in consultation with the Department Chair and other faculty, based on the Resident’s level of education, experience, and demonstrated ability, clinical performance, and professionalism.

Section II: Conditions of Appointment for Graduate Medical Education

- A. Appointment and Reappointment**
- B. Professional Attire and Etiquette**
- C. Structure of Program**
- D. Educational Aspects of the Program:**
- E. Schedules**
- F. Evaluation and Advancement**
- G. Educational Meetings/Conferences**
- H. Roles and Responsibilities of Residents**
- I. Inpatient Services**
- J. Hospital Admissions**
- K. Procedures and Skills**
- L. Medical Records and Clinical Documentation**
- M. Moonlighting**
- N. Duty Hours**
- O. Grievances**
- P. Corrective and/or Adverse Actions**
- Q. Conditions of Separation**
- R. General Information**
- S. Exposure to Infectious Diseases**
- T. Disaster Preparedness Plan**

A. APPOINTMENT AND REAPPOINTMENT

Appointment

Applicants to the Internal Medicine Program must meet one of the following criteria to be eligible for appointment to the Program:

- Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
- Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
 - (a) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment, or,
 - (b) Have a full and unrestricted license to practice medicine in a US licensing jurisdiction in which they are training.
- Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME accredited medical school.

Generally, a Notice of (Re-) Appointment will be issued to an “on-cycle” Resident no earlier than four months prior to the Resident’s proposed start date. The appointment will generally extend for a period encompassing the PGY year, typically 12 months; Residents may be appointed for shorter time periods at the discretion of the Program Director. Residents may not have concurrent agreements, appointments, and/or contracts with other hospitals or institutions while under appointment to the Program. To be fully effective, the Notice of Appointment is signed by the Resident and an authorized representative of the Medical School on behalf of the Foundation.

** Only J-1 Visas are issued.

Promotion and Reappointment

Promotion to the next level of training and/or reappointment is made annually at the discretion of the Program Director. The decision to promote and/or reappoint a Resident (hereinafter “Resident”) will be based on performance evaluations and an assessment of the Resident’s readiness to advance (including, but not limited to attainment of the ACGME Competencies at the respective level of education, experience, demonstrated ability, clinical performance, and professionalism).

In order to receive credit for a month, the Resident must work at least two (2) weeks of that month. Any rotations where a resident received an overall rating of “Unsatisfactory” will need to be repeated. Interns, who, in the opinion of the Program Director, Chairman and other pertinent faculty are not prepared for the responsibilities of an upper level resident, may be offered the opportunity to extend his or her internship up to one year. Interns who fail to successfully complete the repeat of a PGY-1 year will not have their contract renewed.

In instances where a Resident will not be promoted and/or reappointed, the Program Director will provide the Resident with a written notice of intent not to promote and/or not to reappoint no later than four months prior to the end of the Resident's current appointment term. However, if the primary reason(s) for the nonpromotion and/or non-reappointment occur(s) within the four-month period preceding the end of appointment term, the Program Director will provide the Resident with as much written notice of the intent not to promote and/or reappoint as circumstances will reasonably allow.

B. PROFESSIONAL ATTIRE AND ETIQUETTE

Resident's should always dress and behave in such a way as to earn the respect of patients, nurses, students, fellow physicians, and other hospital personnel. White coats should be worn on the wards and in the clinic; the names embroidered on the coats should be clearly and easily visible. Residents are expected to dress in professional attire and to demonstrate good personal hygiene and cleanliness. Scrubs may be worn on weekends and "after hours" during on call shifts.

Business cards are issued to each resident. Residents should always keep business cards handy to distribute to patients in an effort to cultivate strong patient-physician communication.

C. STRUCTURE OF THE PROGRAM

The Internal Medicine Residency Program is 36 months of Graduate Medical Education. There are at least 32 rotations available for Residents in the Program and each resident can expect an experience in the following rotations:

Intensive Care Unit MHH/LBJ *	Cardiology Consults MHH/LBJ (Upper Level)
Ambulatory MHH/LBJ	Endocrinology Consults MHH/LBJ (Upper Level)
General Medicine Wards MHH/LBJ	Geriatrics MHH/LBJ (Upper Level)
Emergency Room LBJ	Gastroenterology Consults MHH/LBJ (Upper Level)
Coronary Care Unit MHH	Hematology Consults MHH/LBJ (Upper Level)
Renal Wards MHH/LBJ	Infectious Diseases Consult MHH/LBJ (Upper Level)
Gastroenterology Wards MHH/LBJ	Pulmonary Consults MHH/LBJ (Upper Level)
Hepatology Wards MHH/LBJ	Renal Consults MHH/LBJ (Upper Level)
Float MHH/LBJ	Rheumatology Consults MHH/LBJ (Upper Level)
Oncology Consults LBJ	

* Intensive Care Unit :Total required emergency medicine experience will not exceed 3 months in a 3-year residency. Total Required critical care experience will not exceed 6 months in a 3-year residency. If a resident requests critical care electives, the total experience may not exceed 8 months.

Medical Licensure

Housestaff should obtain a valid Texas Medical License when possible. The major requirements for licensure in Texas are graduation from an accredited medical school, one year of satisfactory postgraduate training, and successful completion of the USMLE examinations and the Jurisprudence Examination.

Graduates of foreign medical schools will become eligible for licenses after three years of residency training. Licensure information may be obtained from the house staff office.

If you are licensed while still completing residency training, you must maintain your license and ensure that the Residency Program has your current information. If you allow your license to expire, you will be unable to perform your Residency duties until it is renewed.

D. EDUCATIONAL ASPECTS OF THE PROGRAM

The Internal Medicine Residency Program values education of our Residents above all else. Each Policy and/or Procedure is formulated with this in mind. Educational experiences of the program include interactions with residents, fellows and attending physicians, as well as attendance at conferences and teaching rounds. All patient care activities in which residents are engaged must be supervised by attending physicians.

E. SCHEDULES

Monthly Schedules

Each Resident's schedule is formulated so that by the end of training, he/she will satisfactorily have completed 36 calendar months, including vacation time, of accredited graduate medical education and will be eligible to sit for the Boards. The educational efforts of faculty and residents are designed to enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training occurs in the ambulatory setting and at least 1/3 occurs in the inpatient setting.

Resident's monthly schedules are posted on AMION on June 24 of each year (<http://www.amion.com>; password uthim) and updated there as well. Should there be a valid reason a resident would need to change his/her schedule, the request must be made in writing to the Assistant Chiefs of Service in charge of scheduling. All changes are reviewed by the Assistant Chiefs of Service and the Program Director because of the needs for staffing of services, and the requirements of the American Board of Internal Medicine and the ACGME.

Every rotation lasts an entire month. As part of the Residents appointment to the Program, it is agreed that he/she will comply with the rotation requirements as stipulated by the Program Director. In order to get credit for an assigned rotation, you must complete a total of 14 days of the month; Factoring in one day off every seven days, residents must work a total of **12 days** to get this credit.

No extra time off will be given for completion of USMLE Step exams. Also, residents interviewing for fellowship opportunities, attending classes, or other elective endeavors must arrange their own coverage. No coverage will be provided for the above situations and the Resident must arrange their own coverage or use a day off for this. If no coverage is found by the resident, they must report to their assigned duties that day.

Vacations and Time Off

Residents classified as PGY-1 are permitted the equivalent of two (2) calendar weeks of vacation each year.

Residents classified as PGY-2 and above are permitted the equivalent of three (3) calendar weeks of vacation each year.

The Resident must coordinate vacation scheduling with the Internal Medicine Residency Program, as well as with the Assistant Chief of Service in charge of scheduling to ensure adequate coverage of services. No more than two (2) consecutive week's vacation may be taken without permission of the Program Director. The vacation schedule is incorporated into the yearly master schedule. A Resident is not eligible to accumulate annual vacation. A Resident leaving the Program will not be compensated for unused vacation.

Residents are provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period. It is the obligation of the Resident who is off to coordinate with his/her team members to ensure that days off are staggered and not more than one intern is away at a time. Patients of a resident who are off should be covered by other residents on the team.

Requests for a change in vacation schedule should be turned in to the Internal Medicine Residency Office, MSB 1.134, at least three months in advance and are subject to the approval of the Assistant Chiefs of Service and Program Director.

Ready Reserve/Jeopardy Call

The Ready Reserve is for emergencies only. The Chief Resident Float Pager (22001) must be called by 6:00 am on a sick day to get somebody pulled for an illness. If you do not inform the chief residents by 6:00 am, then you will be expected to show up for your rotation until coverage is found for you. In addition, any absences for more than 24 hours will require a physician visit and note (this can be your PCP, the ER or the student health center).

It is important to note that if you require someone to be pulled for you, then you must pay them back on a 1:1 basis. For example, if someone is pulled for an overnight call for you, then you owe them a call night of their choice. If you fail to comply with this responsibility, you will be formally scheduled to do so. Failure to report this obligation will be considered dereliction of duty, and the appropriate actions will be taken. In addition, schedule preference forms filed by 1st and 2nd year residents that do not comply with the 1:1 payback rule, will be given lowest priority for scheduling the following year's rotations.

Any other time off not scheduled or outlined above must be cleared with the Chief Medical Residents. If time off is taken or a change in the schedule is made to accommodate the request, this will be noted for future reference.

Sick Leave/Leave of Absence

Paid **Sick Leave** accumulates at a rate of one (1) day (eight (8) hours) each month and accumulates to a maximum of thirty (30) days. Paid sick leave carries forward from year to year, but will not be compensated upon termination or graduation from the program. In the event an illness exceeds accumulated paid sick leave and vacation time, a leave of absence without pay may be granted by the Program Director.

All requests for **Leave of Absence** must be approved by the Program Director in accordance with applicable state and federal laws and accreditation requirements. An extended LOA, which exceeds the twelve (12) week allotment, **may** necessitate resignation from the Program. The Resident may seek reappointment to the Program at a later date.

LOA may be comprised of paid leave (including both paid sick leave and vacation) and/or leave without pay (LWOP). When LOA is requested for a medical reason (including pregnancy), the eligible Resident must exhaust all accumulated paid sick leave and accumulated vacation prior to beginning any LWOP.

Consistent with the Federal Family and Medical Leave Act of 1993 (FMLA), the University of Texas System – Medical Foundation will grant up to 12 calendar weeks of leave in a 12-month period to residents. Family and medical leave may be granted for one or more of the following reasons:

- Birth of son/daughter and care after such birth;
- Placement of son/daughter for adoption or foster care;
- Serious health condition of spouse, child, or parent of resident; or
- Serious health condition of resident (unable to perform the functions of his or her position)

The duration of LOA must be consistent with satisfactory completion of training (credit toward specialty board qualification), which will be determined by each department in consultation with the GME office.

A Resident may continue both his or her personal insurance coverage and dependent insurance coverage's during a period of LOA at his or her own personal expense. Arrangements for these premium payments must be made prior to the commencement of the leave. The program is responsible for payment of the resident's portion of the premium when the LOA qualifies under the Family Medical Leave Act.

Twelve (12) weeks are allowed for **Leave** consistent with the Family and Medical Leave Act of 1993. The Internal Medicine trainee will be paid for an appropriate amount of leave time, beginning with sick leave and following with any remaining vacation. After all of these options have been exhausted, the resident will be put on Leave of Absence (LOA). Once the resident has been put on LOA he/she will not receive their monthly stipend. The department will pay for benefits only when all sick leave and vacation has been exhausted.

The first four (4) weeks of leave are consistent with the ABIM policy and therefore no make up rotations are required. The ABIM allows up to 3 months leave for vacation time, parental leave, or illness in a 36 month training period. Trainees may take up to one month per year of training. Training must be extended to make up any absences exceeding the one month per year of training.

The Department tries to maintain a flexible and reasonable policy concerning maternity leave. As rearrangement of schedules will likely be necessary, **you must notify the program director, as well as one of the residency coordinators, as soon as you know that you or your spouse is pregnant!**

Holidays

Residents are not subject to the UTHSC-H holiday schedule. Any holidays taken are at the discretion of the Program Director based on staffing needs for full coverage of services that will be operating during any "holiday" period. Time off must be approved in advance.

All residents get an additional 4 day vacation around the holiday of choice, depending on the schedule and need for coverage. During this time, while the Resident is on holiday, the remainder of the Residents will cover the ward and emergency services. There will be no other Holidays allotted to the Resident besides the one chosen.

F. EVALUATION AND ADVANCEMENT

Interns and Residents must successfully complete the clinical and educational requirements in order to be promoted to the next level, or to complete the program. The decision to reappoint will be based on performance evaluations, participation in conferences and lectures, mastery of the six core competencies delineated by the ACGME and an assessment of the resident's readiness to advance.

Interns, who, in the opinion of the Program Director, Chairman and other pertinent faculty are not prepared for the responsibilities of an upper level resident, may be offered the opportunity to extend his or her internship up to one year. Interns who fail to successfully complete the repeat of a PGY-1 year will not have their contract renewed. Interns and residents who are not being offered a reappointment will receive written notice no less than four (4) months prior to the end of his or her current contract.

At mid-month and at the end of the month, residents will meet with their attending physicians to review their progress. At the end of the month, they should meet with the attending to review the evaluation form. On each rotation, performance is evaluated by the attending physician through an on-line evaluation system. Before an evaluation is considered complete, it must be acknowledged or protested on-line by the resident.

Resident evaluations are available online at the end of the month and email reminders will be automatically sent to each resident and attending. The attending will fill out his or her evaluation on the resident and the resident will fill out an evaluation on both the attending and the rotation. When a resident has completed his/her evaluation of the attending, he/she will be able to view the comments made by the attending physician applicable to the rotation. Residents are given the opportunity to respond to comments made by the attending, if they wish. The evaluations are sent out on the 25th of each month and requested to be completed before the 9th of the following month.

Residents will also be asked to evaluate other residents, interns, fellows and medical students that they work with each month.

The online evaluation system developed by UT Houston can be found at:
<https://gmeis.uth.tmc.edu/gmeis/index.jsp>

Evaluation of advancement of the Residents is performed by the Chairman and Program Directors, with the advice of the Internal Medicine Directors at M.D. Anderson and St. Luke's hospitals, and the Assistant Chiefs of Service. These reports are printed and kept in the

resident's permanent file in the Residency Program office. A resident may review that file any time he or she wishes. Progress of residents is reviewed regularly by the Residency Clinical Competency Committee, which meets monthly.

Resident Evaluations

Resident evaluations occur on a monthly basis. The evaluations are an analysis of the Residents performance during the month based on the 6 ACGME core competencies.

Any rotations where a resident received an overall rating of "Unsatisfactory" will need to be repeated.

Rotation Evaluations

Rotation evaluations are an opportunity for the Residents to evaluate their experience on each Rotation. These evaluations are assigned monthly and the Resident assesses patient diversity, workload, responsibility, and supervision amongst other things. The Program Director utilizes these evaluations in his/her review of the Programs curriculum.

Peer Evaluations

Peer evaluations are completed and submitted by team members that rotated with the resident for the month.

Attending Evaluations

Attending evaluations are Residents evaluations of their attending for the month that the Resident worked with him/her. This evaluation can be completed anonymously by the Resident and gages the attending's availability, teaching ability, patient care and professionalism, medical knowledge, support for the resident and attending feedback.

Resident Self-Evaluations

This self assessment is completed by the resident at the end of his/her training and discussed with them in their 6 month evaluation meeting with the Program Director. The program Director has also completed an assessment of the trainee to compare.

Six Month Evaluations

These evaluations are completed by the Program director and summarize the residents progress over the previous six month period. Residents meet with the Program Directors semi-annually and discuss educational progress, performance in the program and provide career counseling.

Clinical Evaluation Exercise

During the PGY-1 year, the clinical skills of each resident will be formally evaluated by a member of the faculty. This exercise requires that the faculty member observe the

resident perform a history and physical examination, and then discuss the diagnosis and plans for management with the house officer. If the evaluating physician believes that further improvement of clinical skills is desirable, the exercise will be repeated at later stages of training. Satisfactory completion of the Clinical Evaluation Exercise is required before we will declare the house officer to be eligible for the examination of the American Board of Internal Medicine.

Each resident will receive an email on about the first week of September with the CEX form attached which will include instructions for completion and will be due no later than the last day of October. It is the residents responsibility to print out the form, take it to the assigned clinic attending, or hospital attending, and have it completed. After both the attending and resident sign it, it should be delivered to the Program Coordinators.

In-Training Exam

The In-Training Examination by the American College of Physicians is mandatory for all residents. It is administered in October of every year and all categorical residents will sit for the exam each year. You will be excused from clinical duties on that day and you will take the 8 hour exam in two sessions. Lunch will be provided by the program on that day.

Problems and Complaints

If a resident received an unsatisfactory evaluation from any attending physician, one of the program directors will discuss the matter both with the attending physician and the house officer. The outcome of these meetings will be improved understanding of what is expected of the house officer and, if necessary, plans for improvement of performance. Written records of these discussions will be kept in the house officer's file. If there are issues that come up during a rotation, the resident should discuss it first with the attending and then, if necessary, with a program director.

In the event that a patient, house officer, faculty member, member of the hospital administration or nursing staff registers a complaint regarding a member of the Resident, that complaint will be investigated thoroughly. If there appears to be substance to the complaint, the house officer will be asked to discuss the situation with one of the program directors. If desired, the house officer may write a formal rebuttal which will become part of his or her record. If the program director concludes that the complaint was unjustified, no further record will be maintained of the incident. If it is concluded that there has been misconduct warranting disciplinary action, that action will be subject to the rules set forth by the Medical Foundation and outlined explicitly in the resident's contract.

Retaliation

The Program encourages Resident's and Attending's to open and honestly evaluate as is appropriate in the spirit of constructive evaluation. This program does not condone or tolerate retaliation. Should a resident feel that he/she is being retaliated against for any reason, this should be reported to a Program Director immediately for review and proper action.

G. EDUCATIONAL MEETINGS AND CONFERENCES

Scholarly activities are encouraged among the residents. Part of this is attendance at national meetings for Internal Medicine or its subspecialties. Residents who wish to attend medical or scientific meetings must obtain prior approval from their attending physicians and the program director. Coverage for your absence from service must be arranged by the resident ahead of time. The Assistant Chiefs of Service will not pull residents from the Jeopardy Call Pool to provide coverage for a resident's duties while they are away.

There are several Internal Medicine conferences held weekly. Attendance by Residents is mandatory and will be monitored with sign-in sheets. These mandatory conferences are as follows

Morning Report

Morning Reports are offered Mondays from 1-2 and Wednesdays and Fridays from 1-1:40 PM at the Medical School Building (for those rotating at Memorial Hermann) and in the UT Annex building (for those rotating at LBJ Hospital). These conferences are designed to bolster critical thinking on the part of the Residents by developing presentation skills as well as refining their clinical approach to patient problems. Residents and Interns are responsible for presenting clinical cases for discussion.

Core Curriculum Lectures

This is a one-year series of lectures delivered by the Core Faculty/Core Faculty designee. Each subspecialty presents on commonly seen disease processes in Internal Medicine and these presentations are designed to prepare Residents for practice as well as for the American Board of Internal Medicine Certifying Examination. These structured conferences along with consistent reading, attendance at other conferences and patient care help prepare Residents for the Board examination.

Grand Rounds

Internal Medicine Grand Rounds are held on Tuesdays at Noon in the Medical School. They usually consist of presentations by members of our faculty or by visiting professors, concerning important topics in internal medicine. This conference is simultaneously broadcast to LBJ hospital.

Senior Seminars

Every year, the senior residents prepare noon conferences that consist of a review of a topic. The subject matter may be any topic relevant to clinical medicine or the basic sciences which relate to medicine or delivery of health care. The presenting residents are expected to use the PowerPoint presentation format and to distribute handouts outlining the subject and containing pertinent bibliographies. Each resident will present once during his/her PGY-3 year and select a faculty

mentor to assist with this presentation. Residents may be exempt from this requirement if they have presented at an ACP conference or have a publication during their residency.

Other Noon Conferences

Other conferences include medical jeopardy, Morbidity and Mortality conferences, Quality Improvement, Chiefs Conference, Journal Club, and MKSAP review.

Attendance

Failure to maintain 70% attendance to Noon Conference and Morning Report, excluding days off, post call days, or attendance to a subspecialty conference (held at the same time) will result in punitive action.

Conference attendance will be tallied from the first of each month to the last day of each month. Cumulative attendance rate will be available on the 1st day of the following month. Any housestaff with less than 70% attendance rate will be required to do the following:

1st Violation: Housestaff will meet with their assigned Associate Program Director, have a letter placed in their file, and be assigned and complete a CCP

2nd Violation: Housestaff will be required to appear before the Residency Competency Committee, followed by a letter which will be formulated and submitted to the Texas Medical Board

H. ROLES AND RESPONSIBILITIES OF RESIDENTS

Intern residents have the following major responsibilities:

1. Initial evaluation of all patients, including assimilation of old records and outside information.
2. Developing a plan for each patient to present to the resident.
3. Communicating with the patient and family about treatment plans, consultations, risks and benefits of procedures and medications, and other aspects of care.
4. Getting write-ups on the chart no later than 8:00 a.m. following a call day.

The primary role of upper level residents are supervision and education. This includes:

1. Seeing every patient on the day of admission and writing an Upper Level Addendum
 - A. Upper Level Addendum requires a HPI, pertinent PMH, Meds, and PE, along with the Resident's Assessment of the patient's illness and the team-formulated plan
 - B. When working with an AI, Resident must write out a full and complete History and Physical, only Medical Students' Review of Systems may be referred to in the Resident note. All other aspects of the H&P must be independently documented by the Resident.
2. Review and approve diagnostic and treatment plans with the interns *every day prior to Attending Rounds*

3. Review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning
4. Assuming complete responsibility of Interns' patients on PGY-1 days off
5. Organizing and planning attending rounds, meetings with consultants, and other teaching opportunities
6. Setting time aside for teaching medical students, including reviewing write-ups and giving timely feedback
7. Creating an atmosphere such that the intern is encouraged to ask for help when appropriate
8. Supervising procedures
9. Interacting with nurses and other personnel in a way that respects all members of the healthcare team and encourages their input
10. Being certain all members of the team are familiar with the current literature regarding their patients
11. A Resident will not supervise more than 10 new admissions including in-house transfers; and no more than 16 new patients in a 48 hour period
 - A. At MHH on a team with 2 Upper Levels and 2 Interns – the Residents can admit an additional 5 patients
 - B. At MHH on a team with 2 Upper Levels and 3 Interns – the Residents supervise 15 new admissions
12. A Resident will not be responsible for the ongoing care of more than 14 patients with 1 PGY-1 or 20 patients with 2 PGY-1s
13. Participating in Ambulatory curriculum on the day of continuity clinic.

I. INPATIENT SERVICES

The inpatient services are organized so as to provide high-quality medical care, allowing the Residents freedom for independent decision-making while retaining supervision by the faculty and attending physicians. Most ward teams consist of two interns and one upper level resident. There also may be third and/or fourth year medical students assigned to the team. Each team has a designated teaching attending physician. We encourage acceptance of responsibility and independence of thought on the part of the Residents; however, the ultimate legal responsibility for the care of the patient rests with each patient's attending physician. Therefore, important decision should be made only after discussion with the attending physician, unless a critical situation exists. Each patient should be discussed with the attending physician daily on teaching rounds. The attending physician should be notified as soon as possible in the event of a patient's death or any important change in medical status (i.e. transfer to the intensive care unit).

The following general schedule pertains to the inpatient teaching services at most hospitals. Daily pre-rounds should be made by the entire ward team, independently of the attending physician. On these rounds, the ward resident should function as the leader, and should coordinate the details of patient care with the interns and medical students. On morning pre-rounds, each patient should be seen by the supervising resident and carefully evaluated. Important management decisions should be made by the entire team. Morning Report is conducted daily Monday-Friday. Mornings after Morning Report are reserved for teaching rounds with attending physicians. Conferences are held weekdays at noon. Attendance at the noon activities is required. Afternoons are usually spent on patient care tasks.

Each month several interns and upper level residents will be assigned to the “float” rotations. Residents on this rotation will perform cross-cover activities for patients to Memorial Hermann and Lyndon B. Johnson Hospitals, at night and on weekends. The details of this float system will be outlined on the specific hospital orientation documents. Float Interns are only responsible for cross coverage issues, where Float Residents have additional consultation and admitting responsibilities.

The upper level ward resident is responsible for coordinating the activities of the entire professional staff on the service. This staff typically includes one or two interns, medical students, attending physicians, and consultants. Additionally, the ward resident should serve as liaison between the medical team and the nursing services on the floors where his or her patients are located. The ward resident should independently take a history and examine each patient admitted to the service, and write a note with his or her own assessment, recommendations and plan of therapy. The resident must examine the patient daily, but a note is not required from both the resident and intern. The resident should also review the intern’s history and physical examination and countersign it. The resident and intern together should discuss in detail the history and physical examination, the laboratory work that bears on the problems, and should prepare a revised problem list and plan of management. In the resident’s independent note, it is highly desirable that evidence-based practice be utilized, for the benefit of the intern and the students on the service.

In addition to his or her strictly clinical responsibilities, the upper level ward resident has important administrative and educational functions. The resident assigns new patients to the interns, keeping in mind the needs of the service and the workload of each intern. The resident should act as direct consultant to the interns on all matters pertaining to patient care and therapy. He or she should critically review all intern and medical student workups. The ward resident is responsible for organizing work rounds, for leading them and for being sure that he or she personally sees all the patients and that rounds are completed prior to Attending Rounds. The resident is responsible for keeping attending physicians informed of all new admissions, deaths, plans for changes in management, and status of seriously ill patients. Authority for communication with attending physicians may be delegated to interns, if the clinical situation and the work load of the interns will permit.

There are 4 general medicine ward teams at LBJ and 4 general medicine ward teams at Memorial Hermann Hospital. The responsibilities of the admitting team will be thorough evaluation and treatment of patients admitted to the hospital. The admitting team will document an admission history and physical examination, daily progress notes and a discharge summary.

The general medicine ward teams will take overnight call in the hospital at a frequency of every fourth night. On the post call day, the team will have attending rounds and work rounds that are directed toward work-up of the new admissions. The team should check out promptly by 1:00 p.m. on the post call day. Inpatient teams for the Medical Intensive Care Unit and the Coronary Care Unit also take rotating in-house call. Inpatient nephrology wards are composed of patients with renal failure and admit patients daily during weekdays.

Ambulatory Services

The Ambulatory Services consist of ambulatory clinic rotations, resident continuity clinics and subspecialty clinics.

The general medicine clinic LBJ functions as the ambulatory rotation for Interns and select Residents. It will operate on scheduled mornings between the hours of 9:00 am and 12:00 pm. The clinic is located on the first floor of the LBJ Hospital. Patients will be referred to this clinic from the community clinics for internal medicine consultation, as well as patients who were recently hospitalized who present for follow-up care. If an Intern or Resident has their continuity clinic at another location at the same time, preference is given to the continuity clinic.

In the emergency department and clinics, the intern is responsible for efficient and appropriate medical evaluation of each patient. This includes performance of medical histories and physical examinations, and recording of these clinical data. The intern is also responsible for ordering appropriate tests, and for suggesting disposition for patients in these areas. The intern must check with the resident and/or attending physician on these ambulatory services, prior to the actual disposition of a patient. The intern may also contact the admitting resident and/or attending physician regarding an admission to the inpatient service.

The upper level resident is responsible for contacting the admitting resident and/or attending physician regarding an admission from an Emergency Room or a clinic. If the patient has a private attending physician, the resident must notify him or her prior to discharging a patient from the Emergency Room.

General Medicine Continuity Clinic

The goal of the General Medicine Continuity Clinic is to gain and maintain skills in ambulatory internal medicine, including: preventive medicine strategies, knowledge of natural disease processes and experience in a representative office practice. The resident, with the assistance of a faculty member, will be directly responsible for the primary care of each patient assigned to their continuity clinic panel. Teaching will include the process of patient/physician interaction as well as knowledge of specific diagnosis and therapeutic techniques in ambulatory medicine.

Each Resident will attend continuity clinic one-half day per week. Continuity clinic may be housed at either the General Internal Medicine Clinic at the UT Professional Building (Suite 600) or in the General Medicine Clinic at LBJ Hospital. The continuity clinic supersedes all other responsibilities except during rotations in the Medical Intensive Care Unit, Coronary Care Unit or scheduled vacation time. Residents are responsible for rescheduling their continuity clinic if they are post call from a ward team or are on a night float rotation.

If a house officer becomes unable to attend their continuity clinic, he or she should contact the Chief Medical Resident, their clinic attending and the clinic scheduler as soon as possible so patients may be rescheduled.

A house officer may refer his hospital patients to his own continuity clinic for hospital follow-up, with the clinic attending's approval. Patients may be self-referred or the Emergency Room and other departments at Memorial Hermann Hospital and LBJ Emergency Room may refer patients for evaluation. Patients of house officers who have completed their training will be reassigned to other house officers. The number of patients scheduled during each continuity clinic will increase commensurate with PGY level. All residents will be expected to be in clinic during their scheduled time, whether or not they have patients scheduled.

The faculty will review each case history and examine every patient with the resident while in the continuity clinic. Each chart should have an up-to-date problem list and list of medications. Routine health maintenance will also be performed.

Subspecialty Clinics

When rotating on a subspecialty consultation service, residents are encouraged to attend one-half day per week of that subspecialty clinic. The specific clinic location and time are up to the discretion of the service Attending.

Notification of an admission is made to the ward resident, who in turn will assign the new patient to an intern. We expect the intern to act as the patient's primary physician. The intern should be responsible for all aspects of patient care on a day-to-day basis. Assistance will be provided to the intern by the ward resident, attending physician and consultants, depending on the capabilities, educational progress, and work load of the intern. We expect that the degree of supervision and amount of assistance required will diminish as the intern progresses through the year. With complex and/or seriously ill patients, the intern should work closely with the ward resident, the attending physician and the various consultants.

The intern is responsible for taking a full history and performing a complete physical evaluation on all patients assigned to him or her. The written history and physical examination, with initial assessment, problem list, and management plans must be on the chart shortly after admission or dictated on the same day with a brief written note in the chart. The intern is responsible for writing and carrying out orders for initial work-up, therapy, initial and daily care, and for disposition of the patient, all under the supervision of the ward resident. The intern is directly responsible for writing adequate daily progress notes. Mere countersignature of medical student notes is not acceptable. One's written work is a reflection of one's thought processes; up to date charts with rational progress notes are a medical necessity.

Prior to discharge of the patient, the intern should review with the ward resident the diagnoses, inpatient treatment, discharge medications, and plans for medical follow-up. Charts should include all of the following:

1. All primary diagnoses and manifestations have been recorded in the chart

2. All written and verbal orders have been signed by the intern or resident
3. All pertinent physical, laboratory and radiologic findings are documented
4. Daily progress notes have been recorded with the opinion of the attending physician recorded in a note in the chart
5. A Day of Discharge note, including diagnosis, pertinent details of hospital course, discharge medications, and plans for follow-up has been completed
6. The Medication Reconciliation form is completed and signed
7. Core Measures have been addressed
8. The discharge summary has been dictated

The discharge summary must be dictated prior to the discharge of the patient. It should include briefly the reason for entering the hospital, the pertinent points of the history and physical examination, pertinent laboratory and X-ray findings, hospital course, complications, treatment, final diagnosis, discharge medications and instructions, proposed follow-up and the physical condition of the patient at the time of discharge. The summary should be concise, pertinent and well-organized. Copies of the summary should be sent to the patient's private physician, consultants, and the assigned attending physician for the hospitalization. You will not receive credit for a rotation until your dictations are complete.

The specific responsibilities of the upper level resident on a subspecialty consultation service will be defined by the faculty of that service. All requests for inpatient consultation must be answered on the same date that a request is received. In some cases, it may be appropriate for the initial answer to consist of recognition of the request, with a brief outline of the situation and a promise to return later with more detailed information and suggestions. However, in no case should more than 24 hours elapse between the receipt of a consultation request and completion of a consultation note in the chart. All patients seen in consultation must also be seen by a faculty attending physician, whose opinions and suggestions will be added to those of the resident. In some subspecialties, there may also be a fellow who sees the patient, and who advises the subspecialty resident. The subspecialty resident is responsible for communicating the results of the consultation to the ward team, and for maintaining follow-up on all patients seen in consultation. Verbal contact with the ward team, rather than mere filing of the note in the chart, is highly desirable. In many cases, it is especially desirable that the subspecialty resident arrange a meeting of the entire consultation team with the ward team, for discussion of the patient. The subspecialty resident is also responsible for keeping the faculty attending physician aware of any pertinent changes in the status of the patients on the consultation service.

Other duties of subspecialty residents may include attendance at clinics, workup of patients on subspecialty inpatient services or on the clinical research unit, attendance at subspecialty conferences, attendance at rounds, and night call. These additional duties will be explained by the attending physician on the subspecialty.

J. HOSPITAL ADMISSIONS

Memorial Hermann Hospital

The Emergency Room attending physician has full authority to admit patients to the internal medicine services. The service to which the patient will be admitted will be

dictated by the patient's major problem or underlying disease. Once you have evaluated the patient, if you disagree with any decisions from the ER, call your attending to discuss the case. Do not argue with the Emergency Room.

Every patient on the medical teaching service has an attending physician who bears the ultimate responsibility for the care of the patient. In some cases, the patient recognizes a private practitioner, practice group, or member of our faculty as his or her personal primary care physician (PCP). In other cases, the patient will not have an established private physician and an attending physician will be assigned based on the Medicine Ward team that admits the patient.

If a patient has a PCP, including General Medicine faculty or Residents clinic, the PCP should be notified of the admission and plans for management. Thereafter, the Resident and private physician should communicate frequently. The ward resident is ultimately responsible for assuring that continuing communication occurs. The Resident must obtain prior approval from the attending physician or PCP for a diagnostic or therapeutic intervention, any major or minor surgical procedure, any formal consultations, and any transfer or discharge of the patient.

Lyndon B. Johnson General Hospital

At the LBJ Hospital, attending physicians are members of the Medical School faculty, assigned on a monthly basis. As at the Memorial Hermann Hospital, the attending physician has the ultimate responsibility for the patient. The Resident must maintain daily communication with the attending physician regarding the progress of all patients on the service.

M.D. Anderson and St. Luke's Hospitals

Patients at these hospitals usually have an attending physician who has initiated the admission. Just as at Memorial Hermann Hospital, the attending physician should be notified promptly of the admission, and the patient should be discussed with the attending physician at least daily thereafter.

Call Rooms and Food Services:

Residents on call will have access to clean, adequately lit call rooms for study or sleep with available bathroom facilities. Additionally, Residents will have access to food services while on duty at affiliated institutions.

K. PROCEDURES AND SKILLS

PGY-1:

1. An intern performs a history and physical exam on each patient admitted to them. They follow the patient closely while admitted to the hospital with daily progress notes and discharge summaries at the end of the hospitalization.
2. Writes all orders on their patients.
3. Performs procedures necessary for the care of their patients with supervision and under the direction of the attending physician. Although an attending physician is

on call to assist the Housestaff, the following duties may be performed without the presence of the attending physician with the guidance of a PGY-2, PGY-3 or PGY-4 Housestaff:

- a. Lumbar Punctures
 - b. Thoracentesis
 - c. Central Line Placement
 - d. Paracentesis
 - e. Arthrocentesis of knee joint
 - f. Arterial puncture for blood gas analysis
 - g. Critical life-saving procedures
 - h. Nasogastric intubations
4. The following procedures must be done with the direction and supervision of an attending physician. These include:
 - a. Swan-Ganz Placement (ICU or CCU)
 - b. Bone marrow aspirate and biopsy (Pathology attending physicians)
 5. Supervises and helps in teaching the third and fourth year medical students.
 6. Participate on teaching rounds with the residents and the intern(s) and attendings on a daily basis.

PGY-2/PGY-3/PGY-4:

An upper level resident:

1. Performs a history and physical exam on each patient admitted to them. They supervise and follow the patient closely while admitted to the hospital.
2. Writes orders on their patients and oversees intern orders on patients
3. Performs procedures necessary for the care of their patients with supervision and under the direction of the attending physician. Although an attending physician is on call to assist the resident, the following duties may be performed without the presence of the attending physician. These include:
 - a. Lumbar Punctures
 - b. Thoracentesis
 - c. Central Line Placement
 - d. Paracentesis
 - e. Arthrocentesis of knee joint
 - f. Arterial puncture for blood gas analysis
 - g. Critical life-saving procedures
 - h. Nasogastric intubations
4. The following procedures must be done with the direction and supervision of an attending physician. These include:
 - a. Swan-Ganz Placement (ICU or CCU)
 - b. Bone marrow aspirate and biopsy (Pathology attending physicians)
5. Supervises and helps in teaching the third and fourth year medical students as well as the intern.
6. Pre-round with the interns daily
7. Participate in teaching rounds with the intern(s) and attendings on a daily basis.

Interactions with Residents constitute a major source of learning for medical students and other Residents. The educational tone of a service is set largely by the upper level ward resident and the interns. Therefore, Residents have a major obligation to teach. Moreover,

teaching is the best method of active learning. Teaching allows the house officer to think aloud. During the teaching interaction, new questions usually arise, so the teaching process stimulates further exploration of knowledge. We therefore consider every set of work rounds to be an extremely important educational experience. Every new admission should, within the restraints of appropriate patient care, be considered an opportunity for the Residents to teach each other and the students. The residents' teaching rounds are generally viewed by the students as enjoyable and profitable educational experiences.

Junior medical students are expected to have acquired the following basic skills and knowledge by the end of their three months on internal medicine:

- ability to take an accurate medical history and to perform a careful physical examination;
- ability to examine and interpret peripheral blood smears and urine sediments
- ability to understand the fundamentals of interpretation of electrocardiograms, and films of the chest, abdomen and kidneys;
- ability to synthesize clinical data into a problem list with a reasonable differential diagnosis;
- ability to understand the pathophysiologic basis of the manifestations of disease, and the scientific basis of treatment;
- ability to keep concise, meaningful, complete and accurate medical records which objectively document the status of the patient;
- ability to perform the following procedures correctly: Venipuncture, insertion of peripheral venous lines, arterial puncture for blood gases, insertion of urinary catheters, rectal and pelvic examinations, basic cardiopulmonary resuscitation (airway, ventilation and chest compressions)

Residents are expected to help students achieve the above abilities and skills by allowing students to see patients first unless the situation is urgent. Residents should observe the students performing histories and physical examinations during the early part of the rotation, in order to recognize and correct any deficiencies. Residents should discuss historical, physical and laboratory findings with the students. The resident should review the students' recorded histories and physicals. Residents and interns should instruct and supervise the students in basic procedural skills. On regularly scheduled teaching rounds, the resident should point out abnormal physical findings, discuss pathophysiology of disease and the scientific basis of treatment. Housestaff should guide the students and interns to appropriate reading material. Finally, the Residents should always treat junior students respectfully, as valued members of the inpatient health care team.

L. MEDICAL RECORDS AND CLINICAL DOCUMENTATION

It is the responsibility of every house officer to complete all medical records in a timely manner. The Ward resident is ultimately responsible for all documentation completed by the team during his/her month whether it is documented by himself/herself, an intern or acting intern (4th year Medical Student). It is the responsibility of the ward interns and resident to complete admission history and physical examinations and discharge summary dictations. Interns should dictate discharge summaries on the day the patient is discharged. If a discharge summary becomes delinquent, the record will be turned over to the ward resident for completion. Notification of incomplete charts will occur on a regular basis, and

the intern/resident must then complete those charts within 1 week. Failure to do so will result in disciplinary action.

It is the responsibility of consulting residents to complete consultation note dictations within 24 hours of performing the consultation.

M. MOONLIGHTING

Moonlighting is defined as any patient care service a Resident performs as a fully licensed physician where he/she receives financial compensation as a result of those services. Moonlighting occurs outside of the Internal Medicine Residency Program and Residents assignments from the Program are not included in Moonlighting.

Every resident who wishes to engage in moonlighting must provide written notification of their intent and participation to the Program Director for Internal Medicine or Medicine/Pediatrics Residency Training Programs, and receive approval from the Program Director. Failure to notify the program director of moonlighting activities will result in disciplinary action. The Program may revoke approval or initiate corrective action in the event outside professional activity interferes with the ability of the Resident to satisfactorily fulfill the obligations of the Program.

Residents are required to be independently licensed for unsupervised medical practice by the State of Texas and be in good standing with the Residency Program before they can consider moonlighting. A physician-in-training permit does not entitle the Resident to engage in professional activities (i.e., medical practice) outside the educational program. Moonlighting is prohibited during standard work hours and should be limited to no more than 3-4 nights per month, and cannot interfere with performance of one's clinical and academic duties.

All moonlighting will count toward the resident's total duty hours and residents may not exceed 80 hours worked per week.

The University of Texas Health Science Center does not provide liability coverage for moonlighting activities. It is the responsibility of the hiring institution to determine whether the resident has the appropriate licensure in place, whether adequate liability coverage is provided and whether the resident has the appropriate training and skills to carry out assigned duties.

N. DUTY HOURS

Duty hours are defined as all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

Duty hours are reported by the resident on a monthly basis in the UT Houston GMEIS system which can be found at <https://gmeis.uth.tmc.edu/gmeis/index.jsp>. The hours reported are monitored closely by the Program Director and Associate Program Directors. Issues with Duty Hours are addressed with both the reporting Resident and Attending.

Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities. Residents are provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities. Adequate time for rest and personal activities is provided and consists of a 10 hour time period provided between all daily duty periods and after in-house call.

On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

In-house call does not occur more frequently than every third night, averaged over a 23 four-week period. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours however Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as defined in Specialty and

Subspecialty Program Requirements

While on a subspecialty rotation, no new patients may be accepted after 24 hours of continuous duty. At-home call (pager call) is defined as call taken from outside the assigned institution. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.

O. GRIEVANCES

Grievances may involve payroll, hours of work, working conditions, clinical assignments, and issues related to the program or faculty, or the interpretation of a rule, regulation, or policy. The grievance process is not intended to address any aspect of the evaluation of academic or clinical performance or professional behavior, or other academic matters relating to failure of the resident to attain the educational competencies of the Programs (*see II.P*).

If a Resident has a grievance, he or she should first attempt to resolve it by consulting with (1) the Chief Resident; (2) the Program Director; or (3) the Department Chairperson. If the matter is not resolved to the Resident's satisfaction, the Resident should then present the grievance in written form to the DIO through the GME office.

A grievance subcommittee of the GMEC appointed by the DIO will be assigned to review the grievance. The Resident may be invited or permitted to appear before the subcommittee at the discretion of the subcommittee. After the grievance subcommittee has reviewed all information submitted in writing or in person by the Resident, a decision will be communicated in writing to the Resident and other appropriate, involved persons. The decision of the subcommittee is final.

P. CORRECTIVE AND/OR ADVERSE ACTIONS

Academic Actions

In the event a Resident encounters difficulty meeting and/or maintaining performance standards as they pertain to the ACGME Competencies, as well as professional behavior standards (“academic difficulty”), the Program Director will notify the Resident that his/her performance is unsatisfactory

If after the Resident has been notified about his or her unsatisfactory performance, and been offered advice, guidance, and, if appropriate, a corrective plan, but continues to be less than satisfactory, the Program Director, at his or her discretion, may take appropriate academic corrective and/or adverse action. Corrective/adverse actions include, but are not limited to remedial assignments, letters of warning, probation, suspension, non-promotion, non-reappointment, or dismissal from the Program.

In cases where a Resident has been notified of non-promotion, non-reappointment, suspension, or dismissal and believes that such action was levied without the appropriate notice and guidance that would have enabled the Resident to improve his or her performance prior to the corrective/adverse action, the Resident may request that a subcommittee of the GMEC be established to review such action. The Resident must make a written request for review of this decision to the DIO within 14 days of the date that the academic corrective/adverse action in question was levied against the Resident.

The subcommittee review will generally be scheduled within 30 days of the resident's request for a hearing. The hearing panel will consist of at least three members of the GMEC. The DIO will determine the date of the hearing in consultation with the resident and program leadership. The hearing will be presided over by the chairperson selected by the subcommittee. The conduct of the hearing is at the discretion of the chairperson.

The review by the GMEC subcommittee is restricted solely to the determination of whether the requisite notice and guidance was provided by the Program Director to the Resident.

A final decision will be made by a vote of the subcommittee and will be communicated to the resident within 10 working days after the hearing. Within 10 days after the parties have been notified of the decision, either party may give written notice of appeal to the Dean of the Medical School. The Committee's decision will be reviewed by the Dean, who may accept or reject the Committee's decision or may require that the original hearing be reopened. The action of the Dean shall be communicated in writing to the Resident and Program Director as soon as reasonably possible. The decision of the Dean is final.

Non-Academic Actions

In the event allegations of unethical conduct, scholastic dishonesty, theft, or any conduct prohibited by UTHSC-H, The University of Texas System, federal, state, or local law are levied against a Resident, the Program Director or the Foundation may take corrective/adverse action against the Resident, including, but not limited to termination of the appointment of the Resident prior to the end of the appointment term.

If allegations are levied against the Resident that (if confirmed) may subject the Resident to corrective/adverse action, the Program Director will conduct an investigation into the allegations in cooperation with the GME Office or other appropriate office(s). If the investigation substantiates the allegations, notice of the allegations will be delivered by the Program Director to the Resident *via* hand delivery or certified mail with a copy to the GME office.

Upon receipt of a notice of allegations from a Program Director, the GME office will promptly provide a copy of the following procedures to the Resident.

If the Resident does not dispute the allegations, he or she will be asked to sign a Waiver of Hearing and a disciplinary penalty may be assessed by the Program Director or Department Chairperson. If the Resident disputes the allegations, or if the Resident admits the allegations but contests the penalty to be assessed, he or she may request a hearing before a Discipline Committee appointed by the DIO.

The Discipline Committee will consist of three members, one of whom will be a Resident member from a Residency Training Program. The Committee will select its presiding chairperson. The Resident will be given at least 10 days notice of the date, time, and place for such hearing, and names of the members of the Committee. The notice will include a written statement of the allegations and a summary statement of evidence alleged to support such allegations. The notice shall be delivered in person or by certified mail and regular U.S. mail to the Resident at the address appearing in the Program records.

The Resident may challenge the impartiality of any member(s) of the Committee up to three working days prior to the hearing. The challenged member(s) of the Committee shall be the sole judge of whether he or she can serve with fairness and objectivity. In the event a member disqualifies himself or herself, a substitute will be chosen.

At a hearing on the allegations, the Program representative has the burden of going forward with the evidence and the burden of proving the allegations by the greater weight of the credible evidence. The following shall apply:

1. Each party will provide to the GME office a complete list of all witnesses, a brief summary of the testimony to be given by each, and a copy of all documents to be introduced at the hearing. Each party will be provided copies of the above by the GME office prior to the hearing. Deadlines concerning the submission of materials will be set and communicated by the GME office.
2. Each party will have the right to appear and present evidence in person. The Resident may have legal counsel present outside of the hearing room; however, no attorneys will actually appear as an advocate for either party.
3. Each party will have the right to examine witnesses on relevant matters.

4. The hearing will be recorded. If either party wishes to appeal the findings, the record will be transcribed and both parties will be allowed to purchase a copy of the transcript.

The Committee will render and send to both parties a written decision, and at its discretion may impose a penalty or penalties.

Either party may appeal an action taken by the Committee in accordance with the following procedures:

Within 14 days after the parties have been notified of the decision, either party may give written notice of appeal to the Dean of the Medical School. If the decision is sent by mail, the date the decision is mailed initiates the 14-day period. The Committee's decision will be reviewed by the Dean solely on the basis of the transcript and evidence, if any, considered at the hearing. In order for the appeal to be considered, all necessary documentation, including written argument, must be filed by the appealing party with the Dean within 14 days after notice of appeal is given and the transcript is available.

The Dean may approve, reject, or modify the Committee's decision or may require that the original hearing be reopened for the presentation of additional evidence and reconsideration of the decision. The action of the Dean shall be communicated in writing to the Resident and Program Director no more than 30 days after the appeal and related documents have been received. The decision of the Dean is final.

Q. CONDITIONS OF SEPARATION

Resignation

A Resident may resign from a Program by providing 30 days written notice of his or her intent to resign. The Resident's resignation must be submitted to the Program Director and/or department chairperson. All conditions of appointment will terminate on the effective date of the resignation. At the discretion of the Program Director, a resignation may be accepted effective immediately, notwithstanding the proposed effective date provided by the Resident.

Separation

Separation may occur at the end of an appointment term under any circumstances in which reappointment does not occur, including successful graduation from the program.

Termination

A Resident's appointment may be terminated prior to the end of the appointment term as described in section M of this document.

R. GENERAL INFORMATION

Pagers

Residents are issued a personal pager, for which they are financially responsible for the loss or damage of. In addition to the pager issued by the Program, Housestaff may be issued a hospital pager during rotations at MD Anderson or St. Luke's Episcopal Hospital. Residents are **required** to wear your UT pager and leave it on at all times unless on vacation or your day off.

Residents are required to return all pages in a timely manner (i.e. under 5 minutes). It is understood that there are times when you may be in the middle of a procedure, at those times, please return pages as soon as possible.

When paging, please exercise pager courtesy, which is to put the full 10 digit number into the pager, hit the asterisk button (*) and put your pager number in, before hitting pound (#) to send the page.

The pager systems are as follows for each hospital:

Memorial Hermann and LBJ Pagers:

Dial telephone number 713-605-8989. After the beep, enter the 5 – digit beeper number. Then, enter the return number and press the # sign. Or call the Hermann Page Operator at 713-704-4884.

M.D. Anderson Pagers:

From an outside line, dial 713-792-7333, then ####.

From a 792 or 794 line, dial 2-7333, then ####.

When instructed, enter the call back number.

M.D. Anderson Page Operator: 713-792-7090

St. Luke's Pagers:

Within SLEH dial 12345, or 713-605-8989 from the outside. At the tone, enter the five digit pager number and wait for another tone. After the beep, enter the return number, followed by the # key. St. Luke's Page Operator: 713-791-4146

Email

Residents are provided with a University of Texas Houston e-mail account. This is the only account the program will use to disseminate information. It is the Resident's responsibility to check his/her UT account on a regular basis with the recommendation being daily. The UT e-mail is web-based and can be reached by any computer connected to the internet at the following URL: <https://webmail.uth.tmc.edu/>

If you experience problems with your account or password, please contact the UTH Help Desk at 713-486-4848.

Residents are encouraged to disseminate information to each other via email in the form of interesting articles, etc. However, one must remember to be HIPAA compliant in using one's email. You may not include patient names or medical record numbers in emails. You must also make sure that whenever you are emailing presentations or radiographic studies that names and medical record numbers, in addition to accession numbers are

removed from x-rays and other studies, even if they are imbedded in power point presentations.

In addition, please be judicious in using the *Reply All* function of email. Please be careful about your wording of information, especially about other individuals—be aware that your emails (even deleted ones) are archived and written comments about others may be consider libel.

Lab Coats

Four three-quarter length coats are supplied to each Resident through the Program in the first appointment year, and one additional coat is supplied in each subsequent year of training. Information about laundry services is available from the department.

Parking

Parking is available on site. The fee is \$50.00 per month, which will be automatically deducted from your pay. Your UT ID Badge will also serve as your parking card. You will use your ID when entering and exiting the garage. If you choose to have parking available to you, you must sign up during orientation. If you did not sign up for parking during orientation, you will not be able to do so again, until June of the following year.

Housestaff rotating at Memorial Herman will have parking in the UT Professional Building. There will be no offsite parking available for Housestaff.

Parking at LBJ will be provided at no cost to UT Housestaff. However, you will still need to be identified with a UT ID Badge and your vehicle will need to be identified with a decal.

The security office will maintain the decals. When a UT Housestaff presents their ID Badge, the appropriate decal will be issued and the badge will be coded with access to the applicable parking lots. Each UT Housestaff will be issued a decal based upon their work classification.

S. Exposure to Infectious Diseases

Needle Stick and Other Exposures – Including Body Fluids

1. If you have a needle stick or other body fluid exposure go to the Memorial Hermann Hospital Emergency Room. The attending will instruct you as to the course of action depending upon the type of exposure you have had. For 24-hour immediate assistance, information, or counseling contact **713-951-8013 (pager)** and leave message. Your call will be handled immediately.
2. You must complete a First Report of Injury Form. This form establishes the eligibility for Workers Compensation Insurance. The First Report of Injury Form will be available through the ER attending.
3. For follow-up it will be necessary for you to be seen in the UT Student Health Services Clinic. Follow-up will be determined by the EC Attending.

4. If you are significantly exposed to HIV and you choose to take prophylactic antiretroviral medications, they will be prescribed and made available at the Memorial Hermann Pharmacy. The Pharmacy will bill the Medical Foundation if the prescription is written by an ER attending or the physician in the Family Practice Health Clinic.
5. It is YOUR responsibility to follow the above steps and complete all forms for incident reporting. Follow-up with the health clinic is mandatory to be in compliance with worker's compensation regulations. This is very important so that claims can be filed with Worker's Compensation and not billed to you.

T. DISASTER PREPAREDNESS PLAN

In the event of a natural disaster or emergency, all Residents and Interns rotating on the Internal Medicine Service are required to abide by the terms of the official University of Texas- Houston Internal Medicine Residency Program Disaster Plan.

All residents and interns will be notified that the disaster plan is going into effect via a page and an email by the Internal Medicine Office or the Assistant Chiefs of Service Office (ACS). The page and email will state the time and date that the plan is going into effect. The disaster plan will remain into effect until notified to the contrary by the Internal Medicine Office or the ACS's.

All essential personnel¹ will be required to remain in their assigned locations. If you feel you cannot stay due to personal or family concerns you need to find coverage for your assigned duty. Your coverage needs to be approved by the Assistant Chiefs of Service prior to your being excused.

Residents and Interns on the service will be excused when the disaster plan takes effect. All subspecialty patients need to be checked out to their respective fellow or attending. Return to work immediately after the disaster plan is no longer in effect.

For residents and interns rotating on essential services², the following plan will be activated:

1. All residents and interns **ON-CALL and PRE-CALL** on the day the disaster plan is activated are required to report to their assigned duties immediately.
2. Residents and interns will rotate working 12 hour shifts until the disaster plan is no longer in effect.
3. For Ward Teams - there will be two Ward Teams on duty at a time in each hospital. Ward teams must divide the patients from ALL ward services equally and round on

¹ All *consult services* are deemed non-essential, and these services will be covered by the subspecialty Fellow and /or Attendings.

² ER at LBJ; CCU at Hermann; MICU at Hermann and LBJ; Ward Teams at Hermann and LBJ; Interns and Residents on Ready Reserve must report to the ACS's when the disaster plan is activated in order to approve any evacuation plans. These residents may be deemed as essential and required to report to duty until the disaster plan is no longer in effect.

- them on them on a daily basis. The cross-cover and admitting duties will then be divided amongst the two ward teams on duty in 12 hour shifts.
4. Renal Wards at Hermann and LBJ will be covered by the Renal Fellow.
 5. The ER at LBJ will be covered by all of the residents and interns scheduled for the day and night shifts on the day the disaster plan is activated. They will rotate duties in 12 hour shifts.
 6. CCU/Cardiology at Hermann will function similar to the Ward Teams (see number 3).
 7. MICU at Hermann and LBJ will rotate duties in 12 hour shifts.