



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
2009 – 2010**

Effective July 1, 2009

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Section I: General Information about the Internal Medicine Residency Program

- A. Program Overview**
- B. Program Leadership**
- C. Program Staff**

A. Program Overview

The purpose of this training program is to prepare the physician for a career in Internal Medicine. We believe that the foundation for excellence should be the same, whether that career will be in the practice of general Internal Medicine or a subspecialty, or in research or academic medicine. We therefore strive to help the house officer become an excellent general internist. This training demands 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 most important principles of Internal Medicine training is that the house officer should accept progressively increasing degrees of responsibility for the care of patients. The level of responsibility is governed by the relationship between the house staff and the attending faculty. 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 house staff for management of patients on a day to day basis. We expect that 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 resident 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 house staff. Additionally, the attending physician has an obligation to teach general and/or subspecialty internal medicine to the house staff. This teaching is best carried out in the context of the immediate clinical situation. The attending physician and house staff should work together for the benefit of the patient.

The three years of training encompass 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 residents 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 second and third years consist 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.

B. 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 house staff training program. Therefore, the residency program is of the highest departmental priority. All physicians on the faculty are expected to teach and to make contributions to the house staff training program. The ultimate responsibility for administration of the training program rests with the Vice Chair of Medicine for Education, Dr. Philip Orlander. Administration of the program is carried out by the Program Director, Dr. Mark Farnie, the Associate Program Directors and the Assistant Chiefs of Service (also known as the Chief Medical Residents). With respect to the training program, the overriding consideration for decisions of policy is the education of the house staff.

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 resident 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 house staff 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.
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Director, Division of Cardiovascular Medicine
Medical Director, Heart and Vascular Institute, Memorial Hermann Hospital – TMC
Executive Director, Center for Clinical and Translational Sciences
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PROGRAM LEADERSHIP

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Clinical Professor of Medicine

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C. Program Staff

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Department of Internal Medicine
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Phone Number: 713-500-6525
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Section II: General Information about Graduate Medical Education

A. Definitions and Descriptions

B. Affiliated Institutions

C. Level of Training

A. Definitions and Descriptions

- 1. Resident Physicians:** “Resident Physicians,” which shall include both “residents” and “clinical fellows,” pursuing their post-M.D. /D.O. graduate training at The University of Texas Medical School at Houston Affiliated Hospitals Integrated Residency Training Program (“the Residency Training Program” or “Program”), are appointed and employed by The University of Texas System Medical Foundation (“Foundation”). No property interest in employment is created by such appointment. The Foundation reserves the right to change any requirements affecting the terms and conditions of employment of Resident Physicians. Changes to this Handbook will become effective whenever the proper authorities so determine and will apply to both prospective Resident Physicians and those already enrolled in a Program.
- 2. The University of Texas System Medical Foundation:** The Foundation, a not-for-profit corporation, in cooperation with The University of Texas Medical School at Houston (“Medical School”), a component entity of The University of Texas Health Science Center at Houston (“UTHSC-H”), administers all aspects of the Residency Training Programs. The Foundation is responsible for the administrative functions associated with the Programs. These functions include, but are not limited to issuance of paychecks and other personnel services, maintenance of records, procurement and administration of benefits provided by the Foundation, and provision of mechanisms for effective coordination of the Programs among the hospitals. The Foundation is overseen by a Board of Directors consisting of three physicians who maintain appointments at the Medical School.
- 3. Graduate Medical Education Committee (GMEC):** The GMEC is a committee of the Medical School Faculty Senate that provides academic oversight for the Residency Training Programs and ensures compliance with the Accreditation Council for Graduate Medical Education (“ACGME”) Institutional, Common, and Specialty/Subspecialty Program Requirements. The GMEC establishes policy and develops procedures for the Graduate Medical Education (“GME”) Programs. Appointed members include the Designated Institutional Official (DIO), Assistant Dean for GME, Program Directors, other members of the faculty, residents nominated by their peers, representatives of major clinical teaching sites, and other UTHSCH administrative officials. All Program Directors that are not appointed as standing members of the GMEC are invited to attend and participate in GMEC activities.
- 4. Graduate Medical Education Office:** The Graduate Medical Education Office provides administrative services for all residency and fellowship programs. Contact information for the GME Office:
The University of Texas Medical School at Houston
Graduate Medical Education Office
6431 Fannin Street, J1L 310
Houston, Texas 77030
Phone: 713/500-5151
Fax: 713/500-0612
E-mail: ms.gme@uth.tmc.edu
Website: <http://med.uth.tmc.edu/administration/gme/>

B. Affiliated Institutions

1. 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

2. 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)

C. Level of Training

Progressive levels of training in the Programs are designated as Post Graduate Year (“PGY”) 1 through 7, e.g. PGY-1 is the first year of post-M.D. clinical training. However, 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 Physician is appointed will be determined by the Program Director, in consultation with the Department Chair and other faculty, based on the Resident Physician’s level of education, experience, and demonstrated ability, clinical performance, and professionalism.

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A. RESIDENT RESPONSIBILITIES

As a condition of appointment, the Resident Physician is required, among other things, to:

- Serve as assigned at hospitals affiliated with the Programs;
- Accept and perform the duties, responsibilities, and rotations assigned by the Program Director;
- Meet the respective Residency Training Program's standards for learning and advancement, including the objectively measured demonstration of the acquisition of knowledge and skills as defined by the Program;
- Actively participate in all aspects of their training as directed by the Program Director;
- Abide by The University of Texas System Board of Regents' Rules and Regulations, all applicable policies of The University of Texas Health Science Center at Houston as set out in its Handbook of Operating Procedures (HOOP) (which may be found at <http://legal.uth.tmc.edu/hoop/index.html>), all applicable policies of the Medical School, all Medical Staff Bylaws, and all procedural rules, administrative policies, and other applicable rules and regulations of the hospitals to which the Resident Physician is assigned;
- Participate on hospital, departmental, and institutional committees as directed by the Program Director;
- Conduct himself or herself in a professional manner in keeping with his or her position as a physician; and,
- Meet all other conditions outlined in this Resident Handbook ("Handbook"), or as otherwise required by the Program Director and/or Department Chair.

B. APPOINTMENT AND REAPPOINTMENT

1. Notice of Appointment: Selection of the Resident Physician for appointment to the Programs will be in accordance with ACGME Institutional, Common and Specialty/Subspecialty Program Requirements, as well as with Foundation, Medical School, and departmental policies and procedures. Generally, a Notice of (Re-) Appointment will be issued to an "on-cycle" Resident Physician no earlier than four months prior to the Resident Physician's proposed start date. The appointment will generally extend for a period encompassing the PGY year, typically 12 months; Resident Physicians 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 Foundation. To be fully effective, the Notice of Appointment is signed by the Resident Physician and an authorized representative of the Medical School on behalf of the Foundation.

2. 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 Physician will be based on performance evaluations and an assessment of the Resident Physician'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 instances where a Resident Physician will not be promoted and/or reappointed, the Program Director should provide the Resident Physician 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 Physician'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 Physician with as much written notice of the intent not to promote and/or reappoint as circumstances will reasonably allow. Upon a Resident Physician's timely written request, a Program Director's decision not to reappoint or not to promote the Resident Physician will be reviewed pursuant to section II.Q.1 of this Handbook.

3. Federal Health Care Program Exclusions: Employment by the Foundation shall be subject to the UTHSC-H Exclusion Check policy in HOOP Policy 2.13A, located at http://legal.uth.tmc.edu/hoop/02/2_13A_guidelines.html

4. Criminal Background Checks: The Foundation conducts a criminal background check on applicants accepted into graduate medical education programs. Appointment is expressly contingent in part upon a Resident Physician's consent to and timely completion of the background check as well as acceptable results of the background check. Criminal background checks may be periodically conducted on current Resident Physicians employed by the Foundation as may be requested by affiliated hospitals or when a Resident Physician has self-reported an incident as set forth in the policy. A copy of the criminal background check policy may be obtained from the GME Office.

5. Drug Screening: The Foundation may require drug screening of Resident Physicians. Appointment of a Resident Physician to the Foundation is expressly contingent in part upon a Resident Physician's consent to and timely completion of the drug screening as well as acceptable results received by UTMSH. Resident Physicians may be screened periodically during appointment, with each appointment contingent upon consent to such tests, especially as required by affiliated hospitals/clinics or upon reasonable suspicion of impairment.

6. Restrictive Covenants: Resident Physicians are not required to enter into a non-compete or other restrictive covenant agreement with either the Foundation or UTHSC-H as a condition of appointment or reappointment to a Residency Training Program.

C. CONTENT OF PROGRAMS

1. Program Summary: Programs shall be of sufficient quality and duration so that Resident Physicians who successfully complete a Program should be competent and qualified to sit for board certification examinations in the appropriate specialty area. This provision will be subject to receipt of the necessary approval from external agencies that accredit training programs and hospitals. The graduate medical education of Resident Physicians in the practice of their specialties will include, but is not limited to provision of inpatient and outpatient settings within the program's specialty area; provision of equipment and other facilities for the care of patients; provision for supervision and evaluation of the professional work of the Resident Physician by UTHSC-H or affiliated and cooperating institutions' teaching staff; and provision of didactic experiences to supplement practical clinical experiences. The Resident Physician will be expected to participate actively in the care of all patients of the facility to which he or she is assigned.

2. Resident Physicians as Teachers: In addition, the Resident Physician will be provided the opportunity to take an active role in the instruction of undergraduate medical students and/or other hospital personnel. As instructors of medical students, Resident Physicians are expected to maintain the highest ethical standards of conduct in their relationships with their students. The Policy on Appropriate Student Treatment is attached as Exhibit A.

3. Schedule: Resident Physicians will be assigned to a regular schedule, including night rotations and weekend duties. The major objective of the Program is educational; consequently, the educational needs of the Resident Physician will be a major priority of the Program Director and UTHSC-H.

4. Supervision: The teaching staff will supervise the Resident Physician in a manner designed to facilitate progressively increasing responsibility for patient care according to level of training, ability, and experience. The level of responsibility assigned to each Resident Physician will be determined by the Program Director and/or teaching staff.

5. Research and Intellectual Property: Resident Physicians who engage in scientific research at UTHSC-H are responsible for maintaining the integrity of all research projects. Residents who may create intellectual property must comply with The University of Texas System Intellectual Property Policy:
<http://www.utsystem.edu/ogc/intellectualproperty/Policies/iplainenglish.htm>.

6. Duty Hours: UTHSC-H as well as the individual Programs have formal written policies governing Resident Physician Duty Hours. These policies are intended to foster resident education and well-being and to facilitate the quality of patient care. Each program's formal written policy shall be consistent with the ACGME Institutional and Program Requirements of the specialties and subspecialties. These formal policies apply to all institutions among which a resident rotates. Compliance with these policies is a responsibility shared by the Program Director, Faculty, and Resident Physicians. The UTHSC-H Institutional Duty Hours Policy is attached as Exhibit B.

D. COMPENSATION

Stipends and benefits will be paid to the Resident Physician by the Foundation. Stipends will be appropriate to the level of training and responsibility of the Resident Physician. Attainment of each additional level of training should merit an increase in the stipend. All Resident Physicians at any given level of training will comparably compensated.

E. QUALITY ASSURANCE

The Resident Physician will be informed of the various hospitals' organizations for and methods of providing quality assurance. The Resident Physician should participate in the quality assurance activities of the clinical services to which he or she is assigned.

F. MEDICAL RECORDS

The Resident Physician is required to complete medical records in a timely manner. Mandatory components of graduate medical education include: dictation of chart summaries, signing of patient orders, and compliance with the rules and regulations of the medical records departments of each affiliated hospital to which the Resident Physician is assigned. Failure to complete medical records promptly and accurately indicates failure to deliver adequate care to patients, is an issue of professionalism, and may be considered grounds for academic corrective action, including, but not limited to suspension with or without pay, probation, and/or dismissal. Medical records are the property of the respective hospital/clinic and are not to be removed unless properly authorized. Resident Physicians are not “custodians” of medical records, and may not produce records in response to requests for or legal processes (including subpoenas) purporting to require such production. All requests for and/or legal processes requiring production of medical records must be referred to the Office of Legal Affairs immediately upon receipt.

G. FRINGE BENEFITS

The benefit program outlined below applies to all eligible Resident Physicians. The benefit program is administered through the Foundation. (See <http://utsmf.hsc.uth.tmc.edu/>)

1. Group Insurance

- Health Insurance is provided to the Resident Physician at no cost. Resident Physicians may also buy into a premium plan at a minimal monthly cost. Dependent coverage is not paid, but is available at group rates.
- Dental Insurance is provided at no cost to the resident. Dependent coverage is not paid, but is available at group rates.
- Vision Insurance is provided at no cost to the resident. Dependent coverage is not paid, but is available at group rates.
- \$100,000 of Life Insurance is provided at no cost to the Resident Physician. Additional coverage up to \$2,000,000 may be selected at the Resident Physician’s own expense. Dependent coverage is not paid, but is available at group rates. Spousal coverage may not exceed 50% of the Resident Physician coverage amount and children up to 21 years of age are eligible for \$5,000 or \$10,000 of coverage.
- Additionally, \$10,000 Accidental Death and Dismemberment coverage is provided at no cost to the Resident Physician.
- Disability Insurance is provided to the Resident Physician at no cost. Dependent coverage is not available.
- Supplemental Disability. Each Resident Physician shall be required to participate in the supplemental disability insurance coverage program.
- A flexible benefit plan is also available for Resident Physicians.

2. Retirement Plan

The University of Texas System Medical Foundation, as a 501(c) (3) organization, makes a 403(b) tax-deferred annuity program available to all Resident Physicians. The program is currently offered through and administered by TIAA-CREF. Participants may contribute through payroll deduction up to the IRS limit.

3. Vacation

Resident Physicians classified as PGY-1 are permitted the equivalent of two calendar weeks of vacation each year.

Resident Physicians classified as PGY-2 and above are permitted the equivalent of three calendar weeks of vacation each year.

Resident Physicians must coordinate vacation scheduling with their respective Programs, as well as with other Resident Physicians in the department to ensure adequate coverage. It is the responsibility of the Program's Resident Physicians to cover for one another during a Resident Physician's absence. No more than two consecutive weeks of vacation may be taken without permission of the Program Director. Each Program is responsible for tracking Resident Physician vacation. A Resident Physician is not eligible to accumulate annual vacation leave; unused vacation leave shall lapse at the end of each appointment period. A Resident Physician is not compensated for unused vacation upon leaving the Program.

4. Holidays

Resident Physicians 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 and may require the use of vacation time.

The Foundation and UTHSC-H do not discriminate on the basis of race, color, national origin, religion or sex. The Foundation and UTHSC-H recognizes that Resident Physicians come from many religious faiths and practices. Patient care is the first priority and religious leave/observances cannot be guaranteed. At such times when observation of religious practices conflict with clinical duties, it is the responsibility of the Resident Physician to make appropriate arrangements with the Program Director to ensure patient care coverage. It is the Resident Physician's responsibility to ensure that their rotation is covered. Substitute coverage must be approved in writing in advance by the Program Director.

5. Paid Sick Leave

Paid sick leave accrues at a rate of eight hours each month and accumulates to a maximum of 30 days. Paid sick leave carries forward from year to year; however, unused sick leave remaining as of the separation date from the Program is forfeited without compensation. Each Program is responsible for tracking Resident Physician sick leave.

In the event an illness exceeds accumulated paid sick leave and vacation time, a leave of absence without pay may be granted (see section II.H.7).

6. Leave of Absence ("LOA"), Including Extended LOA, Military Leave, Leave Without Pay ("LWOP") and Family Medical Leave ("FMLA")

Leave of Absence:

All requests for LOA must be in writing and approved in advance by the Program Director in accordance with applicable state and federal laws and specialty board and accreditation requirements.

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 Physician must exhaust all accumulated paid sick leave and accumulated vacation prior to beginning any LWOP.

Military Leave:

A Resident Physician who voluntarily enlists in one of the branches of the armed forces and is called to serve, or who is a member of one of the reserve branches of the armed forces, Texas National Guard, or the commissioned corps of the Public Health Service, or a Resident Physician who voluntarily or involuntarily leaves his or her employment position to undertake certain types of service in the National Disaster Medical System, who is called to active duty by the President during an emergency, or who is called for annual tours of duty, will be entitled to no more than 15 days paid military leave during the Resident's appointment period. The Resident Physician must notify their Program Director as soon as they become aware of their military orders and provide the Program Director with a copy of such orders. Military leave over 15 days shall be considered unpaid leave. On completion of military duty, the Resident Physician must report back to his or her regular program.

Family and Medical Leave:

Consistent with the Federal Family and Medical Leave Act of 1993 (FMLA), The University of Texas System Medical Foundation may grant eligible residents up to an aggregate total of 12 calendar weeks of leave in any 12-month period for one or more of the following reasons:

- Birth of son/daughter and care after such birth (includes paternity leave);
- Placement with employee of son/daughter for adoption or foster care;
- To care for the serious health condition of the spouse, son/daughter, or parent of the Resident Physician;
- Serious health condition of Resident Physician (unable to perform the essential functions of his or her position);
- Qualifying exigency arising out of the active military duty or call to active military duty of a covered military member who is the Resident Physician's spouse, son/daughter or parent; or
- To care for the serious illness or injury of a covered service member if the service member is the spouse, son, daughter, parent or next of kin of the Resident Physician.

The Resident Physician is responsible for completing and submitting the appropriate FMLA paperwork to their Program Director.

Extended LOA:

An extended LOA (exceeding 12 weeks) may necessitate resignation from the Program. The Resident Physician may seek reappointment to the

Program at a later date. Resident Physicians are not eligible for UTHSC-H “sick leave pool” leave.

Insurance Coverage during LOA:

A Resident Physician may continue his or her personal insurance coverage and dependent insurance coverage during a period of LWOP 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 premium normally paid by the affiliated hospital when the LOA is provided under the FMLA.

Duration of LOA and Board Eligibility:

The duration of any sick leave, LOA, or any other absence must be consistent with satisfactory completion of training requirements. The amount of sick leave, LOA, or any other absence that will necessitate prolonging the training time (e.g., credit toward specialty board qualification) for the Resident Physician is determined by the Program Director and the requirements of the pertinent RRC and/or certifying board. Programs must provide its Resident Physicians with information relating to access to eligibility for certification by the relevant certifying board. Additional training after an LOA may be needed for successful completion of Program Requirements and/or for board certification requirements.

7. Bereavement Leave:

With the prior approval of the Program Director, a Resident Physician shall be granted up to three days of paid leave to attend the funeral of a family member. Family member is defined as the Resident Physician’s spouse or the Resident Physician’s or spouse’s parents, children, brothers, sisters, grandparents or grandchildren. Funeral leave shall be granted only for scheduled work days.

8. Educational Meetings:

A Program Director may authorize paid leave for a Resident Physician to attend educational meetings. Such paid leave is limited to one week each year and is not considered part of the Resident Physician’s vacation. Attending local, state or national specialty meetings would constitute appropriate use of this leave.

9. Work-Related Injury or Disability:

Injury or disability incurred by a Resident Physician within the course and scope of his or her appointment may be covered by workers’ compensation through a workers’ compensation insurance policy. A Program Director is required to complete and submit a First Report of Injury form in order for the Resident Physician to qualify for workers’ compensation. Leave taken in connection with an injury or disability not incurred during the course and scope of the appointment will be considered sick leave.

10. Professional Liability Insurance:

Professional liability insurance (“PLI”) for Resident Physicians is provided through The University of Texas System Medical Liability Benefit Plan (Plan) at no cost to the Resident Physician.

Except as described below (Memorial Hermann Hospital - TMC), the Resident Physician will be covered by the Plan when performing his or her assigned duties within the Program. Such coverage is valid only at the affiliated hospitals and clinics to which the Resident Physician is assigned through the Program. Current limits of liability are \$100,000/\$300,000. A Resident Physician who takes electives outside the affiliated hospitals is covered by the Plan as long as the elective is a required part of the Program in which the Resident Physician is seeking specialty board certification. There must be documentation in the department office of the elective agreement. The Plan does not cover any professional activities other than those assigned through the Program. (See “Moonlighting,” Section “I,” below)

Resident Physicians on rotation within Memorial Hermann Hospital - TMC are covered under a Memorial Hermann Hospital professional liability insurance policy. The Memorial Hermann Hospital professional liability insurance policy is not concurrent with coverage provided under The University of Texas System Medical Liability Benefit Plan and only applies to rotations occurring in Memorial Hermann Hospital.

Risk Management Education:

Resident Physicians that are covered by the Plan are required to complete five hours of Risk Management Education each year as a condition of their PLI coverage. Failure to complete the required courses will jeopardize the Resident Physician’s coverage; the Resident Physician may be placed on LWOP. To meet this requirement, Resident Physicians must take online courses as provided by UT System.

New users should contact their residency coordinator for their PLI identification number along with a temporary password that will require the creation of a personal password.

11. Counseling and Support Services:

Employee assistance services are provided to Resident Physicians through UT Counseling and WorkLife Services. UT Counseling and WorkLife Services offers confidential counseling services and referral services to assist Resident Physicians resolve problems in their personal lives that may affect performance in their Programs. Refer to the UT Counseling and WorkLife Services web page at <http://publicaffairs.uth.tmc.edu/worklife/index.html> for specific services available.

12. Access to UTHSC-H Network and E-mail:

Upon meeting all requirements, completing all paperwork relevant to their appointment and signing the *User Responsibilities & Accountability Acknowledgment Form*, Residents will receive a UTHSC-H e-mail address and network access for use during the duration of their appointment. Residents are subject to and shall abide by the terms of UTHSC-H HOOP Section 17

(http://legal.uth.tmc.edu/hoop/complete_toc.html#chap17). All use of the UTHSC-H network, including internet access, is a privilege that must not be abused. Any prohibited or inappropriate use of the network and the e-mail system may result in termination of such privilege and may be grounds for other adverse action. **E-Mail is the predominant means of communication between the Resident Physician and the GME Office and the Program. Communications may include information regarding stipends and benefits, important announcements from affiliated hospitals, notification of house staff meetings, etc. Resident Physicians should ensure that they routinely check email and periodically clear unnecessary messages from the email inbox. Resident Physicians have no expectation of privacy in any communication through the UTHSC-H Network, including e-mails; Resident Physicians are encouraged to limit the use of UTHSC-H resources for personal emails and are accountable for information in their UTHSC-H mailboxes.**

13. Professional Memberships:

Resident Physicians are enrolled as members of the Harris County Medical Society and the Texas Medical Association during new resident orientation. Annual dues are paid on behalf of each Resident Physician by the Texas Medical Association Insurance Trust.

14. Lab Coats/Badges:

Four three-quarter length coats are supplied to each Resident Physician 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.

Each Resident Physician receives an official identification badge subject to security conditions applicable in each Program. ID badges shall not be loaned to other Resident Physicians, family members, or other persons.

15. 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, Resident Physicians will have access to food services while on duty at affiliated institutions.

H. MOONLIGHTING

Residents are not required to engage in professional activities outside the educational program (moonlighting). Under Texas law, professional activities involving the practice of medicine outside the program are available only to a Resident Physician who holds a medical license from the Texas Medical Board. A physician-in-training permit **does not** entitle the Resident Physician to engage in professional activities (i.e., medical practice) outside the educational program. Resident Physicians engaging in moonlighting activities may not represent himself or herself as a UTHSC-H Physician nor use the UTHSC-H name in such moonlighting activities.

Benefit coverage, including coverage for any injury or disability (I.H.8) incurred, do not apply during outside or unassigned activity. Professional Liability Insurance (I.H.9) will not cover the Resident Physician for any liabilities incurred in outside professional activity. All moonlighting activities require completion of the appropriate moonlighting request form and approval in writing in advance from the Program Director, for inclusion in the Resident Physician's file. The Program may revoke approval or initiate corrective action in the event outside professional activity interferes with the ability of the Resident Physician to satisfactorily fulfill the obligations of the Program.

Any hours that a Resident Physician works for compensation at the sponsoring institution or any of the sponsoring institution's primary clinical sites (internal moonlighting) must be considered part of the 80-hour weekly limit on duty hours.

I. ESSENTIAL PERSONNEL

Resident Physicians with clinical duties have a professional obligation to be available for work during periods of adverse weather conditions and other declared emergencies and, unless released by the Program Director, are required to report to their designated work site during their appointed schedule even if the institution is closed due to adverse weather conditions. Resident Physicians should contact their Program Director to determine their status during times of adverse weather conditions or other emergencies. Resident Physicians are not authorized to leave their rotations without specific advance approval of their Program Director. Resident Physicians who fail to report to their scheduled rotation because of weather conditions without the approval of their Program Director shall be subject to disciplinary action by the Program.

J. PROFESSIONAL FEES

As a condition of acceptance to the Program, the Resident Physician waives all rights to fees for professional services to patients, regardless of the level of participation in the care of those patients. Such fees will be collected on behalf of the supervising professional staff in accordance with the following:

1. the regulations of the hospitals or other clinical settings in which the work is done;
2. the practices of the professional staff of each hospital or clinical setting; and,
3. the regulations, where applicable, of third-party payers.

K. TEXAS MEDICAL BOARD

1. Physician-in-training permits

A physician-in-training permit must be granted by the Texas Medical Board (TMB) to a physician who serves in Texas as an intern, resident, or fellow in graduate medical education programs accredited by the ACGME, or approved by the TMB or a medical specialty board. For the purposes of appointment of the Resident Physician, the Medical School will seek a physician-in-training permit on behalf of each Resident Physician who has never had an unrestricted license to practice medicine in Texas. The permit shall expire on the earlier of a) the reported ending date of the postgraduate training program, b) the date a postgraduate training program terminates or otherwise releases a permit holder from its training program, or c) the date the permit holder obtains full licensure or temporary license pending full licensure pursuant to TMB rules. The TMB retains the right at any time to place a

physician-in-training permit on inactive status. The fees associated with permit applications, renewals, and changes are the responsibility of the Resident Physician. A physician-in-training permit does not entitle the Resident Physician to assume professional activities outside of the Residency Program (Moonlighting, section II.I).

2. Permanent Texas Medical License

A Resident Physician who obtains a permanent medical license from the TMB during his or her training is required to maintain a current medical license at all times. Additionally, it is the Resident Physician's responsibility to notify the GME office of a newly issued license. A Resident Physician who has not renewed his or her license as necessary will lose PLI coverage effective on the license expiration date and will be removed from clinical duties (on LWOP) until the license is reinstated by the TMB.

3. Professional Name Presentation on Institutional Permit or Permanent License

Pursuant to TMB policy, all residents employed by the Foundation will be required to professionally use the name under which they are licensed with the TMB. Failure to do so may be considered unprofessional conduct by the TMB as defined by the Texas Occupations Code, Chapter 164.052(a) (5). A Resident Physician's physician-in-training permit must match the name as shown on the resident's medical school degree unless acceptable documentation of a legal name change is supplied with the initial permit application. If a name change occurs during the Resident Physician's training, the Resident Physician must contact the GME Office and provide proper documentation reflecting such name change.

4. Duty to Report

The TMB requires all Resident Physicians on "Physician in Training" (PIT) permits to report, in writing, to the Executive Director of the Board, the following circumstances within 30 days of their occurrence:

- the opening of an investigation or disciplinary action taken against the PIT permit holder by any licensing entity other than the Texas Medical Board;
- an arrest, fine (over \$100), charge or conviction of a crime, indictment, imprisonment, placement on probation, or receipt of deferred adjudication; and
- diagnosis or treatment of a physical, mental or emotional condition, which has impaired or could impair the permit holders ability to practice medicine.

Failure to comply with the provisions of this chapter (22 Tex. Admin. Code, Section 171) or Tex. Occ. Code, Sec. 160.002 and 160.003 may be grounds for disciplinary action as an administrative violation. Duties of PIT holders to report are specified in 22 Tex. Admin. Code, Section 171.5.

L. EVALUATION AND ADVANCEMENT

A Resident Physician will be evaluated at least twice each year based on the ACGME competencies and the Resident Physician's performance in patient care, medical knowledge, practice based learning and improvement, interpersonal and communication skills,

professionalism and systems-based practice. To progress in the program and be ultimately successful in completing the program, a Resident Physician must demonstrate his or her ability to assume increased responsibility for patient care. Advancement to higher levels of responsibility will be on the basis of an evaluation of his or her readiness for advancement. This determination is the responsibility of the Program Director with input from members of the teaching staff.

Evaluations will be communicated to the Resident Physician in a timely manner. The evaluations and the Resident Physician's responses to the evaluations, if any, will be maintained in the Program or department office and will be accessible to the Resident Physician for review.

It is the duty of the Program Director to establish a mechanism for evaluating the performance of the Resident Physician, including written progress reports to the Resident Physician. If a Resident Physician is not performing satisfactorily, the Program Director must document the deficiencies and outline a plan or program to correct the deficiencies. The plan or program may be formal or informal and may include corrective action (*see II.P*). It is the responsibility of the Resident Physician to follow up with any questions that he or she may have regarding an evaluation.

M. GRIEVANCES

It is the policy of the Foundation to encourage fair, efficient, and equitable solutions for problems that arise out of the appointment of the Resident Physician to the Foundation. 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 Physician 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 Physician's satisfaction, the Resident Physician 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 Physician 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 Physician, a decision will be communicated in writing to the Resident Physician and other appropriate, involved persons. The decision of the subcommittee is final.

N. RESIDENT PHYSICIAN IMPAIRMENT

The institutional policy regarding substance abuse among Resident Physicians recognizes the importance of prevention through education, recognition of the impaired Resident Physician, and the counseling and rehabilitation of the impaired Resident Physician. Impaired Resident Physicians and related allegations will be handled in accordance with the GME Committee's Resident Impairment Policy (*see Exhibit C, attached*).

O. COMPLAINTS OF SEXUAL HARASSMENT OR UNLAWFUL DISCRIMINATION

Complaints of sexual harassment and/or other forms of unlawful discrimination are to be addressed in accordance with the regulations found in HOOP Policy 2.04

(http://legal.uth.tmc.edu/hoop/02/2_04.html). Requests for Disability Accommodation shall be made in accordance with HOOP Policy 2.18C (http://legal.uth.tmc.edu/hoop/02/2_18C.html).

P. CORRECTIVE AND/OR ADVERSE ACTIONS

1. Summary Actions when the Resident Physician poses a threat to Patient Safety

Under any circumstances in which the Program Director or the clinical department's Education Committee determines that the unsatisfactory performance, conduct, or behavior of the Resident Physician may constitute an immediate threat to patient safety, the Program Director may reassign or suspend the Resident Physician pending a determination by the Program Director regarding the ability of the Resident Physician to continue in the Program. In such cases, the Resident Physician's right to a hearing shall follow the process set forth in Academic Actions, Section II.P.2.15

2. Academic Actions

In the event a Resident Physician encounters difficulty meeting and/or maintaining performance standards as they pertain to the ACGME Competencies, as well as professional behavior standards ("academic difficulty"), the Resident Physician should seek out the advice and guidance of the Program Director. Likewise, if the clinical department's education or clinical competence committee and/or the Program Director know that a Resident Physician's performance is unsatisfactory, the Program Director must contact the Resident Physician and provide adequate verbal and/or written notice and guidance to the Resident Physician about his or her performance and possible corrective action (consistent with section II.M.).

If the Program Director has notified the Resident Physician about his or her unsatisfactory performance, including professional behavior, offered advice and guidance, and, if appropriate, taken corrective action, and the Resident Physician's performance 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.

Procedural Guidelines for Academic Actions

In cases where a Resident Physician 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 Physician to improve his or her performance prior to

the corrective/adverse action, the Resident Physician may request that a subcommittee of the GMEC be established to review such action. The Resident Physician 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 Physician.

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 Physician.

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 Physician and Program Director as soon as reasonably possible. The decision of the Dean is final.

3. 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 Physician, 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 Physician prior to the end of the appointment term.

If allegations are levied against the Resident Physician that (if confirmed) may subject the Resident Physician 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 Physician *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 Physician.

Procedural Guidelines for Non-Academic Actions

If the Resident Physician 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 Physician disputes the allegations, or if the Resident Physician

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 Physician member from a Residency Training Program. The Committee will select its presiding chairperson. The Resident Physician 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 Physician at the address appearing in the Program records.

The Resident Physician 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 Physician 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 Physician 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

1. Resignation

A Resident Physician may resign from a Program by providing 30 days written notice of his or her intent to resign. The Resident Physician'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 Physician.

2. 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.

3. Termination

A Resident Physician's appointment may be terminated prior to the end of the appointment term as described in section II.P.1., II.P.2., or II.P.3, A Resident Physician so terminated will continue to be compensated for 90 days from the earlier of the date of termination or the end of the appointment term.

R. VENDOR INTERACTIONS

Industry support of Residency Programs must be provided through official channels at either the School or Department level. Such support will be used for educational purposes as determined solely by the Department Chair and Program Director. Program Directors

and faculty should be sensitive to potential abuses arising from direct interaction between Resident Physicians and industry representatives. Accordingly, Program Directors should monitor and provide guidance to Resident Physicians in their interactions with industry representatives. Program Directors and faculty should ensure that support of Resident Physicians by industry through funding mechanisms such as scholarships, reimbursement of travel expenses, or other non-research funding in support of scholarship or training, or the furnishing of meals and promotional items, are free of any actual or perceived conflict of interest and any appearance of impropriety. Resident Physicians shall abide by the UTHSC-H Standards of Conduct Guide

(http://legal.uth.tmc.edu/hoop/02/Standards_of_Conduct_Guide.htm); HOOP Policy 2.05 regarding Solicitation on Campus (http://legal.uth.tmc.edu/hoop/02/2_05.html); and HOOP Policy 2.19 regarding Conflicts of Interest (http://legal.uth.tmc.edu/hoop/02/2_19.html).

S. PROGRAM CLOSURE/REDUCTION

If, in its sole discretion, the Medical School determines to either reduce the size of or close a Program(s) or certain parts of a Program(s), the Resident Physician will be notified as soon as practicable. An effort will be made either to allow those Resident Physicians in the Program at that time to finish the Program or assist the Resident Physicians in identifying another ACGME Program in which they may continue their education.

T. CHECKOUT PROCEDURE

Resident Physicians departing a Program, whether through graduation, program closure, resignation, separation, termination, or other means, shall check out through their Program following the check-out procedures set forth by the Program, their training hospitals, and the GME Office. Certain affiliated hospitals may also require a separate check out.

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(http://legal.uth.tmc.edu/hoop/02/Standards_of_Conduct_Guide.htm);

HOOP Policy 2.05 regarding Solicitation on Campus (http://legal.uth.tmc.edu/hoop/02/2_05.html); and

HOOP Policy 2.19 regarding Conflicts of Interest (http://legal.uth.tmc.edu/hoop/02/2_19.html).

Section IV: Specific Policies of the Internal Medicine Residency Program

- A. Residents' Duties:**
- B. Structure of Program**
- C. Educational Aspects of the Program:**
- D. House Staff Evaluations**
- E. Monthly Schedules**
- F. Pagers**
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- I. Medical Records and Clinical Documentation**
- J. Overnight Call**
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- L. Professional Opportunities**
- M. Risk Management**
- N. Parking**
- O. Vacations and Time Off**
- P. Ready Reserve**
- Q. Exposure to Infectious Diseases**
- R. Departmental Conference**
- S. Attendance**
- T. Inpatient Services**
- U. Ambulatory Services**
- V. Hospital Admissions**
- W. Responsibilities of the First Year Resident**
- X. Responsibilities of the Second, Third and Fourth Year Residents**
- Y. Procedures and Skills**
- Z. Teaching Functions of the Residents**

A. Residents' Duties:

1. On inpatient rotations, residents should have continuing responsibility for all of the patients on their services.
2. Residents' service responsibilities are limited to those patients for whom the training program bears major diagnostic and therapeutic responsibility. A few patients are on "non-teaching" status. Residents are **not responsible** for routine care of non-teaching patients. In the event of a medical emergency (e.g. cardiac arrest, status epilepticus) affecting such a patient, residents should provide such emergency care as is needed to stabilize the patient. While residents are providing emergency care to a non-teaching patient, vigorous efforts should be made to notify the patient's attending physician.
3. Residents must not spend more than 80 hours per week, averaged over a 4-week rotation, on patient care duties.
4. Residents will not be assigned to in-house call more often than every third night.
5. Residents at all levels must have, on average, 1 day out of 7 free of patient care duties, (i.e. 4 days off in a 4-week rotation).
6. On emergency medicine, continuous duty will not exceed 11 hours and no more than 60 hours of ER shifts per week.
7. Emergency medicine and night float shifts will be separated by at least 10 hours of non-patient care.
8. Residents must write all orders for patients under their name with the appropriate supervision by attending physicians. In those unusual circumstances in which a consultant or attending physician writes an order, the person writing the order should communicate the action to the patient's resident in a timely manner.
9. If an admitted patient is a clinic patient of one of our residents, that resident should be notified of the admission so he/she may participate in that patient's care and help coordinate after-hospital care.
10. On inpatient rotations:
 - (a) A PGY-1 resident must be responsible for working up no more than 5 new patients per 24-hour admitting day, and no more than 8 new patients in a 48-hour period.
 - (b) A PGY-1 resident must not be responsible for the ongoing care of more than 12 patients.
 - (c) An upper-level resident (PGY-2, PGY-3 or PGY-4 Med/Peds) must not be responsible for working up more than 10 new patients per admitting day, and no more than 16 new patients in a 48-hour period, including any PGY-1 residents' patients being supervised.
 - (d) When supervising more than one PGY-1 resident, an upper-level resident must not be responsible for the ongoing care of more than 24 patients.
 - (e) These limits may be increased by 2 in educationally justified circumstances where an admission does not require a full workup: acceptance of in-house transfers from MICU or overflow or "bounce-back" patients already fully worked up by the previous day's admitting team.
 - (f) Admissions over these limits must be evaluated by float residents or other services in the hospital. Float residents who reach the limit of

their admissions should contact the Chief Resident immediately, so help may be provided.

(g) In the Medical Intensive Care Unit and the Coronary Care Unit, the “cap” usually depends on the number of available beds in that unit. In the unlikely event that a unit is completely empty, the overall caps in (a) and (c) above still apply. Afterwards, patients requiring critical care may be placed in other intensive care units, but they will be managed by the critical care fellow and attending; they will not be under the care of residents and interns.

(h) The interns/residents must leave the hospital no later than 1:00 p.m. post call.

B. Structure of Program:

1. Total required emergency medicine experience will not exceed 3 months in a 3-year residency.
2. 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.

C. Educational Aspects of the Program:

1. All patient care activities in which residents are engaged must be supervised by attending physicians.
2. Educational experiences of the program include interactions with residents, fellows and attending physicians, as well as attendance at conferences and teaching rounds. Evaluation and feedback regarding residents’ performance are integral components of the program.

D. House Staff Evaluations

1. Rotation Evaluations

At mid-month and at the end of the month, residents should 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>

2. Routine Evaluations

Evaluation of the house staff 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.

3. Six Month Evaluations

Residents meet with the Program Directors semi-annually. During these meetings, the program director and house officer will discuss educational progress, performance in the program and provide career counseling.

4. 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 your responsibility to print out the form, take it to your clinic attending, or hospital attending, and have it completed. Both the attending and resident must sign, and then you will then take it to the Program Administrator, Susan Jones, in the House Staff Office, MSB 1.134. If you have any questions concerning the email, form or instructions, contact Susan Jones at 713-500-6525.

5. 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.

6. Continuity Clinic Evaluations

Continuity Clinic Evaluations are sent out quarterly to each attending that conducts a continuity clinic. During the continuity clinic, the resident has regular contact with a particular attending. The attending evaluates the resident on their progression of skills.

E. Monthly Schedules

The rotation schedule will be made prior to the beginning of the academic year (July 1st) and will be available at: <http://amion.com/> --the password is "uthim."

All schedule change requests must be made in writing to the Assistant Chiefs of Service in charge of scheduling. Scheduling changes must be approved 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 **there is little room for adjustment in this schedule.**

F. Pagers

You will be issued a personal pager, for which you are responsible. You will be financially responsible for the loss or damage of your pager. Also, you may be issued a hospital pager during rotations at MD Anderson or St. Luke's Episcopal Hospital, but you still should ALWAYS wear your UT beeper and leave it on at all times unless on vacation or your day off.

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.

How to use the pager system:

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

Remember: Even when you are at MD Anderson or St. Luke's, you still need to have your UT pager on at all times

You 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.

G. Email

You will be provided with a University of Texas Houston e-mail account. This is the only account the program will use to disseminate information to you. It is your personal responsibility to check you UT account on a regular basis. We recommend checking it 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 have problems with your account or password, please contact the UTH Help Desk at 713-500-4848.

Official emails will be sent on behalf of the program from the email address: residency.imed@uth.tmc.edu

We encourage you 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.

H. Educational Meetings

Scholarly activities are encouraged among the residents. Part of this is attendance at national meetings for Internal Medicine or its subspecialties. House Staff 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.

I. Medical Records and Clinical Documentation

It is the responsibility of every house officer to complete all medical records in a timely manner. 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. Residents are

responsible for medical records of Acting Interns, which are Fourth Year Medical Students rotating on the Medicine Ward service. The Ward resident is ultimately responsible for all documentation completed by the team during his/her month. 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.

J. Overnight Call

House Staff are responsible for covering all inpatient services twenty-four hours per day. Most house staff will be on call every third or fourth night.

K. Professional Attire and Etiquette

House staff 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 during on call shifts.

L. Professional Opportunities

Opportunities available to graduates of the training program are will be posted on online.

M. Risk Management

Each resident is required to complete Risk Management Training. This is now done on-line and you will be contacted via email by the Program Administrator, Susan Jones, with the website and instructions for completing your Risk Management. This email will be about the first week of July and will have to be completed by all, no later than the last day of August. If a resident fails to complete this training by the specified date the program may deem it necessary to remove resident from service, without pay, until the requirement is met.

N. 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.

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

Parking at LBJ will be provided at no cost to UT residents. 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 resident 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 resident will be issued a decal based upon their work classification.

O. Vacations and Time Off

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

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

The Resident Physician 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. If a change becomes necessary, a request should be turned in to the Internal Medicine Residency Office, MSB 1.134, at least **TWO MONTHS** in advance. **All changes will be subject to the approval of the Assistant Chiefs of Service and Program Director.**

A Resident Physician is not eligible to accumulate annual vacation.

A Resident Physician leaving the Program will not be compensated for unused vacation.

All residents get an additional 4 day vacation around the holiday of your choice, dependent on the schedule. During this time, while the house staff is on holiday, the remainder of the house staff will cover the ward and emergency services. If a resident opts for a holiday other than Christmas or New Years, that resident will be required to work both of those holidays.

All residents on service are allowed one day off every seven days. Days off should be staggered, so that not more than one intern is gone at a time. Patients of a resident who are off should be covered by other residents on the team. A resident should take no more than four days off each month (assuming they worked 28 days during the month).

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 specialty conferences, attending classes or other elective endeavors must arrange their own coverage. The Assistant Chiefs of Service will not pull a resident from the ready reserve pool for these purposes. If no coverage is found by the resident, they must report to their assigned duties that day.

P. Ready Reserve

The Ready Reserve list 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.

Q. 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.

R. Departmental Conferences

There are several internal medicine conferences held weekly. Attendance by house staff and medical students is MANDATORY and will be monitored with sign-in sheets. Attendance at conferences is a requirement of the ACGME. Topics are selected by Assistant Chiefs of Service and Program Directors, in order to cover the most important areas in Internal Medicine.

1. Morning Report

Morning Reports are offered Weekdays at 8:00 am in 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 House Staff 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. Frequently, senior residents are also given the opportunity to discuss cases on the post call morning with senior faculty, namely Dr. James T. Willerson and Dr. Herbert Fred, both of whom hold regular morning reports.

2. Core Curriculum Lectures

This is a one-year series of lectures. Each subspecialty is assigned one month throughout the year and noon conferences are conducted by the faculty in that subspecialty. Topics are based on commonly seen disease processes in Internal Medicine and attendance is required. These are directed at preparing resident physicians 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 house staff for the Board examination.

3. 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.

4. Clinicopathologic Conferences

Many conferences utilize an established partnership with the Departments of Pathology and Radiology. There is a monthly autopsy CPC, monthly medicine-radiology and monthly medicine-pathology conference.

5. Senior Seminars

Every year, the senior residents prepare noon conferences that consist of a review of a topic. The subject matter may 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.

6. Other Noon Conferences

Other conferences include medical jeopardy, Morbidity and Mortality conferences, pathology for clinicians and MKSAP review.

S. 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 which will consist of additional Emergency Room shifts. These ER Shifts must be scheduled within 30 days of notice of poor attendance, and if not scheduled, will be assigned by the chief residents. A formal letter will be forwarded to the Chair of the Department of Medicine and a copy will be placed in the resident's file. Failure to complete ER shifts will be considered dereliction of duty, and appropriate actions will be taken.

T. Inpatient Services

The teaching hospitals for this program are the Memorial Hermann Hospital, Lyndon B. Johnson General Hospital, the M.D. Anderson Cancer Center and St. Luke's Episcopal Hospital.

The inpatient services are organized so as to provide high-quality medical care, allowing the house staff freedom for independent decision-making while retaining supervision by the faculty and attending physicians. Most ward teams consist of one or 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 house staff; 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 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.

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.

U. Ambulatory Services

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

1. Ambulatory Clinic Rotations

The general medicine clinic LBJ will function 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.

Other sites for ambulatory rotations are the Thomas Street Clinic (Harris County AIDS Clinic), Internal medicine clinics at U.T. Professional Building and the UT West Loop Clinic.

2. 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, Emergency Room, 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.

Business cards will be given to each resident so that they can give them to their patients.

3. 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.

V. Hospital Admissions

1. 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 the patient has a private PCP, they should be notified of the admission and plans for management. Thereafter, the house staff and private physician should communicate frequently. The ward resident is ultimately responsible for assuring that continuing communication occurs. The house staff 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.

2. 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 house staff must maintain daily communication with the attending physician regarding the progress of all patients on the service.

3. 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.

W. Responsibilities of the First Year Resident

1. Inpatient Services

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.

2. Ambulatory Services

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.

X. Responsibilities of the Second, Third and Fourth Year Residents

1. Inpatient Services

The 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 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.

2. Subspecialty Rotations

The specific responsibilities of the 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.

3. Ambulatory Service

As noted above the 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.

Y. Procedures and Skills

Residents at all levels of training are supervised by faculty members of the Department of Internal Medicine. A faculty member is on call and available to assist and supervise residents at all times.

All residents at each level of training in Internal medicine are supervised by an attending Internist. Residents are expected to be able to work more independently as they progress through training.

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 resident, 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 resident:
 - 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:

1. A resident 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.

Z. Teaching Functions of the Residents

Interactions with house staff constitute a major source of learning for medical students and other house staff. The educational tone of a service is set largely by the ward resident and the interns. Therefore, residents and interns 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 house staff 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)

House Staff are expected to help students achieve the above abilities and skills by allowing students to see patients first unless the situation is urgent. House staff should observe the students performing histories and physical examinations during the early part of the rotation, in order to recognize and correct any deficiencies. House staff 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. Residents should guide the students and interns to appropriate reading material. Finally, the house staff should always treat junior students respectfully, as valued members of the inpatient health care team.

Section V: Additional Policies from the UT Medical School
A. Policy on Appropriate Student Treatment
B. UTHSC-H Duty Hours Policy
C. Resident Impairment Policy

**UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON
POLICY ON APPROPRIATE STUDENT TREATMENT**

I. Standards for Conduct in the Teacher-Learner Relationship

The academic environment, particularly in medical education, requires civility from all participants, regardless of role or level, and a particular respect for the values of professionalism, ethics, and humanism in the practice of medicine.

The relationship between teacher and learner is based on mutual respect and trust. Faculty must respect students' level of knowledge and skills, which students have the responsibility to represent honestly to faculty. Faculty are obligated to evaluate students' work fairly and honestly, without discrimination based on gender, ethnicity, national origin, sexual orientation, or religious beliefs. Faculty have a duty not only to promote growth of the intellect but at the same time to model the qualities of candor, compassion, perseverance, diligence, humility, and respect for all human beings.

Because this policy and document pertains to students as learners, references to teachers and faculty also include residents and fellows in their teaching and supervisory role with regard to students.

Examples of behavior that are unacceptable at The University of Texas Medical School at Houston include:

- Physical or sexual harassment or abuse
- Discrimination or harassment based on race, gender, age, ethnicity, religious beliefs, sexual orientation, or disability
- Speaking in disparaging ways about an individual including humor that demeans an individual or a group
- Sending students on inappropriate errands
- Loss of personal civility: shouting, displays of temper, publicly or privately abusing, belittling, or humiliating a student
- Use of grading or other forms of evaluation in a punitive or retaliatory manner

Students are also expected to maintain the same high standards of conduct in their relationships with faculty, residents, support staff, and fellow students.

II. Procedures for Reporting and Investigating Violations

Students enrolled in the Medical School (or Medical School portion of the M.D. /Ph.D. program) should report abuse or mistreatment to the Associate Dean for Student Affairs. The Associate Dean for Student Affairs will meet with the student to discuss the incident or behavior and the options for action.

UTHSC-Houston policies and procedures concerning misconduct by faculty and staff, including sexual and physical abuse and harassment, are outlined in the Handbook of Operating Procedures (HOOP). The Rules and Regulations of the Board of Regents ("Regents' Rules") contain provisions for student misconduct, including misconduct against fellow students. The Associate Dean for Student Affairs will advise and assist the student in following applicable procedures of the institution. 20

In the event there is no applicable existing procedure, the Associate Dean for Student Affairs in consultation with the student will determine the most appropriate plan of action. This may involve an investigation by the Associate Dean for Student Affairs to establish the facts while respecting the rights and confidentiality of the involved parties.

Depending on the nature or scope of the reported mistreatment, the Associate Dean for Student Affairs has the authority to appoint an ad hoc Committee on Student Treatment consisting of three faculty members, one of whom will be appointed to chair the committee.

An attorney from the UTHSC-H Office of Legal Affairs & Institutional Compliance will serve as an ex officio member of the Committee to ensure that University and Health Science Center policies and procedures are followed. The purpose of the ad hoc Committee will be to investigate the complaint, establish facts respecting the rights and confidentiality of the involved parties, and recommend a course of action to the Associate Dean for Student Affairs.

It will be made clear from the fact-finding or investigation stage forward and through final disposition of the report that retaliatory behavior or reprisals of any kind will not be tolerated.

The Committee on Student Treatment will be required to report its findings in writing within thirty days of its constitution to the Associate Dean for Student Affairs.

If, following determination of the facts and considering the recommendation of the ad hoc Committee on Student Treatment, if one was appointed, the Associate Dean for Student Affairs may take one or more of the following actions in consultation with the Office of Legal Affairs & Institutional Compliance:

- Arrange mediation between the parties
- Report findings and recommendations to the perpetrator
- Report findings and recommendations to the Dean
- Report findings and recommendations to the perpetrator's department chair
- Report findings and recommendations to the faculty member in charge of the course, clerkship, or elective in which the mistreatment took place
- In the event the perpetrator is a resident, report findings and recommendations to the residency program director and Associate Dean for Educational Programs

These actions may be in addition to or superseded by actions taken by the appropriate bodies or individuals if specific UTHSC-H procedures are followed.

III. Dissemination and Education

In order to make sure that faculty, residents, fellows, and students are aware of the Policy on Appropriate Student Treatment, several mechanisms for dissemination will be used. The Policy will be added to the Medical School website on the principal students, faculty, and house staff web pages.

A hard copy of the Policy will be given to current house staff and fellows and given to new house staff during orientation.²¹

A hard copy of the Policy will be given to current students and thereafter to entering students at orientation. It will be reviewed and discussed at Orientation and later in the fall semester meetings of the Master Advisory groups.

A hard copy of the Policy will be given to faculty and distributed at faculty orientations. Chairmen and Directors will be responsible for seeing that the Policy is made known to their faculty and discussed at departmental/division meetings.

Each course director, clerkship director and residency director will be responsible for seeing that the Policy is made known to their teaching faculty and to all students at the start of each course, clerkship or rotation.

**UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON
POLICY FOR RESIDENT DUTY HOURS
AND THE WORKING ENVIRONMENT**

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.

2. Duty Hours

- a. 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.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be 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.
- d. Adequate time for rest and personal activities must be provided. This should consist of a 10 hour time period provided between all daily duty periods and after in-house call.

3. 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.

- a. In-house call must occur no more frequently than every third night, averaged over a 23 four-week period.

- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. 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.
- c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty.
- d. At-home call (pager call) is defined as call taken from outside the assigned institution.
 - 1. 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.
 - 2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 - 3. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

4. Moonlighting

- a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
- b. Each program must have a written policy regarding moonlighting that:
 - 1. specifies that residents must not be required to engage in moonlighting
 - 2. requires a prospective, written statement of permission from the program director that is made part of the resident's file; and,
 - 3. states that the residents' performance will be monitored for the effect of these activities upon performance and that adverse effects may lead to withdrawal of permission.
- c. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), i.e., internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.

5. Oversight

- a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment.

These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- b. Back-up support systems must be provided when patient care responsibilities are 24 unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

6. Duty Hours Exception

An RRC may grant exceptions for up to 10 % of the 80-hour limit, to individual programs based on a sound educational rationale. The University of Texas Medical School at Houston (UTMS-H) Graduate Medical Education Committee (GMEC) Policy for Review of Requests from Programs for Extension of the 80-Hour per Week Limit on Resident Duty Hours specifies how programs in this institution may apply for such an extension.

Approved by the GMEC 4/23/2003

**UNIVERSITY OF TEXAS MEDICAL SCHOOL AT HOUSTON
RESIDENT PHYSICIAN IMPAIRMENT POLICY**

STATEMENT OF POLICY OVERVIEW

The University of Texas Medical School at Houston (UTMSH) and The University of Texas System Medical Foundation (Foundation) are committed to maintaining or restoring the physical and mental health of Resident Physicians as well as maintaining a drug free environment. The primary goal related to substance abuse in the Resident Physician community is prevention. UTMSH recognizes that substance abuse and mental disorders are treatable medical conditions, and as an institution dedicated to health, facilitate the treatment and rehabilitation of these conditions for both patients and healthcare providers

POLICY

The unlawful purchase, manufacture, distribution, possession, sale, storage, or use of any controlled substance or medication by Resident Physicians while on duty, or while in or on premises or property owned or controlled by UTHSC-H or any of its affiliated institutions is prohibited.

The unauthorized use or possession of alcohol by Resident Physicians while on duty is prohibited. State law will be enforced at all times in or on all premises or property owned or controlled by UTHSC-H or any of its affiliated institutions.

Any use of alcohol or any other substance by Resident Physicians that adversely affects job performance or that may adversely affect the safety of other Resident Physicians, students, visitors or patients in any facility owned or controlled by UTHSC-H or its affiliated institutions is prohibited, regardless of whether such use occurs during duty hours.

Prescription and over-the-counter medications that may induce impairment and any mental or physical condition that may induce impairment are included in this policy. A Program Director's advice and assistance may be necessary when duty adjustments are required to ensure a Resident Physician's ability to perform assigned work in a safe manner because of the use of such medications. Failure to comply with this published policy by any Resident Physician will constitute grounds for corrective action, up to and including termination.

At the discretion of UTHSC-H or the Foundation, a Resident Physician may be referred to the Resident Physician Assistance Program (RAP) for evaluation, and a Resident Physician with a diagnosed or claimed impairment may be referred to RAP for and be required to participate in and satisfactorily complete an approved treatment and follow-up program.

PROCEDURES

Because substance abuse has a potential for serious adverse effects upon the Resident Physician, patients, colleagues and the institution, it is necessary to have a comprehensive program that:

1. educates both Resident and Faculty physicians about the problems associated with substance abuse, mental illness and behavioral problems and trains them to recognize the associated signs and symptoms.
2. provides a means for immediate evaluation and appropriate referral for diagnosis, treatment and follow-up, including monitoring; and,

3. complies with state and federal law as well as policies included in The University of Texas Health Science Center at Houston Handbook of Operating Procedures.

I. Educational Efforts

UTHSC-H relies on the observations and judgment of Program Directors, teaching faculty, and peers to evaluate the behavior of Resident Physicians, to identify suspected impaired behavior, and to refer Resident Physicians exhibiting such behavior to the RAP for evaluation. The RAP and UT Counseling and WorkLife Services are also a benefit available to all Resident Physicians for self-referral. The RAP also provides assessment and referral for assistance with personal problems such as difficulty with a marital, family or other significant relationship, stress/burnout, depression, and grief as well as attitudinal and behavioral problems noted in the workplace. Program Director and faculty awareness of RAP and the issues and implications of substance abuse and the other problems noted above will be facilitated through discussions with the GME Office.

II. RAP/UT COUNSELING Referral and Treatment

A. Course of Action:

- Resident Physicians whose behavior or performance gives rise to reasonable suspicion of impairment has likely exhibited performance problems prior to being referred to the RAP for assessment. The Program Director will work in partnership with other sources of departmental supervision to document the progress of the Resident Physician's failure to meet program expectations. The Program Director will meet regularly and counsel with Resident Physicians in need of remediation.
- Resident Physicians reasonably suspected of substance abuse or other impairment, based on direct observations by faculty or staff, will be immediately referred by the Program Director to the RAP for evaluation. If the Program Director determines in his or her judgment that a reasonable possibility of patient harm exists as a result of the Resident's suspected impairment, the resident will immediately be removed from clinical responsibilities pursuant to Section II.P.1 of the GME Resident Handbook. Descriptions of the observed behavior will be documented for the Program Director as soon as possible. The Department Chair will also be notified of the allegation of impairment.
- All documentation of the presenting incident along with any prior effort to remediate problem behavior will be forwarded on to the RAP to be used as part of a comprehensive evaluation. The Resident Physician's evaluation may include drug and alcohol testing if improper uses or abuses of those substances are reasonably suspected. This evaluation by the RAP will assess the Resident Physician's physical and mental condition, and the results of the assessment will be utilized to determine the likelihood that the observed behavior might be caused by chemical substance use and/or abuse, mental illness, and/or behavioral problems.
- The evaluation, when completed, will be forwarded to the appropriate Program Director and may include recommendations for further evaluation, if needed, as well as for treatment and monitoring. A "last chance" contract between the Resident Physician, the RAP, and UTHSC-H Residency Program will also be given to the Resident to sign. This contract will include the requirements and expectations of the treatment and monitoring for the duration of

the residency. Guidelines for actions to be taken in those instances of a relapse will also be included.

- Program Directors and Department Chairs should make every effort to communicate the message that mandatory referrals are not punitive in nature. Instead, these referrals are intended to assist the Resident Physician to address impairment with the intent of returning to full productivity whenever possible, while ensuring the health and wellbeing of all involved.
- Corrective actions, including back-to-work restrictions, if any, and regular random blood and or urine test monitoring, regular follow-up, or other consequences of the identified problem will be decided upon by the Program Director, Department Chair, and RAP Director following consideration of all pertinent information, including the evaluation and treatment recommendations and the requirements of the signed contract.
- The RAP will coordinate the necessary follow-up and monitoring and will inform the Resident Physician's Program Director as to whether or not the Resident Physician has cooperated. Regular reports of the Resident Physician's progress will be provided as needed to ensure smooth transitions to full employment. Reports will ultimately be provided a minimum of twice annually to the Program Director/Department Chair by the RAP.
- Failure to comply with treatment and or positive body fluid tests for prohibited substances will be reported to the Program Director.
- The RAP will participate in a return-to-duty meeting in all cases when the treatment and monitoring plan are fully in place. The assessment and referral function of the RAP provides a measure of protection for the Resident Physician who has made a good faith effort towards recovery, codified by the signed contract.
- Reinstatement of a Resident Physician who was previously monitored by the RAP into the UTHSC-H Residency Program should be referred back to the RAP upon re-admission. This Resident Physician will be assessed and evaluated for risk factors. It will be up to the RAP to determine if the resident remains in need of ongoing UT Counseling supervision.

B. Course of Action: Self-referral

Resident Physicians who wish to obtain assistance for the treatment of a drug-related or mental health problem are encouraged to seek assistance through the RAP. The RAP can help coordinate short or long-term problem evaluation and potential resolution through treatment free of charge to the Resident Physician.

Resident Physicians may use health insurance to defray the cost of many treatment programs, although certain restrictions may apply, depending on the type of treatment recommended. The RAP will assist in determining how a Resident Physician's insurance coverage may be applied most efficiently. In addition, medical leaves of absence may be granted to accommodate outpatient and/or extended hospital care.

Seeking help through the RAP will not jeopardize the Resident Physician's current position or potential in the training program. Involvement with the RAP will not grant special privileges or exceptions from normal performance standards. Confidentiality between the Resident Physician, Program Director and Department Chair, and the RAP will be respected in all cases unless the Resident

Physician authorizes disclosure or as otherwise required by law. **In all cases, regardless of the method of referral, the rules and regulations of the Texas Medical Board (TMB), including the required initial and follow-up reports, will be strictly observed.** The RAP will also offer counseling to each Resident in treatment as to how and when they should notify the TMB of their treatment and rehabilitation.

III. Sanctions

Corrective actions or other consequences of the reported behavior will be determined exclusively by the Program Director or Department Chair, in consultation with the GME Office, following their consideration of all pertinent information.

Any Resident Physician who is arrested under a criminal statute for any misdemeanor or felony offense, including, but not limited to drug-related offenses, whether or not the Resident Physician is on duty, is required to notify the Program Director not later than five days after such arrest. In turn, the Program Director is required to notify the Office of Graduate Medical Education immediately after receiving notice of such arrest to provide for the Institution's compliance with the law. A conviction of a Resident for a violation of any misdemeanor (except Class C) or felony criminal offense, including, but not limited to drug offenses (e.g., for use, possession, distribution, or manufacture of an illegal drug) may result in termination of the Resident Physician's appointment. The TMB will be immediately notified of such termination and the nature of the conviction. Additionally, Resident Physicians will be expected to self report any matters to the TMB, as may be required by the TMB.

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