



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

**Internal Medicine/ Pediatric
Residency Training Program**

**Policies and Procedures Manual
2011 - 2012**

Effective July 1, 2011

Table of Contents

| | | |
|-----|---|----|
| I. | DEFINITIONS AND DESCRIPTIONS | 5 |
| II. | PROGRAM OVERVIEW | 5 |
| A. | PROGRAM LEADERSHIP | 6 |
| 1. | Chair – Internal Medicine | 6 |
| 2. | Vice Chair – Internal Medicine | 7 |
| 3. | Chair – Pediatrics | 7 |
| 4. | Program Director – Internal Medicine & Pediatrics | 8 |
| 5. | Program Director – Internal Medicine | 9 |
| 6. | Program Director – Pediatrics | 9 |
| 7. | Associate Program Director – Internal Medicine & Pediatrics | 10 |
| 8. | Associate Program Directors – Internal Medicine | 10 |
| 9. | Associate Program Director – Pediatrics | 11 |
| 10. | Core Faculty | 11 |
| 11. | Program Staff | 12 |
| B. | SPONSORING INSTITUTION | 13 |
| C. | AFFILIATED INSTITUTIONS | 13 |
| 1. | Hospitals | 13 |
| 2. | Clinics | 14 |
| D. | LEVELS OF TRAINING | 14 |
| E. | APPOINTMENT AND REAPPOINTMENT | 14 |
| 1. | Appointment and Selection Criteria | 14 |
| 2. | Reappointment and Promotion | 15 |
| F. | STRUCTURE OF THE PROGRAM | 15 |
| G. | SCHEDULES | 16 |
| 1. | Monthly Schedules | 16 |
| 2. | Vacations and Time Off | 17 |
| 3. | Ready Reserve/Jeopardy Call | 17 |
| 4. | Sick Leave/Leave of Absence | 18 |
| 5. | Leave of Absence (LOA) | 18 |
| 6. | Military Leave | 18 |
| 7. | Family and Medical Leave (FMLA) | 18 |
| 8. | Holidays | 19 |
| H. | SUPERVISION POLICY | 19 |
| 1. | General | 20 |
| 2. | Inpatient Services | 21 |
| 3. | Outpatient Services | 35 |
| 4. | Procedures Performed by the resident | 36 |
| I. | ROLES AND RESPONSIBILITIES OF RESIDENTS | 37 |
| 1. | Inpatient Services | 38 |
| 2. | Ambulatory Services | 39 |
| 3. | General Medicine/Pediatric Continuity Clinic | 39 |
| 4. | Subspecialty Clinics | 40 |
| J. | HOSPITAL ADMISSIONS | 40 |
| 1. | Memorial Hermann Hospital | 40 |
| 2. | Lyndon B. Johnson General Hospital | 40 |

| | | |
|-----|--|----|
| 3. | M.D. Anderson and St. Luke's Hospitals | 40 |
| 4. | Call Rooms and Food Services | 41 |
| K. | MEDICAL RECORDS AND CLINICAL DOCUMENTATION..... | 43 |
| L. | EXPOSURE TO INFECTIOUS DISEASES | 43 |
| M. | EVALUATION AND ADVANCEMENT | 44 |
| 1. | Resident Evaluations | 44 |
| 2. | Rotation Evaluations | 45 |
| 3. | Peer Evaluations | 45 |
| 4. | Attending Evaluations | 45 |
| 5. | Resident Self-Evaluations..... | 45 |
| 6. | Six Month Evaluations | 45 |
| 7. | Clinical Evaluation Exercise | 45 |
| 8. | In-Training Exam | 46 |
| 9. | Problems and Complaints about Evaluation | 46 |
| 10. | Retaliation | 46 |
| N. | Medical Licensure | 46 |
| 1. | DEA AND DPS NUMBERS..... | 47 |
| O. | EDUCATIONAL MEETINGS AND CONFERENCES..... | 47 |
| 1. | Resident Case Conferences | 48 |
| 2. | Core Curriculum Lectures | 48 |
| 3. | Grand Rounds..... | 48 |
| 4. | Senior Seminar | 48 |
| 5. | Morning Report..... | 48 |
| 6. | Multidisciplinary Week | 48 |
| P. | PROFESSIONAL ATTIRE AND ETIQUETTE..... | 49 |
| Q. | MOONLIGHTING | 49 |
| R. | DUTY HOURS..... | 50 |
| 1. | Policy..... | 50 |
| 2. | On-Call Activities..... | 51 |
| 3. | Subspecialty Program Requirements..... | 51 |
| 4. | Professionalism, Personal Responsibility, and Patient Safety | 52 |
| 5. | Transfer Protocols and Hand-over of Patient Care | 52 |
| S. | GRIEVANCES | 53 |
| T. | CORRECTIVE AND/OR ADVERSE ACTIONS | 53 |
| 1. | Summary Actions when Resident May Pose a Threat to Patient Safety... | 53 |
| 2. | Academic Actions..... | 53 |
| 3. | Non-Academic Actions..... | 54 |
| 4. | Duty to Report..... | 55 |
| U. | CONDITIONS OF SEPARATION | 56 |
| 1. | Resignation | 56 |
| 2. | Separation..... | 56 |
| 3. | Termination..... | 56 |
| V. | PAGERS | 56 |
| W. | EMAIL..... | 57 |
| X. | LAB COATS | 58 |
| Y. | PARKING..... | 58 |

Z. HIPAA..... 58
AA. DISASTER PREPAREDNESS PLAN..... 58
BB. Conclusion 59

I. DEFINITIONS AND DESCRIPTIONS

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

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

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

Program: The term “Program” refers to the Internal Medicine Residency training program.

Sponsoring Institution: The term Sponsoring Institution refers to the University of Texas Medical School at Houston.

UTHealth: The term UTHealth is an alternative name for the University of Texas Medical School at Houston.

II. PROGRAM OVERVIEW – EDUCATIONAL GOAL

The purpose of this training program is to prepare the physician for a career in Internal Medicine/Pediatrics. We believe that the foundation for excellence should be the same, whether that career will be in the practice of general Internal Medicine/Pediatrics or a subspecialty, or in research or academic medicine. We therefore strive to help the house officer become an excellent general internist and pediatrician. 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/Pediatrics 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/Pediatrics 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 four years of training encompass several different kinds of clinical experiences. There are inpatient services staffed by full time faculty at Memorial Hermann Hospital, M.D. Anderson Cancer Center and Lyndon B. Johnson General Hospital, At Memorial Hermann and St. Luke's Episcopal hospitals. At St. Luke's Episcopal Hospital 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, pediatric/neonatal 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, third and fourth 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/Pediatrics 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/Pediatrics 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 four 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/Pediatrics that there be at least twenty-two months of twenty-four months in each specialty of "meaningful patient responsibility" in the four 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.

A. PROGRAM LEADERSHIP

Our faculty strives to be distinguished for its scientific, clinical and teaching excellence in all major disciplines within the broad field of internal medicine. Attainment of this goal requires the operation of an excellent Resident training program. Therefore, the residency program is of the highest departmental priority. All physicians on the faculty are expected to teach and make contributions to the Residency training program.

1. Chair – Internal Medicine



Dr. David D. McPherson is Chairman, Department of Internal Medicine, Professor and Director of the Division of Cardiology, Executive Director – Center for Clinical and Translational Sciences, he is the holder of the James T. and Nancy B. Willerson Chair, and Medical Director of the Heart and Vascular Institute at the University of Texas Health Science Center at Houston. In 2006 he was recruited to the University of Texas Health Science Center at Houston to head the Division of Cardiology. He was appointed the Willerson Chair of Internal Medicine in 2008 with a mandate to direct, lead, and expand the Department into a new decade of Academic Achievement.

2. Vice Chair – Internal Medicine



Dr. Carmel Bitondo Dyer is Vice Chair of Medicine, professor and director of the geriatric medicine division at the University of Texas Medical School at Houston, and the Roy M. and Phyllis Gough Huffington Chair in Gerontology. She is a 1988 graduate of Baylor College of Medicine, where she completed her Internal Medicine residency and Geriatrics Fellowship. She founded the geriatrics program at the Harris County Hospital District and the Texas Elder Abuse and Mistreatment Institute. Her research and publications have been in the area of elder mistreatment. She was a delegate to the 2005 White House Conference on Aging and has addressed the U.S. Senate. She has received national and local recognition for her teaching abilities and her dedication to the health care of older persons.

3. Chair – Pediatrics



An internationally known researcher and pediatrician, Giuseppe N. Colasurdo, M.D., was appointed president *ad interim* of The University of Texas Health Science Center at Houston (UTHealth) April 1, 2011. He became dean and H. Wayne Hightower Distinguished Professor in the Medical Sciences of The University of Texas Medical School, part of UTHealth, Sept. 1, 2007. Dr. Colasurdo will continue to serve as dean during his term as president *ad interim*.

Born in Morrone Del Sannio, Italy, Dr. Colasurdo completed his undergraduate education at Liceo Scientifico Galileo Galilei in Pescara, Italy. He earned his medical degree summa cum laude from G. D'Annunzio School of Medicine in Chieti, Italy. Determined to achieve the best medical training in the world, Dr. Colasurdo decided to come to the United States in 1988. He now has dual citizenship—a commitment to that choice he made more than 20 years ago.

He completed his residency at The University of Texas Medical Branch in Galveston and his fellowship at the University of Colorado Health Science Center and the National Jewish Medical and Research Center in Denver. In Colorado, he worked in the laboratory of Dr. Gary L. Larsen and initiated his studies on the autonomic regulation of the airway smooth muscle, the biology of respiratory syncytial virus (RSV) infection, and ontogeny of airway dysfunction and inflammation in childhood asthma.

Dr. Colasurdo joined the Medical School's faculty in 1995 as an assistant professor of pediatrics in the Division of Pulmonary Medicine. He became the division head in 1997 and started directing the fellowship training program in pediatric pulmonary medicine in 2001. He was named chair of the Department of Pediatrics in 2005.

The physician-in-chief at Children's Memorial Hermann Hospital, Dr. Colasurdo specializes in respiratory syncytial virus (RSV), pediatric asthma, and other lung disorders in infants and children. Dr. Colasurdo has received research funding from the National Institutes of Health, the Children's Miracle Network, and the Cystic Fibrosis Foundation.

His numerous awards include the Dean's Excellence Awards, the David W. Smith Trainee Award from the Western Society for Pediatric Research, and the Basic Scientist Development Award from the National Institutes of Health. In 2008, he received Houston's Executive Communicator of the Year Award from the International Association of Business Communicators; the Distinguished Alumnus Award from the Department of Pediatrics at The University of Texas Medical Branch (UTMB); was elected to faculty membership in the Alpha Omega Alpha Honor Medical Society-Houston Delta Chapter; received the Facolta di Medicina e Chirurgia Award from the G. D'Annunzio School of Medicine in Chieti, Italy; and

received the Knight of the Order of Merit of the Italian Republic, presented by the Consul General of Italy.

In addition to publishing more than 120 manuscripts, abstracts, book chapters, and review articles, Dr. Colasurdo holds editorial reviewer positions on several scientific journals, including *The American Journal of Physiology*, *The American Journal of Respiratory and Critical Care Medicine*, and *Pediatric Pulmonology*. He is a member of the American Thoracic Society and the Society for Pediatric Research.

A strong proponent of preserving and promoting the best in medical education, Dr. Colasurdo brought to our school two fellowship training programs recognized by the Accreditation Council of Graduate Medical Education: pediatric pulmonology and pediatric critical care. He has trained numerous fellows and junior faculty currently holding positions in academic centers. He created a Division of Medical Education in the Department of Pediatrics dedicated to focusing on new strategies and technologies for resident learning.

As dean, Dr. Colasurdo has created a structure to promote health care quality and safety throughout the clinical, research, and educational missions of the Medical School. He also promulgated a Scholarly Concentrations Program aimed at helping medical students enrich their academic pathways into medical specialties. Under his leadership, the UT Physicians clinical practice of the Medical School has expanded beyond the confines of the Texas Medical Center and into the neighborhoods of Houston.

Board certified in Pediatric Pulmonology and licensed to practice medicine in Italy, Texas and Colorado, Dr. Colasurdo remains an active clinical pulmonologist and has hospital privileges at Memorial Hermann-Texas Medical Center, Lyndon B. Johnson General Hospital, and MD Anderson Cancer Center. He is the CEO and president of UT Physicians, the medical practice of The University of Texas Medical School at Houston.

Responsibilities of the Program Director

The Program Director administers and maintains an educational environment conducive to educating the House staff in each of the ACGME competencies: Patient Care, Medical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and System-Based Practice. The Program Director initiates and monitors the didactic and clinical education at all participating sites and, continually evaluating the effectiveness of the teaching/learning environment. As approved by the Program Director, the local director at each participating site is accountable for Residency Education and is evaluated regularly to ensure that the best education quality is achieved at each site. The Program Director is also responsible for approving faculty for teaching of House staff. Faculty is reviewed annually and given a summary review of their performance for the preceding year based on the confidential and anonymous resident evaluations and comments.

4. Program Director – Internal Medicine & Pediatrics



Mark A. Farnie, MD born and raised in Beaumont, Texas attended The University of Texas Medical School at Houston. He then began his Internal Medicine/Pediatric Residency at the same institution. Upon completion he joined the faculty at The University of Texas Medical School at Houston as an Assistant Professor and the Program Director for the Internal Medicine Pediatric Residency. He has always enjoyed teaching young physicians and helping them further their career. He has participated as a GIMPSA preceptor for over 10 years and also serves on the Board for the National Youth Leadership Foundation. He was awarded the Distinguished Alumnus award from The University of Texas Medical School at

Houston in 2004 as well as being elected to Alpha Omega Alpha Honor Society. He continues to serve as the Program Director of the Internal Medicine / Pediatric Residency Program since 1991 and recently stepped down as the Program Director of the Internal Medicine Residency Program after ten years. He serves as the Internal Medicine Clerkship Director and as a member of the Admissions Committee at the Medical School.

5. Program Director – Internal Medicine



The ultimate responsibility for administration of the Internal Medicine training program rests with the Vice Chair of Medicine for Education and GMEC approved Program Director for Internal Medicine, Dr. Philip Orlander. Prior to beginning his tenure with the Residency Program, Dr. Orlander was the Program Director for the Endocrinology, Diabetes and Metabolism fellowship beginning in January 1991. He has been instrumental in the education of the Internal Medicine Residents since his appointment as Assistant Professor with the University of Texas Medical School at Houston in 1983. Dr. Orlander is certified in both Internal Medicine (1979) and Endocrinology, Diabetes and Metabolism (1981) and maintains current certification in both areas. He is currently licensed in both Texas and Arizona with Medical Staff appointments at the University of Texas Medical School at Houston.

Dr. Orlander received his undergraduate degree from New York University and was awarded his medical degree from the Free University of Brussels, Belgium. He completed his internship and residency training in Internal Medicine at St. Raphael's Hospital, New Haven, CT. His Endocrinology fellowship training was at St. Raphael's Hospital, New Haven, CT, and at the University of Arizona, Tucson, AZ. He is board certified in Internal Medicine, and Endocrinology and Metabolism. In 1983, he joined the faculty at the University of Texas Medical School at Houston as an Assistant Professor, and subsequently was promoted to Associate Professor in 1991, Professor in 1997, and Division Director of Endocrinology, Diabetes, and Metabolism in 1993. In 2004, he became Vice-Chairman of Internal Medicine for Education and was named Interim Chairman of the Department of Internal Medicine in May, 2007.

Dr. Orlander has had a strong interest in Medical Education, both at the undergraduate and postgraduate level. He was course director for Physical Diagnosis from 1991 to 2004, Chairman of the Curriculum Committee from 1993 to 1998, from 2002-2007, and was named Assistant Dean for Curricular Affairs in 2005. On the post-graduate level, he has been Program Director for the Endocrinology, Diabetes, and Fellowship program since 1991, and Vice-Chairman for Education since 2005. He is a member of Alpha Omega Alpha and was elected to the University of Texas Academy of Health Science Education in 2006. He is the recipient of the Herbert L. and Margaret W. Dupont Master Clinical Teaching Award, the Award for Humanism in Medicine, and multiple Dean's Excellence in Teaching Awards.

6. Program Director – Pediatrics



Dr. Keely G. Smith has served at the Pediatric Program Director for the past 3 years. She is a true resident advocate. Prior to matriculating at The University of Texas Medical School where she graduated in 2001, she graduated from the University of Oklahoma. Upon graduation from Medical School at UT she began her internship and residency in Internal Medicine & Pediatrics at The University of Texas Medical School at Houston. She served as a Chief Resident

in the Department of Internal Medicine after completion of her residency. She is now an Assistant Professor of Internal Medicine and Pediatrics and works in the Division of Pulmonary Medicine.

7. Associate Program Director – Internal Medicine & Pediatrics



Dr. Jacqueline PC Meeks has served as associate Program Director since 2009 and runs the Good Neighbor Clinic, our prime outpatient clinic for the Internal Medicine & Pediatric Residency. Dr. Meeks graduated from the University of Texas Medical School at Houston in 2005. She then began her internship and residency at Brody School of Medicine/Pitt county Memorial Hospital. She then transferred to The University of Texas Medical School at Houston to complete her training. She serves as an Assistant Professor of Internal Medicine and Pediatrics.

8. Associate Program Directors – Internal Medicine

The Program Director is aided in the administrative and clinical oversight of the educational program by 5 Associate Program Directors of Internal Medicine as follows:



Brett Stephens, MD

Senior Associate Program Director
Program Site Director, LBJ Hospital
Assistant Professor of Medicine
Division of Renal Diseases and Hypertension



Andrew Ho, MD

Associate Program Director
Assistant Professor of Medicine
Division of General Internal Medicine



Robby Wesley, DO

Associate Program Director
Assistant Professor of Medicine
Division of General Medicine



David Wolf, MD

Associate Program Director
Assistant Professor of Medicine
Division of Gastroenterology, Hepatology and
Nutrition



Amber Podoll, MD

Associate Program Director
Assistant Professor of Medicine
Division of Renal Diseases and Hypertension

9. Associate Program Director – Pediatrics

The Program Director is aided in the administrative and clinical oversight of the educational program by 1 Associate Program Director of Pediatrics as follows:



Mark D. Hormann, MD

Associate Program Director
Associate Professor of Pediatrics
Division of Community & General Pediatrics

Each Associate Program Director is a clinician with broad knowledge of, experience with and commitment to Internal Medicine as a discipline, patient centered care, and to the generalist training of residents, and hold current certification from the American Board of Internal Medicine in Internal Medicine and if applicable, his/her respective subspecialty. Each Associate Program Director reports directly to the Program Director. Each will commit an average of 20 hours per week to the administrative and educational aspects of the educational program.

10. Core Faculty

The residents in the Internal Medicine Residency enjoy the expertise of 9 institutionally based core faculty members, one faculty for each Internal Medicine subspecialty, who not only serve as core faculty, but also as the subspecialty education coordinators. These faculty are expert competency evaluators who work closely with the program director and associate Program Directors in development and implementation of the evaluation system and in teaching and advising the House staff. Each core faculty is ABIM certified in Internal Medicine and, if applicable, his/her respective subspecialty, and are clinically active in both direct patient care and observation of residents in their patient care. Each core faculty member is accountable to the Program Director for coordination of the residents' subspecialty educational experiences in order to accomplish the goals and objectives in the subspecialty. The core faculty also participate in the Internal Medicine mentorship program available to interns to help guide and advise interns, and House staff as a whole, about career and educational goals.

Sandeep Agarwal, MD
Division of Rheumatology

Eugene Boisauvin, MD
Division of General Medicine

Anu Davis, MD
Division of Endocrinology

Maxine De La Cruz, MD
Division of Geriatrics

Ali Denktas, MD
Division of Cardiology

Rodrigo Hasbun, MD
Division of Infectious Disease

Anneliese Gonzalez, MD
Division of Oncology

Brandy McKelvy
Division of Pulmonary and
Critical Care

Amber Podoll, MD
Division of Renal Disease and
Hypertension

11. Program Staff

The main House staff office is located in the Medical School Building, MSB 1.126 and houses the clerical staff responsible for the operation of the program.

Vera "Susan" Jones
Senior Administrative Coordinator, Internal Medicine & Pediatric Residency Program
UT Houston Medical School, MSB 1.126

Charity Sembera
Residency Coordinator II, Internal Medicine Residency Program
UT Houston Medical School, MSB 1.124

Shirlene Edwards
Residency Coordinator III, Pediatric Residency Program
UT Houston Medical School, MSB 3.244

Residency Program Office Contact Information

University of Texas Medical School at Houston
Department of Internal Medicine
6431 Fannin, Suite 1.126
Houston, TX 77030
Phone Number: 713-500-6525
Fax Number: 713-500-6530
Email: residency.imed@uth.tmc.edu

B. SPONSORING INSTITUTION

The Internal Medicine & Pediatric Residency Program is sponsored by UTHealth and established under the department of Internal Medicine. The Sponsoring Institution provides technical and professional personnel as requested by House staff and as delegated by the University of Texas Medical School at Houston's Handbook of Operating Procedures.

The mission of The University of Texas Medical School at Houston is to provide the highest quality of education and training of future physicians for the State of Texas, in harmony with the State's diverse population, and to conduct the highest caliber of research in the biomedical and health sciences. The institution aims to provide an educational environment stressing primary care and quality care, and to prepare advanced Residents to serve all patients in need, whatever their means, to make contributions to the understanding, prevention and treatment of disease and injury, and to pursue a lifetime of study so that they will remain the best possible practitioners of medicine. The fulfillment of the academic mission requires the provision of exemplary clinical services, primacy of prevention, leadership in research and research training, and continuing education of graduates and other healthcare providers.

The University of Texas Medical School at Houston is part of The University of Texas Health Science Center at Houston, a comprehensive health science center located in the world-renowned Texas Medical Center. The institution, on behalf of its administration and faculty, assumes ultimate educational responsibility for all of the graduate medical education programs under its sponsorship. To that end, the institution is committed to excellence in both education and patient care and will provide an ethical and scholarly environment for these activities. Through the Associate Dean for Educational Programs in collaboration with the Graduate Medical Education Committee, the institution will ensure substantial compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements and enable the ACGME accredited-programs to achieve substantial compliance with the Institutional, Common and specialty-specific Program Requirements and the ACGME Policies and Procedures. In order to provide effective educational experiences for residents that lead to measurable achievement of educational outcomes, the institution will provide appropriate clinical venues for resident education through agreements with approved patient care facilities. Therein, the institution will provide guidance and supervision of residents while facilitating their professional, ethical and personal development and will further ensure that the patient care provided by residents is safe and appropriate. The institution is committed to providing the necessary educational, financial and human resources necessary to support graduate medical education.

C. AFFILIATED INSTITUTIONS

1. Hospitals

The Residents in the Internal Medicine Residency Program enjoy access to facilities located in the world renowned Texas Medical Center. Specifically, hospitals affiliated with UTHealth for the purpose of the Internal Medicine Residency Training Program include:

- a. Memorial Hermann Hospital-TMC
- b. Children’s Memorial Hermann Hospital
- c. Memorial Hermann-TIRR (IM Only)
- d. Lyndon B. Johnson General Hospital (Harris County Hospital District)
- e. The University of Texas M.D. Anderson Cancer Center
- f. St. Luke’s Episcopal Hospital (IM Only)
- g. The Mainland Allergy and Immunology Clinic
- h. Quentin Mease (IM Only)

2. Clinics

Clinics/Ambulatory Settings affiliated with UTHealth for the purpose of the Residency Training Programs include:

- a. The Good Neighbor Health Clinic
- b. University of Texas Professional Building (UT Physicians)
- c. UTHSC-H Center (West Loop Clinic)
- d. Thomas Street Clinic (Harris County Hospital District)
- e. Quentin Mease (Harris County Hospital District)
- f. Lyndon B Johnson Hospital Clinic (Harris County Hospital District)
- g. Northwest Ministries Clinic
- h. Spring Branch Clinic
- i. Good Neighbor Health Clinic

D. LEVELS OF TRAINING

Progressive levels of training in the Program are designated as Post Graduate Year (“PGY”) 1 through 4 for Categorical Residents. After the initial PGY-1 appointment term, the PGY level to which a Resident is appointed will be determined by the Program Director, in consultation with the Department Chair and other faculty, based on the resident’s level of education, experience, and demonstrated ability, clinical performance, and professionalism.

E. APPOINTMENT AND REAPPOINTMENT

1. Appointment and Selection Criteria

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

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

- Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME accredited medical school.
- Only J-1 Visas are issued.

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

2. Reappointment and Promotion

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

In order to receive credit for a month, the Resident must actively participate in at least two (2) weeks of the month. In addition, credit will only be given to those residents who successfully pass the rotation. Unsatisfactory or non-passing scores are a 3 and below on any competency and/or comments indicating that the performance needs attention. Any rotations where a resident received an overall rating of “Unsatisfactory” will need to be repeated. An intern, who, in the opinion of the Program Director and Chairman or other pertinent faculty are not prepared for the responsibilities of an upper level resident, *may* be offered the opportunity to extend his or her internship up to one year. Interns who fail to successfully complete the repeat of a PGY-1 year will not have their contract renewed.

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

F. STRUCTURE OF THE PROGRAM

The Internal Medicine & Pediatric Residency Program values education of our Residents above all. The policies of the Program are formulated with this in mind. Educational experiences of the program include interactions with residents, fellows and attending physicians, as well as other members of disciplinary teams including Nurses, Physician Assistants and administrative personnel.

The Internal Medicine & Pediatric Residency Program consists of 48 months of Graduate Medical Education. There are at least 56 rotations available for residents in the Program and each resident can expect an experience in the following rotations:

| | |
|-----------------------------------|---|
| Intensive Care Unit MHH/LBJ * | Cardiology Consults MHH/LBJ (Upper Level) |
| Ambulatory MHH/LBJ | Endocrinology Consults MHH/LBJ (Upper Level) |
| General Medicine Wards MHH/LBJ | Geriatrics MHH/LBJ (Upper Level) |
| Emergency Room LBJ | Gastroenterology Consults MHH/LBJ (Upper Level) |
| Coronary Care Unit MHH | Hematology Consults MHH/LBJ (Upper Level) |
| Renal Wards MHH/LBJ | Infectious Diseases Consult MHH/LBJ (Upper Level) |
| Gastroenterology Wards MHH/LBJ | Pulmonary Consults MHH/LBJ (Upper Level) |
| Hepatology Wards MHH/LBJ | Renal Consults MHH/LBJ (Upper Level) |
| Oncology Consults LBJ | Rheumatology Consults MHH/LBJ (Upper Level) |
| General Pediatrics Wards CMHH/LBJ | Pediatric Intensive Care Unit MHH (Upper Level) |
| Well Baby Nursery | Adolescent Medicine |
| Neonatal Intensive Care Unit | Developmental & Behavior |
| Pediatric Emergency Medicine | Elective |
| Medical Genetics | Med/Peds Ward |
| Infectious Disease (Pediatrics) | Neurology Consults |

Each graduating Resident that successfully completes the program will be competent and qualified to sit for the Internal Medicine and Pediatrics Certification exams.

* Intensive Care Unit :Total required emergency medicine experience will not exceed 3 months in a 4-year residency. Total Required critical care experience will not exceed 6 months in a 4-year residency. If a resident requests critical care electives, the total experience may not exceed 8 months.

G. SCHEDULES

1. Monthly Schedules

Each residents schedule is formulated so that by the end of training, the resident will have completed 48 calendar months (including vacation time) of accredited graduate medical education and will be eligible to sit for the Boards upon completion of the program. The educational efforts of faculty and residents are designed to enhance the quality of patient care, and the education of the residents. At least 1/3 of the residency training occurs in the ambulatory setting and at least 2/3 occurs in the inpatient setting.

Beginning June 24 of each academic year, resident's schedules are posted on AMION for the full academic year (<http://www.amion.com>; password uthim for Internal Medicine and uthpeds for Pediatrics) and uthem for Emergency Medicine and updated as needed. Changes should be made three weeks after the initial schedule is released. Three weeks after the residents are notified of the posting of the initial schedule, each resident shall review his/her individual schedule and make any necessary changes with the appropriate scheduling chief. After the three weeks for schedule changes has passed, there will be no changes made upon request unless there is an emergency or adjustments are required based on the needs of the scheduling chief. Should there be a valid emergency; the request must be made *in writing* to the scheduling chief and Program Director. All changes are reviewed by the Assistant Chiefs of Service of the pertinent program and the Program Director because of the needs for staffing of services, and the requirements of the American Board of Internal Medicine, American Board of Pediatrics and the ACGME.

2. Vacations and Time Off

Residents classified as PGY-1 are permitted the equivalent of two (2) calendar weeks of vacation each 12 month appointment term. Vacation leave is pro-rated for appointment terms of less than twelve months. Residents classified as PGY-2 and above are permitted the equivalent of three (3) calendar weeks of vacation each year. In addition to these allotted days the Program allows each resident 4 days off around their choice of Holiday. The 4 days off are given on a first come, first serve basis.

Resident's must coordinate vacation scheduling with the Internal Medicine and Pediatric Residency Programs, as well as with the Assistant Chief of Service/Chief Residents in charge of scheduling to ensure adequate coverage of services. No more than two (2) consecutive weeks of vacation may be taken within the same month without permission from the Program Director. The vacation schedule is incorporated into the yearly master schedule. Resident's are not eligible to accumulate annual vacation and unused vacation does not roll over from one academic year to the next. Resident's leaving the Program will not be compensated for unused vacation nor sick leave.

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

Requests for a change in vacation schedule should be turned in to the appropriate scheduling chief before the beginning of the academic year. Any request for a change in requested vacation time is subject to the approval of the appropriate scheduling chief and the Program Director or the Program Directors designee.

Residents are not allotted extra time off for completion of USMLE Step exams or interviews for fellowship opportunities, attending classes, or other elective endeavors. For situations where outside obligations interfere with your ability to complete your required work within the program, residents must ask for vacation in advance or arrange their own coverage and notify the appropriate scheduling chief and the Program Director or the Program Directors designee. If no coverage is found by the resident, they must report to their assigned duties that day. It is a breach of professionalism not to show up to your required rotation without notifying all of the appropriate personnel including but not limited to the scheduling chief and the Program Director or the Program Directors designee. Each resident is responsible for discussing the policy of time-off with his/her attending at the beginning of the month to ensure that the attending policies with regards to time off are also met.

3. Ready Reserve/Jeopardy Call

The Ready Reserve is backup call for emergency situations only. This is not considered "at-home call." Every day there are 2 Upper Levels and 2 Interns that on an ambulatory or consult service for the month. If a resident has an emergency situation where he/she cannot take call we pull someone from the Ready Reserve pull to work. The Chief Resident must be informed by paging them at 22001 and must be called as soon as you know you will not make it to work, to get somebody pulled. No other mode of communication is acceptable other than telephone conversation. If you do not inform the chief residents appropriately, 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).

4. Sick Leave/Leave of Absence

Paid sick leave accrues at a rate of one (1) day (eight (8) hours) each month and may accumulate to a maximum of thirty (30) days. Paid sick leave carries forward from year to year; however, unused sick leave remaining as of the date of separation from the Program is forfeited without compensation.

Residents are not eligible for UTHealth “sick leave pool” leave. The program is responsible for tracking Residents' sick leave through the GMEIS system. All requests for sick leave must be approved by the appropriate scheduling chief, Program Director/Program Director's designee, and reported to the appropriate Residency Coordinator.

5. Leave of Absence (LOA)

In the event an illness exceeds accumulated paid sick leave and vacation time, a leave of absence without pay may be granted by the Program Director.

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

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

6. Military Leave

A resident 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 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 of the United States 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. Residents 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 must report back to his or her regular program.

7. Family and Medical Leave (FMLA)

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

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

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

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

The Internal Medicine/Pediatric Resident taking FMLA will be paid for an appropriate amount of leave time, beginning with sick leave and any remaining vacation. After these accumulations have been exhausted, the resident will be put on Leave of Absence (LOA). Once the resident has been put on LOA he/she will not receive his/her monthly stipend. The department will pay for benefits only when all sick leave and vacation has been exhausted.

The first four (4) weeks of leave are consistent with the ABIM and ABP policy and therefore no makeup rotations are required. The ABIM and ABP allows up to 3 months leave for vacation time, parental leave, or illness in a 48 month training period. Residents may take up to one month per year of training. Training must be extended to make up any absences exceeding the one month per year of training.

The Program tries to maintain a flexible and reasonable policy concerning maternity leave. As rearrangement of schedules will likely be necessary, you must notify the program director, as well as one of the residency coordinators, as soon as you know that you may have a situation that will require FMLA and or greater than 2 weeks of time off.

8. Holidays

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

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

H. SUPERVISION POLICY

Degrees of supervision are utilized by the Program as follows to ensure that limited autonomy and decision making is available as the Resident graduates through the levels of education.

Direct Supervision – the supervising physician is physically present with the resident and patient.

Indirect Supervision

- with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
- with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

1. General

The ultimate responsibility for the supervision of the residents within the Program rests with the Program Director. He/she monitors resident supervision at all participating sites. The Program Director, in conjunction with the Associate Program Directors, elects qualified faculty to provide appropriate Direct Supervision of residents and interns in patient care activities. At the beginning of each rotation, the House staff will be introduced to his/her attending who will be an identifiable, appropriately-credentialed and privileged attending physician who is ultimately responsible for that patient's care and for the Direct Supervision of the resident and intern. Each site and rotation has adequate faculty to instruct and supervise all the residents assigned to the rotation and location. The number of learners on each service will be limited to 8 so that attendings have adequate time to effectively teach the House staff. Residents are provided with rapid reliable systems for communication with supervision faculty. Faculty scheduled to supervise on a rotation are required to provide residents with continuous supervision and consultation.

Over the course of the 48 months of residency, each resident must demonstrate proficiency in each of the critical clinical skills to be allowed increasing responsibility in patient care, leadership, teaching, and administration. These skills include, but are not limited to, using appropriate interview and examination techniques, documenting the encounter in a timely manner, ordering invasive diagnostic and therapeutic studies, ordering high risk medications, and performing common procedures. All residents must demonstrate proficiency in a simulated environment prior to attempting supervised procedures. Residents must then be certified by the attending after Direct Supervision of the procedure prior to performing or supervising the procedure. An electronic log will be kept of all procedures and signed off by the appropriate individual in the University's GMEIS system. Unless otherwise specified, promotion to a PGY-2 PGY-3 or PGY-4 year will carry with it the ability of performing or supervising certain procedures as specified at each clinical site. Regardless of the site or time of day, an attending physician must Indirectly Supervise procedures by being physically present at the site to be able to help if Direct Supervision is necessary with procedures. The academic hospitalist will serve this purpose at times that the designated attending is not on site. For all other medical decision making, an attending physician must be easily available by phone at all times. When on a rotation where a fellow is present, the resident and intern will also be directly supervised by him/her in procedures and patient care matters only after the attending has certified that the resident is competent to perform and supervise the procedure. Residents and faculty members are responsible for informing patients of their respective roles in each patient's care.

Overall delegation of progressive authority is assigned by the Program Director. The Program director has entrusted the authority to determine appropriate authority within a rotation to the attending faculty on service, directly supervising the resident and intern's patient care interactions. Attendings are allowed to delegate portions of care to Residents based on the needs of the patient and the skills of the resident, however, all medical decisions are reviewed by the attending physician. The progressive authority that necessarily comes with advancement in PG year is determined solely by the Program Director after review of evaluations and comments based on the 6 ACGME core competencies.

There are certain circumstances and events in which residents must communicate with the appropriate supervising faculty members. Those circumstances include, but are not limited

to a significant change in the patient's status, a need for a high risk procedure or treatment, a concern on a treatment decision, and any act that may impact patient safety. House staff should use their judgment on any other issues that arise, however if there is any question about the seriousness of a circumstance, it should always be addressed with the attending.

2. Inpatient Services

The inpatient services are organized so as to provide high-quality medical care, allowing the house staff limited autonomy for independent decision-making while allowing the attending the opportunity to directly and indirectly supervise the residents, ensuring appropriate patient care.

General Medicine Ward Team (MHH; LBJ)

Each Ward team consists of one (1) or two (2) upper level Resident(s), two (2) interns, and three students. In this setting the intern has Direct Supervision in patient care and procedures from the attending physician and upper level resident during the day. At night, the intern is indirectly supervised by the attending, with direct supervision immediately available via telephonic or electronic modalities as well as the academic hospitalist, who will serve as Indirect Supervision. The upper level resident is responsible for seeing every patient on the day of admission and writing an upper level note. He/she is responsible for reviewing and approving diagnostic and treatment plans with the interns and students every day prior to Attending Rounds with oversight by the attending. The upper level will review patient's progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning with oversight from the attending. The upper level is also responsible for supervising procedures by the interns as well as creating an atmosphere where the interns and students are encouraged to ask for help when appropriate. An attending is always physically on site to help with procedures if and when necessary. The academic hospitalist may serve this purpose when the designated attending is not on site.

The upper level resident on General Medicine Wards is directly supervised by the attending physician assigned to his/her team during the day and indirectly supervised by the attending, with direct supervision immediately available via telephonic or electronic modalities. The academic hospitalist is also available onsite for Indirect Supervision of the upper level resident, and is immediately available to provide direct supervision if necessary. Patient based teaching must include direct observation or indirect consultation between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attending will be available to oversee procedures and medical decision making of the residents.

Coronary Care Unit (CCU MHH)

Each CCU team consists of 4 residents and 4 interns and 1 Cardiology fellow. Each resident is paired with one intern comprising a sub-team. In this setting interns have Direct Supervision and education from the attending physician and upper level resident. The primary role of the PGY-2 and 3 residents are to directly supervise and educate the interns and students. The resident will be responsible for initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. The resident is responsible for creating an atmosphere such that the intern is

encouraged to ask for help when appropriate. The resident will directly supervise procedures done by interns. As the intern progresses further into his/her training and when appropriate, the resident should allow the Intern limited autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position, being always physically located at the sight for Direct Supervision or Oversight.

The upper level resident on the CCU is directly supervised by the attending physician assigned to his/her team. With the progressive responsibility given to upper levels, the attending may also indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the Resident to work independently, based on the ability of the resident in the judgment of the attending. Patient based teaching must initially include Direct Observation and interaction between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attendings will generally oversee procedures by the residents after having certified the residents' competency in the procedure through Direct Observation. In addition, the attending will oversee and review instruction given to the interns by the resident and provide feedback to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing oversight to the care provided.

Intensive Care Unit (ICU MHH; LBJ)

Each ICU team consists of 4 residents and 4 interns and 1 pulmonary/critical care fellow. Each resident is paired with one intern comprising a sub-team. In this setting interns are indirectly supervised by the attending physician, with direct supervision immediately available, and direct supervision and education of the interns is accomplished through the upper level resident. The primary role of the PGY-2 PGY-3 and PGY-4 residents are to directly supervise and educate the interns and students. The resident will be responsible for initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. It is expected that the resident and intern will divide up progress note writing responsibility equitably. The resident is responsible for creating an atmosphere such that the intern is encouraged to ask for help when appropriate. The resident will directly supervise procedures done by interns. As the intern progresses further into his/her training, the resident should allow the Intern progressively more autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position.

The upper level resident on the ICU is directly supervised by the attending physician assigned to his/her team. With the progressive responsibility given to upper levels, the attending may also indirectly supervise the upper level resident as the rotation progresses, being physically within the hospital for consultation on patient care if necessary, while allowing the resident to work independently, based on the attending judgment in conjunction with the General Supervision policy. Patient based teaching must include direct observation and interaction between resident and attending including bedside teaching, discussion of pathophysiology and teaching rounds. Attending's will generally oversee procedures of the residents in addition to discussion with the upper level resident about instruction given the interns with feedback provided to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing oversight to the care provided.

Renal Wards and Renal Consults (MHH, LBJ)

Each Renal Ward/Consult team consists of 3-4 residents and Interns and 1 renal fellow. The Renal Ward/Consult team comprised of Residents and Interns is also supervised by a renal fellow in addition to the Renal Attending. In this setting interns are directly supervised and educated by the attending physician, renal fellow, and upper level resident throughout the day. The primary role of the PGY-2 and 3 residents are to directly supervise and educate the interns and students. The resident will be responsible for Initial evaluation of all patients, including assimilation of old records and outside information, seeing every patient on the day of admission with the intern and dividing the admissions equitably, commensurate with experience level. The upper level resident will review and approve diagnostic and treatment plans with the intern every day prior to Attending Rounds, review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning. The attending has direct observation and oversight through the attending rounds that occur daily with the residents and Interns. It is expected that the resident and intern will divide up progress note writing responsibility equitably. The Resident is responsible for creating an atmosphere such that the intern is encouraged to ask for help when appropriate. The upper level resident will directly supervise procedures done by interns. As the intern progresses further into his/her training, the resident should allow the Intern progressively more autonomy through indirect supervision and ultimately observation when the intern is prepared to move to a team lead position.

The upper level resident on the Renal Wards is directly supervised by the attending physician assigned to his/her Renal Ward team in addition to the renal fellow on duty for the month. With the progressive responsibility given to upper levels, the attending and fellow may also indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the Resident to work independently, based on the attending's or fellow's judgment. Patient based teaching must include direct observation and interaction between resident and attending or fellow including bedside teaching, discussion of pathophysiology and teaching rounds. Attending's will generally oversee procedures of the Residents in addition to discussion with the upper level resident about instruction given the interns with feedback provided to the upper level after care or instruction is delivered. The attending will make daily rounds with residents on all patients providing oversight to the care provided.

Hepatology (MHH)

The Hepatology team is comprised of one upper level residents directly supervised by a Hepatology attending and fellow. Initially the attending and fellow guide the resident with direct supervision of patient care and procedures. With the limited progressive responsibility allotted to upper level resident, the attending may begin to oversee the progress and procedures and the fellow may begin to indirectly supervise the upper level resident, being physically within the hospital for consultation on patient care if necessary, but allowing the resident to work in a more independent manner. Patient based teaching must initially include direct observation and interaction between resident and attending or fellow including bedside teaching, discussion of pathophysiology and teaching rounds. The attending will make daily rounds with residents on all patients providing oversight to the care provided.

Emergency Room (LBJ)

Approximately eight (6) interns are sent each month to LBJ for the Emergency Room rotation from the Internal Medicine and Internal Medicine/Pediatric Residency programs. The Interns attending is responsible for direct supervision of the Intern, being physically present with the intern during any patient care contact, including but not limited to procedures, bedside teaching, and discussion of pathophysiology and teaching rounds.

The ER attendings will initially demonstrate necessary procedures performed and mastered in the ER. After demonstration, the attending will directly supervise patient care and procedures done by the interns and are also responsible for signing off and providing feedback on these procedures.

Cardiology Consults

The Cardiology Consult team consists of 1 upper level, 1 intern and 1 fellow. The upper level residents are directly supervised by the Cardiology attending and fellow assigned to the rotation for the month. By directly supervising and overseeing the resident while on rotation, the attending is able to utilize this information in the evaluation process to gauge the resident's progress with regards to 6 ACGME core competencies. In addition to the attending and fellow, the upper level resident is responsible for direct supervision and education of the Intern on service. After the attending oversees patient care and procedure's completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Endocrinology Consults

The Endocrinology Consult team consists of 1-2 upper levels, 1 intern, and 1 or more fellow(s). The upper level residents are directly supervised by the Endocrinology attending and fellow assigned to the rotation for the month. Direct supervision and education of the intern is accomplished through the attending, fellow, and upper level resident. The attending oversees daily patient care and procedure's completed by the resident and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Gastroenterology Consults (MHH; LBJ)

The Gastroenterology Consult team consists of 1 upper Level, occasionally 1-2 interns, and 1 or more Gastroenterology fellow(s). The upper level residents are directly supervised by the Gastroenterology attending and fellow assigned to the rotation for the month. Direct supervision and education of the intern is accomplished through the attending, fellow, and upper level resident. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Hematology/Oncology Consults (MDA; MHH; LBJ)

The Hematology/Oncology Consult team at MD Anderson consists of 5 residents/interns and 1 or more Heme/Onc fellow(s). The MD Anderson rotation consists of a combined inpatient and outpatient experience. The Oncology service at Memorial Hermann consists of 1 resident and entails 4 days of outpatient oncology with 1 day of inpatient consults. The Hematology/Oncology Consult team at LBJ consists of 4 residents/interns and 1 or more Heme/Onc fellow(s). The upper level residents and interns are directly supervised by the Heme/Onc attending and fellow assigned to the inpatient and outpatient clinics for the month. Direct supervision and education of the intern is also accomplished through upper level resident. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Pulmonary Consults (MHH; LBJ)

The Pulmonary Consult team consists of 1 upper level and 1 or more Pulmonary fellow(s). The upper level residents are directly supervised by the Pulmonary attending and fellow assigned to the rotation for the month. The attending oversees daily patient care and procedure's completed by the resident and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Rheumatology Consults (MHH; LBJ)

The Rheumatology Consult team consists of 1 upper level and 1 or more Rheumatology fellow(s). This rotation consists of both inpatient and outpatient clinic settings. One attending is responsible for direct supervision of the resident's patient care and procedures in the inpatient and setting and the individual clinic physician is responsible for supervision within the outpatient clinic setting. The upper level residents are directly supervised by the Rheumatology attending and fellow assigned to the rotation for the month. The attending oversees daily patient care and procedure's completed by the resident or intern and is available to provide review of the procedure or encounter with feedback after the care is delivered. Under the direct supervision of the attending, the residents should be able to demonstrate the attributes, attitudes and skills of a consulting physician and be able to respond to the common reasons for consultation in this specialty.

Adolescent Medicine

The Adolescent Medicine rotation is a required subspecialty experience for all Pediatric PGY-2 and Medicine-Pediatric PGY-3 residents. It is a one-month outpatient rotation which takes place at a variety of outpatient sites including the Adolescent Clinic at the University of Texas Professional Building, the Adolescent Clinic at Lyndon B. Johnson General Hospital, Planned Parenthood, Burnett-Bayland Home, and the Harris County Juvenile Detention Center. Adherence to the 80-hour work week is mandated. Residents are supervised by faculty members who are board certified in Adolescent Medicine.

At all sites health maintenance, disease prevention, family planning, STDs, and reproductive health and gynecology are regular experiences. Residents attend to general healthcare needs, violence prevention and chemical dependency and psychological issues at the

Juvenile Detention Center. Residents are assigned homework in the form of written material and quizzes throughout the course of the rotation.

Allergy & Immunology

Pediatric Residents at a PGY-2 or 3 level and Medicine-Pediatric Residents at a PGY-3 or PGY-4 level may choose a one month block elective rotation in Allergy and Immunology. The elective is scheduled with Dr. Susan E. Pacheco, and Dr. Dat Tran, both AAAAI certified subspecialists at the University of Texas, Department of Pediatrics.

This is an outpatient and inpatient rotation. During this rotation, residents are expected to attend all rotation conferences as well as Department of Pediatrics conferences. Adherence to the 80-hour work week is mandated.

Cardiology (Pediatric)

The Cardiology rotation is a required subspecialty experience for all Pediatric residents. It is a one-month rotation and typically occurs during the PGY-2 year. Medicine-Pediatric residents may select it as an elective during their PGY-3 year.

The Cardiology rotation occurs primarily at Children’s Memorial Hermann Hospital (CMHH) and at The University of Texas Outpatient Clinics. Residents also provide consultation services and see patients presenting to the Outpatient Clinic at Lyndon B. Johnson General Hospital (“LBJ”). Patients seen during the month-long rotation include patients newly referred for cardiologic evaluation as well as patients who are in the continuing care of a cardiologist. Residents are supervised by faculty from the Department of Pediatrics Division of Cardiology. Adherence to the 80-hour work week is mandated.

Child Abuse

The Child Abuse Pediatrics rotation is an elective subspecialty experience for PGY-2 or PGY-3 Pediatric residents. It is a 2 – 4 week inpatient and outpatient rotation which takes place at the Child Abuse Resource and Education (C.A.R.E.) Clinic and Children’s Memorial Hermann Hospital, with occasional consultations also at Lyndon B. Johnson General Hospital. Residents are supervised by faculty members who are board-eligible in Child Abuse Pediatrics.

Over the course of the rotation, residents are exposed to child victims of intentional trauma, including burns, head trauma, fractures, and sexual abuse, and child neglect. Residents are also exposed to cases of non-inflicted pediatric conditions that may be confused for maltreatment. Residents are expected to read child abuse literature and review visual diagnosis cases during the rotation.

General Inpatient Pediatric

Residents assigned to Children’s Memorial Hermann Hospital (CMHH) inpatient service. They work in teams of one supervising resident (PGY-2, 3, or 4) and two PGY-1 residents. Two to three medical students are also members of the medical team. The supervising resident functions as the team leader and is responsible for the daily management of the team and the patients in the team’s care. One faculty attending is assigned to each team and participates in direct patient care and as a consultant to the team.

During the PGY-1 year, the general inpatient pediatric rotation is three one-month blocks at CMHH. Transitional year, PGY-1 Family Practice and PGY-1 Anesthesia residents may constitute a PGY-1 member of the team. Goals and objectives for PGY-1 residents apply to all PGY-1s from any rotating service. During the PGY-2 year, residents are assigned a one month general inpatient rotation at CMHH. PGY-3/4 residents have one or two months as supervisor of an inpatient pediatric service at CMHH.

All ward teams care for patients with both general medical and subspecialty problems as well as surgical problems. Resident teams develop diagnostic and therapeutic management plans in collaboration with the attending physician of record through daily evaluation and discussion. Call is every fourth night; the post-call team leaves the hospital at 12:00 p.m. There are 5 days off per month. There is always one senior resident and one or two PGY-1/2 residents on call. Adherence to the 80-hour work week is mandated.

There are 4 inpatient teams at CMHH (Teams A, B, C, and D). Each team admits new patients every other day. The senior resident functions as the team leader and is responsible for the daily management of the team and the patients in the team's care. A faculty attending from The University of Texas Medical School at Houston Division of Community and General Pediatrics is assigned to each team and participates in direct patient care and as a consultant to the team.

Patients seen on the general inpatient rotation include patients admitted from the ED, University of Texas clinics, patients referred to faculty physicians, private patients of faculty physicians, and patients of community practitioners who have appointments as volunteer faculty.

Chronic Care

The unique purpose of the Pediatric Chronic Care Rotation is to increase residents' experience and competency in delivering medical care with a long-term perspective to children with complex chronic conditions. Residents assigned to this rotation treat and manage children with chronic illnesses at three primary sites: HealthBridge Children's Hospital, the CHOSEN Clinic, and the High Risk Clinic at the University of Texas Kid's Place. At each of these sites, residents work directly with a faculty attending to deliver medical care within a coordinated team approach. The residents work in a team that consists of one to three residents of any training level. During the PGY-1 year, residents are assigned one month on this rotation. During the PGY-2/3/4 years, this rotation is offered as an elective. HealthBridge Children's Hospital is a pediatric long-term acute care facility that provides comprehensive, multidisciplinary care for children who require inpatient treatment for congenital disorders, complications of prematurity, severe illness, or traumatic injury. The children at HealthBridge are generally stable children who need intensive nursing care, time to rehabilitate, training for their caregivers, and/or resolution of social situations. The goal of care for all patients at HealthBridge is to facilitate their transition from the hospital to the home environment. Residents are involved in formulating the care plans for each patient through direct patient care, rounds with the attending physician, and participation at weekly multidisciplinary staff meetings.

The CHOSEN Clinic is a general pediatric outpatient clinic at the Kid's Place in the University of Texas Professional Building. It serves as the medical home for medically fragile children with chronic medical problems. As a primary care provider, the CHOSEN clinic meets the general pediatric needs of this special population of children, including preventive care, developmental surveillance, anticipatory guidance, and management of acute and chronic illness. Residents see clinic patients under supervision of the attending physician and are involved in formulating the care plans for each patient through direct patient care and participation at weekly multidisciplinary staff meetings. They assist in care coordination

and case management for new patients, helping families navigate the complexities of the medical system.

The High Risk Clinic is a subspecialty outpatient clinic at the Kid's Place. It provides follow-up care for high-risk infants discharged from the Neonatal Intensive Care Unit at Children's Memorial Hermann Hospital. Residents see clinic patients under supervision of the attending physician to learn the fundamentals of developmental surveillance and management of common complications of prematurity.

Other sites at which residents may receive educational training during the course of the month include home visits through Project DOCC, palliative care rounds at Children's Memorial Hermann Hospital, and site visits to the Houston Hospice. The purpose of these activities is to educate residents on the principles of family-centered care, home health, and palliative care. Residents do not provide direct patient care during these encounters.

Dermatology

The Dermatology elective rotation is available to residents during their PGY-2 PGY-3 and PGY-4 years. Residents will receive instruction and supervision from University of Texas Medical School at Houston faculty. Residents also have an option to rotate through a private dermatology clinic. Adherence to the 80-hour work week is mandated.

Development & Behavior

Residents assigned to the Developmental and Behavioral Pediatrics rotation work in a team of one or two PGY-1, PGY-2, PGY-3 or PGY-4 trainees. Residents are exposed to outpatients with developmental and psychiatric problems. Adherence to the 80-hour work week is mandated.

Pediatric residents are required to fulfill a one-month block rotation in Developmental and Behavioral Pediatrics. The rotation occurs at a variety of clinical rotations including the Duncan Pediatric Neurodevelopmental Clinic, the Monarch School Clinic, High Risk Neonatology Clinic, and observations with Early Childhood Intervention and Head Start.

Residents see patients in the outpatient Duncan Clinic, the Monarch School Clinic, and the High Risk Neonatology Clinic. Residents are supervised by faculty in the Department of Pediatrics and Developmental Pediatrics.

Emergency Medicine and Acute Illness Rotation

Residents are assigned to the Memorial Hermann Hospital ("MHH") and the Lyndon B. Johnson General Hospital ("LBJ") for the emergency medicine rotation. Residents are assigned a one-month rotation at the LBJ emergency room during the PGY-1 and PGY-2 years. Residents are assigned to MHH for a one-month rotation during the PGY-2 and PGY-3 year. PGY-2 Pediatric residents and PGY-1 Transitional year residents have a one-month rotation at the Kid's Place in the Hermann Professional Building (HPB), where they see ambulatory patients scheduled for a sick visit. Faculty attendings from The University of Texas Medical School at Houston Department of Emergency Medicine supervise the residents in the Emergency Rooms at LBJ and MHH. Faculty from The University of Texas Medical School at Houston Department of Pediatrics supervise residents at the Kid's Place clinic. Adherence to an 80-hour work week is mandated for the emergency medicine rotation and the ambulatory acute illness rotation.

All Internal Medicine/Pediatric PGY-1s are required to take Pediatric Advanced Life Support ("PALS") and PGY-2s are required to take Advanced Pediatric Life Support ("APLS"). Residents rotating in the Emergency Center at MHH attend the Emergency Medicine

Department Conferences as well as Pediatric Noon Conferences. Residents rotating at the Emergency Center at LBJ receive a series of lectures in emergency medicine and acute illness in addition to scheduled Pediatric Noon Conference.

Endocrinology (Pediatric)

Pediatric residents are required to fulfill a one-month block rotation in pediatric endocrinology. The rotation occurs at Children's Memorial Hermann Hospital (CMHH), The University of Texas Outpatient Clinics, and LBJ Hospital. Residents provide primary care for inpatients admitted to the Endocrinology service at CMHH, see Endocrinology consults on other services, and see patients in the Endocrinology outpatient clinics. Residents are supervised by faculty in the Department of Pediatrics' Division of Endocrinology.

PGY-3 and PGY-4 residents are assigned to the pediatric endocrinology rotation. Residents are exposed to both outpatient and hospitalized pediatric endocrinology patients. Adherence to the 80-hour work week is mandated.

Gastroenterology (Pediatric)

The Pediatric Gastroenterology (G.I.) rotation is a one-month rotation to which Pediatrics PGY3 residents are assigned. Residents are exposed to both outpatient and hospitalized pediatric gastroenterology patients. The rotation occurs at Children's Memorial Hermann Hospital (CMHH), The University of Texas Outpatient Clinic, and the Lyndon B. Johnson (LBJ) General Hospital. Adherence to the 80-hour work week is mandated.

Hematology (Pediatric)

The overall goal of the one-month rotation experience in hematology is to provide the pediatric hematology/oncology resident with the fund of knowledge and appropriate skills for evaluation, diagnosis, treatment, and management of pediatric patients with disorders in hematologic function. These include hemostatic disorders, thrombophilia disorders, hemoglobinopathies, other anemias, thrombocytopenias, and congenital neutropenias.

Residents assigned to the pediatric hematology rotation work in a typical team of one attending physician, one fellow, one pediatric or Med/Peds resident (PGY-2 or PGY-1), two medical students and nursing staff. Residents are exposed to both outpatient and hospitalized pediatric Hematology patients. Adherence to the 80-hour work week is mandated.

The hematology rotation occurs at Children's Memorial Hermann Hospital (CMHH), The University of Texas Outpatient Clinics, and the UT MD Anderson Cancer Center. Under the supervision of faculty in the Department of Hematology, residents assume responsibility for the evaluation, treatment, and management of the patient with disorders of the blood.

Residents are expected to attend all appropriate Department of Pediatrics conferences. In addition, residents will attend the Division of Pediatric Hematology/Adult Hematology teaching conferences.

Infectious Disease (Pediatric)

Residents assigned to the pediatric infectious Diseases rotation work in a team of one or two first year Pediatric or Medicine-Pediatric residents. Residents are exposed to both

outpatient and hospitalized pediatric infectious disease patients. Adherence to the 80-hour work week is mandated.

Pediatric residents are required to fulfill a one-month block rotation in pediatric infectious disease. The rotation occurs at Memorial Hermann Children's Hospital (MHCH) and the University of Texas Outpatient Clinics and LBJ outpatient clinics. Residents provide primary care for inpatients admitted to the Infectious Diseases service, see Infectious Diseases consults on other services, and see patients in the Infectious Diseases and HIV outpatient clinics. Residents are supervised by faculty and subspecialty resident in the Department of Pediatrics' division of Infectious Diseases.

The goals and objectives are covered through rounding on the inpatient service, discussions about patients seen on an outpatient basis, various conferences and reading assignments in article section of Blackboard and the AAP Red Book. Additional reading in ID textbooks (ie Long, Pickering and Prober 2008, as well as literature searches in Pubmed are encouraged for development of a more in depth knowledge base.

Each resident is required to present Morning Report and pediatric ID conference on an infectious disease patient of his/her choice during the rotation. Residents will also be evaluated on their effectiveness and willingness to teach medical students.

LBJ General Pediatrics

The general pediatric experience at LBJ is gained through a vertically integrated rotation which includes general inpatient pediatrics, outpatient pediatrics, well baby Level 1 nursery, and Level 2 nursery. The team at LBJ is composed of one senior resident, two Pediatric PGY-1 residents, and 2-3 PGY-1 residents from UT Family Medicine or the LBJ Transitional Residency Program. Goals and objectives for PGY-1 residents apply to all PGY-1s from any rotating service. The team admits patients to the floor and nursery daily. The senior resident functions as the team leader and is responsible for the daily management of the team and the patients in the team's care. A faculty attending from The University of Texas Medical School at Houston Division of Community and General Pediatrics is assigned to the team and participates in direct patient care and as a consultant to the team.

The team cares for inpatients with both general medical and subspecialty problems as well as surgical problems. With the exception of trauma patients, all pediatric patients admitted to LBJ are cared for by this team. Further, once a trauma patient is stabilized, care is transferred to the general pediatrics team. In addition, the team routinely follows several well babies daily in the Level 1 nursery. They also may follow Level 2 babies that require antibiotics, fluids, or extensive diagnostic evaluations for congenital conditions. In addition, members of the team participate in a daily outpatient clinic at LBJ in which they see patients recently discharged from their inpatient service, as well as routine health maintenance visits and sick visits. The purpose of this integrated rotation was to approximate the workflow of a general pediatrician in private practice.

The resident team develops diagnostic and therapeutic management plans in collaboration with the attending physician of record through daily evaluation and discussion. Call is every fourth to fifth night, and the post-call team leaves the hospital by 12:00 p.m. There are 5 days off per month. There is always one senior resident and one or two PGY-1 residents on call. Adherence to the 80-hour work week is mandated.

Patients seen during the integrated rotation are admitted from the LBJ ED, from LBJ Labor & Delivery, from the LBJ Pediatric Clinic, or directly from another facility.

MD Anderson Cancer Center (Pediatrics)

Residents assigned to The University of Texas M.D. Anderson Cancer Center (“MDACC”) oncology rotation work in a team of one senior resident (PGY-2) and two to three pediatric, medicine-pediatric PGY-1s. PGY-1s are exposed to both outpatient and hospitalized pediatric oncology patients and see new patients as they present in the clinics. The PGY-2 resident takes care of the more complicated patients under the direction of a faculty attending. Residents take call every fourth night. Faculty and residents in Hematology-Oncology (PGY-4-6) from MDACC are on call from home. They provide immediately available phone consultation and rapidly available in-house supervision for all new admissions and major problems. ICU level patients are managed by the ICU team (MDACC ICU residents and faculty). Adherence to an 80-hour work week is mandated.

Pediatric residents are assigned to two months at M.D. Anderson. Inpatient activities include bone marrow transplant and general oncology patients. Outpatient activities include seeing newly referred patients. Residents seeing these patients are expected to observe and perform procedures. Patients seen on this rotation include patients with a variety of oncological disorders. New patients are admitted through the outpatient clinic at MDACC. Residents seeing patients through the outpatient clinic are provided the opportunity to take initial patient history, diagnose, and initiate management of oncological disorders. The inpatient experience enables residents to work with patients that have already been diagnosed with oncological disorders and that are currently undergoing specific treatments. The inpatient component allows residents the opportunity to gain experience administering and monitoring treatments for oncological disorders.

Didactic sessions are held at least twice a week with days being determined by the residents’ schedule as a group. Residents are also expected to attend Noon Conference (Mondays), Pediatric Grand Rounds, Leukemia/Lymphoma Conference, UTMSH Pediatric Grand Rounds (via TV), PGY-1 Support Groups, Resident Support Groups, and Inpatient Reports (Mondays and Fridays). On days when there is no specific Noon Conference at MDACC, residents will attend Noon Conference at CMHH via a video streamed link (TV).

Medical Genetics

Medical Genetics Outpatient Clinics and Consults comprise approximately 75% of the required Medical Genetics and Selected Subspecialty Clinics for all Pediatric PGY-1 residents. This is a one-month rotation that occurs at a variety of outpatient sites including the Pediatric Medical Genetics Clinics at the Hermann Professional Building (HPB) and Lyndon B. Johnson General Hospital, the Medical Genetics Clinic at the Shriners Hospital for Children, Pediatric Dermatology Clinics at HMC and San Jose, Pediatric Ophthalmology Clinic at HPB, Craniofacial Clinic at Texas Children’s Hospital, Head Molding Clinic at HPB and Pediatric Dental Clinic at HMC. Approximately 50% (half-days) will be devoted to Genetics Rounds or Inpatient Consults at Children’s Memorial Hermann Hospital and background/follow-up work on Genetics patients (software searches, literature searches, dictation/corrections of notes and letters, reading assignments). Approximately 25% time will be spent in Medical Genetics outpatient clinics. The remaining 25% time will be devoted to the Specialty Clinics: Pediatric Dermatology, Pediatric Ophthalmology, Head Molding Clinic and Pediatric Dental Clinic. Adherence to the 80-hour work week is mandated. Residents are supervised by faculty members who are boarded in Clinical Medical Genetics (either M.D., Ph.D. or M.D./Ph.D.).

The philosophy of the Medical Genetics Rotation is two-fold: 1) to teach the resident to recognize when a patient may have a disorder with an underlying genetic etiology and 2) to

provide the resident with the tools to initiate the work-up on a patient who may have a genetic condition.

Neonatal ICU

Residents rotate in the Neonatal Intensive Care Unit (“NICU”) at Children’s Memorial Hermann Hospital (CMHH) and at Lyndon B. Johnson General Hospital (“LBJ”). The NICU experience is comprised of four one-month block rotations, one as a PGY-1, two as a PGY-2, and one as a PGY-3. PGY-1s are assigned to a one-month block at either CMHH (Level II) or LBJ. PGY-1s are supervised by a senior resident, a fellow and/or an attending. PGY-2s are assigned one month as a supervisor for a NICU team at either CMHH or LBJ. They are responsible for overseeing the PGY-1s and acting interns on those services. PGY-2s spend their second month on the NICU Team Level III at CMHH where they are under the direct supervision of a PGY-3 resident and the neonatal fellows and faculty. PGY-2s are assigned to the CMHH Level III month prior to their supervisory month. PGY-3s have one NICU supervisory month at either LBJ or CMHH NICU Team Level III. PGY-3s are more autonomous and are expected to supervise and teach junior residents and acting interns. PGY-3s are under the direct supervision of the neonatal faculty who are available 24 hours a day to provide assistance.

Full-time faculty from the University of Texas Medical School at Houston supervise residents at both LBJ and CMHH. A neonatal faculty member is assigned to each of the NICU teams and rounds are conducted on all patients with the residents seven days a week. Residents assigned to the NICU take call every fourth night.

PGY-1s are required to take the Neonatal Resuscitation Program prior to beginning clinical duties; they repeat the course as PGY-3s. Didactic instruction in physiology and pathophysiology are provided during attending rounds and as a set of lectures in the Newborn Medicine Sessions of the Resident Education Series. Residents are exposed to all forms of invasive and non-invasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral and metabolic function. A full-time neonatal nutritionist and clinical pharmacist round with the NICU team(s) and provide input/instruction in the appropriate selection of nutrition, use of total parenteral nutrition, and use of various medications. Residents work with a multidisciplinary team of case managers, social workers, home health care providers and high-risk follow-up clinic physicians and nurses for discharge planning and appropriate follow-up.

Nephrology and Hypertension

Residents assigned to the pediatric nephrology rotation work in a team of one to two senior PGY-3 pediatrics residents and 1 PGY-3 Med/Peds resident. Residents are exposed to both outpatient and hospitalized pediatric nephrology patients. Adherence to the 80-hour work week is mandated.

Pediatric residents are required to fulfill a one-month block rotation in pediatric nephrology. The rotation occurs at Children’s Memorial Hermann Hospital (CMHH), The University of Texas Outpatient Clinics, UT MD Anderson Cancer Center and LBJ Hospital. Residents provide primary care for inpatients admitted to the Nephrology service at MHCH, see Nephrology consults on other services, and see patients in the Nephrology/Hypertension outpatient clinics. Residents are supervised by faculty in the Department of Pediatric’s Division of Nephrology and Hypertension. Transitional year residents may choose Nephrology as one of their Pediatric rotations.

Residents are expected to attend all appropriate Department of Pediatric conferences. In addition, residents will attend the Division of Pediatric Nephrology/Adult Nephrology teaching conferences.

Neurology (Pediatrics)

Pediatric residents are required to fulfill a one-month block rotation in pediatric neurology. The rotation offers a variety of experiences in clinical, educational and research settings. Residents will observe, evaluate, and manage children with neurological and developmental disorders of the nervous system. Residents assigned to the pediatric neurology rotation work in a team of one PGY-1 resident, one or more senior Medicine-Pediatric resident (PGY-3 or 4), and a Pediatric Neurology resident. Adherence to the 80-hour work week is mandated.

Residents will work in both outpatient and inpatient clinics, located at Children's Memorial Hermann Hospital (CMHH), The University of Texas Outpatient Clinics, UT MD Anderson Cancer Center, LBJ Hospital, and the Hermann Professional Building. Residents are provided opportunities to work with medical professionals as well as assist children with neurological problems. Residents are supervised by faculty in the Department of Pediatrics Division of Neurology.

Pediatric ICU

Residents rotate in the Pediatric Intensive Care Unit ("PICU") at Children's Memorial Hermann Hospital ("CMHH"). The PICU experience is comprised of two one-month block rotations, one as a PGY-2 and one as a PGY-3. PGY-2 residents are assisted by the PGY-3 resident and are supervised by an intensivist on faculty at the University of Texas Medical School-Houston. The PGY-3 residents have primary patient care responsibility, assist the PGY-2s and supervise any Anesthesia residents who are rotating in the PICU. The PGY-3 residents have more autonomy, but are still closely supervised by the attending.

While rotating in the PICU, residents are exposed to a wide variety of medical and surgical patients. Surgery patients are jointly admitted to the PICU. Residents participate in the management of those patients, round with the Surgery team and participate in pre-operative and post-operative care. As MHCH is a Level 1 Trauma Center, patients are admitted with major as well as minor trauma. Residents are exposed to patients with isolated and multiple organ failure as well as to invasive and noninvasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral and metabolic functions.

Attendings make rounds seven days a week and discuss patient management and basic issues of physiology/path physiology. All residents are required to take Pediatric Advanced Life Support as a PGY-1 and Advanced Pediatric Life Support as a PGY-2. Residents are also exposed to other members of the health care team working in the PICU. A clinical pharmacist rounds with the team. Residents work with social workers and case managers in discharge planning and evaluation/referral for child abuse cases.

Pulmonary (Pediatrics)

Residents assigned to the pediatric pulmonology rotation work in a team of one senior Pediatric or Medicine-Pediatric resident (PGY-2 or 3/4) and one Transitional or Anesthesia PGY-1 resident. Residents will experience treating outpatient and hospitalized pediatric pulmonary patients.

Upper level Pediatric residents are required to fulfill a one-month block rotation in pediatric pulmonology. The rotation occurs at Children's Memorial Hermann Hospital

(CMHH), The University of Texas Outpatient Clinics, and at The Lyndon B. Johnson General Hospital (LBJ) and clinics. Residents see pulmonary inpatient and outpatient consults and participate in the management of outpatients followed by the Pulmonary service. In addition, they provide care of continuity for patients on the pediatric pulmonary inpatient service. Residents are supervised by faculty in the Department of Pediatrics' Division of Pulmonology.

The Pediatric Pulmonology team consults on patients in General Pediatrics, PSCU, PICU, NICU and NBSCU at Children's Memorial Hermann Hospital. The team or attending will occasionally provide consultation to patients at LBJ Hospital, and MD Anderson Cancer Center.

Care for asthmatic patients at MHCH should be individualized to the child's needs; however, the *NEAPP Guidelines for the Diagnosis and Management of Asthma* have been translated into a clinical pathway with orders and educational guidelines. Residents are encouraged to use these materials and individualize them to their asthmatic patients. The pathway and orders are part of the reading packet. It is very important that patients get the necessary education about disease process, medications, environmental control, emergency management and follow-up care. Residents are a valuable part of the Pediatric Pulmonary Medicine Team and they will participate in educating patients.

Radiology (Pediatrics)

The Pediatric Radiology elective rotation is available to residents during their PGY-2, PGY-3 and PGY-4 years.

The Pediatric Radiology elective will take place at Children's Memorial Hermann Hospital (CMHH) and Lyndon B. Johnson General Hospital ("LBJ"). Residents are supervised by faculty from the University of Texas Medical School Department Of Pediatric Radiology. Adherence to the 80-hour work week is mandated.

Rheumatology (Pediatrics)

The Pediatric Rheumatology rotation is an elective subspecialty rotation available to all Pediatric and combined Medicine/Pediatric PGY-2, 3, & 4 residents. It is a one-month outpatient and inpatient rotation which takes place at the Pediatric Rheumatology clinic at the University of Texas Professional Building, and Children's Memorial Hospital. Adherence to the 80-hour work week is mandated. Residents are supervised by faculty members who are board certified in Rheumatology.

The subspecialty of Rheumatology includes a wide array of inflammatory, non-inflammatory, and degenerative disease states that affect multiple organ systems. The purpose of this rotation is to train residents to be accomplished general practitioners with a focus of understanding of how to diagnose and perform an initial evaluation for rheumatologic diseases, as well as encourage the professional and scholarly attitudes and approaches of a competent generalist that are needed to maintain an understanding of current concepts in rheumatology as advances occur. In order to achieve the goals and objectives for the Rheumatology rotation, the following experiences have been established for the purpose of teaching residents.

At all sites, diagnosis of systemic inflammatory/non-inflammatory diseases, development of a complete diagnostic differential, & interpretation of objective lab data are regular activities for both inpatient and outpatient settings. Residents are assigned homework in the form of literature/chapter review throughout the course of the rotation, which is reviewed the following day.

Well Baby Nursery

Residents are assigned to the Lyndon B. Johnson General Hospital (“LBJ”) and Children’s Memorial Hermann Hospital for the normal/term newborn rotation. At both LBJ and CMHH, while on the inpatient team, a PGY-1 resident will spend one two-week period in the well-baby nursery as the primary caregiver. During this time the resident admits 5-12 new infants per day, manages their care until discharge, provides anticipatory guidance to the new parents and arranges for follow-up care. Faculty from The University of Texas Medical School at Houston Division of Community and General Pediatrics are assigned to the nursery at LBJ and MHCH and participate in direct patient care and as a consultant. Adherence to the 80-hour work week is mandated.

3. Outpatient Services

Neurology

This rotation consists of 2-4 upper level residents. Residents have direct supervision from their attending for all procedures and patient care. The upper level residents are directly supervised by the Neurology attending and assigned to the rotation for the month. After the attending oversees patient care and procedure’s completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Geriatrics

This rotation consists of 3-4 upper level residents and 1 or more fellow(s). It is a 4 week rotation with 2 weeks of outpatient clinics and 2 weeks of inpatient. The upper level residents are directly supervised by the Geriatric attending and fellow assigned to the rotation for the month. By directly supervising and overseeing the resident while on rotation, the attending is able to utilize this information in the evaluation process to gage the resident’s progress with regards to the 6 ACGME core competencies. In addition to the attending and fellow, the upper level resident is responsible for direct supervision and education of the Intern on service. After the attending oversees patient care and procedure’s completed by a member of the team he/she will provide review of the procedure or encounter with feedback after the care is delivered.

Allergy and Immunology

The Allergy and Immunology rotation consists of 1-2 Residents. Set in Dr. Susan Andrews Outpatient clinic, the allergy and immunology rotation provides an opportunity for PGY-2, PGY-3 and PGY-4 residents to have basic exposure to the principles in the field of allergy and immunology. Residents in the allergy and immunology rotation will participate in directly supervised patient encounters and discussion sessions with the attending. The resident will be supervised at all times by the attending allergist who will be present on site for consultation. The resident will also have the opportunity to work with nurse practitioners as well as other specialized ancillary staff as they initially view and eventually participate in the various procedures performed in an allergist’s office.

Ambulatory

The Ambulatory rotation at MHH consists of 1 upper level resident at the outpatient clinics located at University of Texas Professional Building. At LBJ there are approximately 2-3 upper level residents and 6-8 interns at the subspecialty outpatient clinics located at the site. The residents and interns rotate through these clinics with Direct Supervision from the outpatient clinic attending for the first six months of their internship year. After the expiration of the first six months of their intern year, the resident and intern can be indirectly supervised by the Attending Physician. At LBJ, the subspecialty clinic attending may also have fellow for direct supervision of the residents and interns. After the expiration of the first six months of their intern year, the resident and intern can be indirectly supervised by the Attending Physician.

In the primary care clinics, after the expiration of the first six months of their intern year, the resident can be indirectly supervised by the Attending Physician, under the primary care exemption. This does not apply to the subspecialty at any site. An attending must be present to directly supervise patient care and Procedures of the resident and intern.

Continuity Clinics

The Continuity Clinics consist of 4 residents and interns per attending per clinic session. These sessions take place at the Good Neighbor Health Clinic. The clinic site serves as the outpatient clinic venue for primary care UTHealth faculty. Interns are Directly Supervised for the first six months of their internship year at the clinic and indirectly supervised after under the primary care exemption.

4. Procedures Performed by the resident

Each Resident will need Direct Supervision while performing any procedure until he/she has completed or assisted in 5 of the following:

1. Resident must demonstrate competence and safe performance of:
 - ACLS
 - Venous/Arterial Blood Draws
 - PAP's
 - Placing Peripheral lines
2. Resident must understand indications, complications, preparation, result, interpretation of:
 - Abdominal paracentesis
 - Arthrocentesis
 - EKG
 - Lumbar puncture
 - PA catheter placement
 - Intubations
 - Arterial line placement
 - Central venous line placement
 - Incision and drainage of an abscess
 - Nasogastric intubation
 - Thoracentesis
 - Umbilical vein placement
 - Umbilical artery placement

I. ROLES AND RESPONSIBILITIES OF RESIDENTS

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

- Serve as assigned at hospitals affiliated with the Program;
- 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 UTHealth policies as set out in the GME Handbook of Operating Procedures(HOOP)(located at <https://inside.uthouston.edu/hoop/index.htm>, all applicable Medical School Policies and Program requirements and guidelines, all Medical Staff Bylaws, and all procedural rules, administrative policies, and other applicable rules and regulations of the hospitals to which the Resident is assigned;
- Participate as a member of 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, the GME Resident Handbook, or as otherwise required by the Program Director and/or Department Chair.

Interns are responsible for the following:

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

The primary roles of the upper level include supervision and education. This is comprised of the following:

- Seeing every patient on the day of admission and writing an Upper Level Addendum
 1. Upper Level Addendum requires a HPI, pertinent PMH, Meds, and PE, along with the Resident's Assessment of the patient's illness and the team-formulated plan. This is not intended to be a full H&P.
 2. When working with an AI, resident must write out a full and complete History and Physical, only Medical Students' Review of Systems may be referred to in the resident note. All other aspects of the H&P must be independently documented by the resident.
- Review and approve diagnostic and treatment plans with the interns *every day prior to Attending Rounds*
- Review patients' progress daily, giving feedback to the intern on progress notes, order writing, and discharge planning
- Assuming complete responsibility of interns' patients on Intern days off
- Organizing and planning attending rounds, meetings with consultants, and other teaching opportunities

- Setting time aside for teaching medical students, including reviewing write-ups and giving timely feedback
- Creating an atmosphere such that the intern is encouraged to ask for help when appropriate
- Directly and Indirectly supervising procedures
- Interacting with nurses and other personnel in a way that respects all members of the healthcare team and encourages their input
- Being certain all members of the team are familiar with the current literature regarding their patients
- A resident will not supervise more than 10 new admissions including in-house transfers; and no more than 16 new patients in a 48 hour period
 1. At MHH on a team with 2 Upper Levels and 2 Interns – the residents can admit an additional 5 patients
 2. At MHH on a team with 2 Upper Levels and 3 Interns – the residents supervise 15 new admissions
- A resident will not be responsible for the ongoing care of more than 14 patients with 1 PGY-1 or 20 patients with 2 PGY-1s
- Participating in Ambulatory curriculum on the day of continuity clinic.

1. Inpatient Services

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

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. Credit will not be granted for a rotation until dictations are complete.

2. Ambulatory Services

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

The general medicine clinic LBJ functions as the ambulatory rotation for interns and select residents. The clinic is located on the first floor of the LBJ Hospital. Patients will be referred to this clinic from the community clinics for internal medicine consultation, as well as patients who were recently hospitalized who present for follow-up care. If an Intern or Resident has their continuity clinic at another location at the same time, preference is given to the continuity clinic.

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

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

3. General Medicine/Pediatric Continuity Clinic

The goal of the Internal Medicine and Pediatric Continuity Clinic is to gain and maintain skills in ambulatory internal medicine and ambulatory pediatrics, 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 is housed at the Good Neighbor Health Clinic. The continuity clinic supersedes all other responsibilities except during rotations in the Medical Intensive Care Unit, Coronary Care Unit or scheduled vacation time. Residents are responsible for rescheduling their continuity clinic if they are post call from a ward team.

If a house officer becomes unable to attend their continuity clinic, he or she must contact the Chief Medical Resident, their clinic attending and the clinic scheduler as soon as possible so patients may be rescheduled. Any communication other than telephone is unacceptable.

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

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.

4. 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.

J. 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 the patient has been evaluated and disagree with any decisions from the ER, call your attending to discuss the case. Any disagreement over patient care or disposition should be referred to the Medicine Attending or Pediatric attending for appropriate action.

If a patient has a PCP, including General Medicine or General Pediatric faculty or residents clinic, the PCP should be notified of the admission and plans for management.

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 Memorial Hermann Hospital, the LBJ attending physician has the ultimate responsibility for the patient. The resident must maintain daily communication with the attending physician regarding the progress of all patients on the service.

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.

4. Call Rooms and Food Services

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

K. PROCEDURES AND SKILLS

PGY-1:

1. An intern performs a history and physical exam on each patient admitted to them. They follow the patient closely while admitted to the hospital with daily progress notes and discharge summaries at the end of the hospitalization.
2. Writes all orders on their patients.
3. Performs procedures necessary for the care of their patients with supervision and under the direction of the attending physician. Although an attending physician is on call to assist the House staff, 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 House staff or fellow who has been appropriately credentialed to perform these procedures:
 - 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
 - i. Umbilical Vein placement
 - j. Umbilical Artery placement
4. Supervises and helps in teaching the third and fourth year medical students.
5. 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
 - i. Umbilical Vein placement
 - j. Umbilical Artery placement
4. The following procedures must be done with the direction and supervision of an attending physician. These include:
 - a. Swan-Ganz Placement (ICU or CCU)
 - b. Bone marrow aspirate and biopsy (Pathology attending physicians)
 5. Supervises and helps in teaching the third and fourth year medical students as well as the intern.
 6. Pre-round with the interns daily
 7. Participate in teaching rounds with the intern(s) and attendings on a daily basis.

Interactions with residents constitute a major source of learning for medical students and other Residents. The educational tone of a service is set largely by the 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 Residents to teach each other and the students. The residents' teaching rounds are generally viewed by the students as enjoyable and profitable educational experiences.

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

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

Residents are expected to help students achieve the above abilities and skills by allowing students to see patients first unless the situation is urgent. Residents should observe the students performing histories and physical examinations during the early part of the rotation, in order to recognize and correct any deficiencies. Residents should discuss

historical, physical and laboratory findings with the students. The resident should review the students' recorded histories and physicals. Residents and interns should instruct and supervise the students in basic procedural skills. On regularly scheduled teaching rounds, the resident should point out abnormal physical findings; discuss pathophysiology of disease and the scientific basis of treatment. House staff should guide the students and interns to appropriate reading material. Finally, the residents should always treat junior students respectfully, as valued members of the inpatient health care team.

K. MEDICAL RECORDS AND CLINICAL DOCUMENTATION

It is the responsibility of every house officer to complete all medical records in a timely manner. The Ward resident is ultimately responsible for all documentation completed by the team during his/her month whether it is documented by himself/herself, an intern or acting intern (4th year Medical Student). It is the responsibility of the ward resident to complete admission history and physical examinations and discharge summary dictations. Interns should dictate discharge summaries on the day the patient is discharged. If a discharge summary becomes delinquent, the record will be turned over to the ward resident for completion. Medical students, including 4th year students, must not dictate discharge summaries. 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.

L. 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.

M. EVALUATION AND ADVANCEMENT

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

Each attending is reminded that at the beginning of the month, he/she is to go over the goals and objectives with his/her resident(s) and explicitly outline what is expected of the resident throughout the month. Mid-month each resident shall meet with their attending physicians to review his/her progress. At the end of the month, the resident and attending shall meet to review the evaluation. On each rotation, the resident's performance is evaluated by the attending physician through an on-line evaluation system, GMEIS. 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 UTHealth can be found at:
<https://gmeis.uth.tmc.edu/gmeis/index.jsp>

Evaluation of advancement of the residents is performed by the Chairman and Program Directors, with the advice of the Internal Medicine Directors at M.D. Anderson and St. Luke's hospitals, and the Assistant Chiefs of Service. These reports are printed and kept in the resident's permanent file in the Residency Program office. A resident may review that file any time he or she wishes. Progress of residents is reviewed regularly by the Residency Clinical Competency Committee, which meets monthly.

1. Resident Evaluations

Resident evaluations occur on a monthly basis and are completed by the appropriate attending. The evaluations are an analysis of the Residents performance during the month based on the 6 ACGME core competencies. These evaluations are assigned within 7 days of the beginning of each rotation. Any rotations where a resident received an overall rating of "Unsatisfactory" will need to be repeated.

2. Rotation Evaluations

Rotation evaluations are assigned on a monthly basis and completed by the Resident. The rotation evaluations are an opportunity for the resident to evaluate their experience on each rotation with an assessment of patient diversity, workload, responsibility, and supervision amongst other things. The Program Director utilizes these evaluations in his/her review of the Programs curriculum.

3. Peer Evaluations

Peer evaluations are assigned monthly and completed by the resident on his/her peers conduct throughout the rotation. They must be completed and submitted by team members that rotated with the resident for the month and can be submitted confidentially. These evaluations are reviewable by the individual being evaluated however, if it is submitted anonymously, the reviewing neither the reviewing Resident nor any Program Director or administrator will not be able to determine who submitted the evaluation.

4. Attending Evaluations

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

5. Resident Self-Evaluations

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

6. Six Month Evaluations

These evaluations are completed by the Program Director/Associate Program Director are provided to the resident at least semiannually and each resident is provided feedback about their progress in the program. The summary presented to the resident details the residents progress over the previous six month period. Career counseling is also discussed in this meeting. This meeting is documented in the GMEIS system and a copy of the meeting details is placed in the residents file.

7. 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 and the American Board of Pediatrics.

Each resident will receive an email within the first week of September with the CEX form attached which will include instructions for completion and will be due no later than the last day of October. It is the resident's responsibility to print out the form, take it to the

assigned clinic attending, or hospital attending, and have it completed. After both the attending and resident sign it, it should be delivered to the Program Coordinator.

8. In-Training Exam

The In-Training Examination by the American College of Physicians for Pediatrics is mandatory for all residents. It is administered in July of every year and PGY-1, PGY-2, PGY-3 and PGY-4 residents will sit for the exam. Additionally the In-Training Examination by the American College of Physicians is mandatory for all residents. It is administered in October of every year and PGY-1, PGY-2, PGY-3 and PGY-4 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.

9. Problems and Complaints about Evaluation

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

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

10. Retaliation

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

N. Medical Licensure

Eligibility requirements for Texas Medical licensure are found in Chapter 163 of the Texas Medical Boards rules. The major requirements for completion of either 60 hours of pre-medical education or completion of the required pre-medical education of the country where the medical school is located, graduation from a U.S. or Canadian medical school or an acceptable unapproved medical school, and you must have passed an examination acceptable to the Board. Graduates of foreign medical schools will become eligible for licenses after three years of residency training. Licensure information may be obtained from the house staff office. Complete information about licensure can be found on the Texas Medical Board webpage at http://www.tmb.state.tx.us/apps/physician_eligibility.php. House staff should obtain a valid Texas Medical License as soon as possible.

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

1. DEA AND DPS NUMBERS

Institutional Drug Enforcement Administration (DEA) numbers are assigned by the affiliated hospital to the resident. The institutional DEA number allows prescription-writing privileges for only educational training program activities. Institutional DEA numbers are not valid for "external moonlighting" or any other activities outside of the educational training program. Institutional Department of Public Safety (DPS) numbers are assigned to Residents that hold a Texas Medical Board PIT permits. These numbers are assigned by the GME Office in coordination with affiliated hospitals. The DPS number allows prescription-writing privileges for controlled substances only as part of educational training program activities. DPS numbers are not valid for "external moonlighting" or any other activities outside of the educational training program.

Once a resident obtains a full, unrestricted Texas medical license, the licensed resident must apply for and obtain individual DPS and DEA numbers. All fully licensed residents are responsible for obtaining their own individual DPS and DEA number.

O. EDUCATIONAL MEETINGS AND CONFERENCES

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

There are several Internal Medicine and Pediatric conferences held weekly. Attendance by Residents is mandatory and will be monitored with sign-in sheets. Failure to maintain 80% attendance to Noon Conference and Morning Report, excluding days off, post call days, or attendance to a subspecialty conference (held at the same time) will result in punitive action.

Conference attendance will be tallied from the first of each month to the last day of each month. Cumulative attendance rate will be available on the 1st day of the following month. Any house staff with less than 80% attendance rate will be required to do the following:

1st Violation: House staff will meet with their assigned Associate Program Director, have a letter placed in their file, and be assigned extra jeopardy calls and/or on the holiday jeopardy call pool.

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

These mandatory conferences are as follows:

1. Resident Case Conferences

These conferences include resident intake report, intern conference, sub-specialty conference, and post-call morning reports. Conferences occur at both hospitals and will be clinical case presentations by the residents or interns scheduled for that day. Attendance at these conferences is required and will count toward your total attendance for the month.

2. Core Curriculum Lectures

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

3. Grand Rounds

Internal Medicine Grand Rounds are held on Tuesdays at 12:00 PM in the Medical School 2.103. Pediatric Grand Rounds are held on Tuesdays at 8:00 AM in the Medical School 2.103. These presentations are given by members of UTHealth faculty or by visiting professors, concerning important and relevant topics in Internal Medicine and Pediatrics. This conference is simultaneously broadcast to LBJ hospital.

4. Senior Seminar

Every year, the senior residents prepare noon conferences that consist of a review of a topic. The subject matter may be any topic relevant to clinical medicine or the basic sciences which relate to medicine or delivery of health care. The presenting residents are expected to use the PowerPoint presentation format and to distribute handouts outlining the subject and containing pertinent bibliographies. Each resident will present once during his/her PGY-4 year and select a faculty mentor to assist with this presentation. Residents may be exempt from this requirement if they have presented at an ACP conference or have a publication during their residency.

5. Morning Report

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

6. Multidisciplinary Week

One week of the month will be dedicated to multidisciplinary conferences including radiology, pathology, quality improvement, journal club, and research conferences. Attendance at these conferences is required and will count toward total attendance for the month.

P. PROFESSIONAL ATTIRE AND ETIQUETTE

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

Residents should always have business cards handy to provide to patients in an effort to cultivate strong patient-physician communication. If you do not have the appropriate University of Texas business cards, these can be retrieved from the House staff office by a coordinator.

Q. MOONLIGHTING

Moonlighting is defined as any patient care service a resident performs as a fully licensed physician where he/she receives financial compensation as a result of those services. Moonlighting occurs outside of the Internal Medicine & Pediatric Residency Program and residents assignments from the Program are not included in Moonlighting. Residents are *not required* nor are they encouraged to engage in professional activities outside the educational program. Moonlighting must not interfere with the ability of the resident to achieve the goals and objective of the program.

Every resident who wishes to engage in moonlighting must provide written notification of their intent and participation to the Program Director and receive approval from the Program Director. This request and approval/disapproval will become part of the Residents file. Failure to notify the program director of moonlighting activities will result in disciplinary action. The Program may revoke approval or initiate corrective action in the event outside professional activity interferes with the ability of the Resident to satisfactorily fulfill the obligations of the Program.

Residents are required to be independently licensed for unsupervised medical practice by the State of Texas and be in good standing with the Residency Program before they can consider moonlighting. A physician-in-training permit does not entitle the resident to engage in professional activities (i.e., medical practice) outside the educational program. Moonlighting is prohibited during standard work hours and should be limited to no more than 3-4 nights per month, and cannot interfere with performance of one’s clinical and academic duties. All moonlighting will count toward the resident’s total duty hours and residents may not exceed 80 hours worked per week.

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

Interns are not permitted to moonlight under any circumstances.

R. DUTY HOURS

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

Night Float is defined as a rotation or educational experience designed to either eliminate in-house call or to assist other residents during the night. Residents assigned to night float are assigned on-site duty during evening/night shifts and are responsible for admitting or cross-covering patients until morning and do not have daytime assignments. Rotation must have an educational focus. Residents must not be scheduled for more than six consecutive nights of night float. Programs must further abide by any program specific requirements.

1. Policy

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. Duty periods for PGY-1 residents must not exceed 16 hours in duration. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. The program encourages residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly encouraged.

- (i) Residents may be allowed to remain on site in order to ensure that effective transitions occur, however this period of time must be no longer than an additional four hours.
- (ii) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or an unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
 - a. Under those circumstances, the resident must:
 - i. appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
 - ii. document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
 - b. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Residents must be scheduled for a minimum of one day free of duty every week when averaged over 4-weeks. At home call cannot be assigned on these free days. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

Minimum Time Off Between Scheduled Duty Periods: PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. Intermediate-level residents should have 10 hours free of duty, and must have eight hour between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. Residents in the final years of education must be prepared to enter

the unsupervised practice of medicine and care for patients over irregular or extended periods. This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. PGY-2 residents and above must be scheduled for in-house call no more frequently than every third night, averaged over a four-week period. PGY-2 residents and above must not be assigned additional clinical responsibilities after 24 hours of continuous duty

Duty Hours are formally monitored through the Institutional GMEIS system and each Resident is required to submit their duty hours on a monthly basis.

2. On-Call Activities

At-home call (pager call) is defined as call taken from outside the assigned institution. At-Home Call may not be scheduled on the resident's one free day per week (averaged over four weeks). At-home call does not occur during the Internal Medicine and Pediatric Residency.

1. Time spent in the hospital (exclusive of travel time) by residents on at home call must count towards the 80 hour per week limit.
2. The frequency of at-home call is not subject to the every third night limitation, but must satisfy the requirement for 1 day in 7 free of duty when averaged over a 4-week period.
3. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. 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. Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period".

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

3. Subspecialty Program Requirements

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

4. Professionalism, Personal Responsibility, and Patient Safety

All Residents and Interns in the Internal Medicine and Pediatric Residency Program must appear for duty appropriately rested and fit to provide the services required of patients. This is not only important for professional aspects of the job but also to ensure patient safety while practicing patient care. The S.A.F.E.R program, provided by the GME office, is a required presentation that each House staff officer must view and understand. This presentation is designed to educate Residents and Interns to recognize the signs of fatigue and sleep deprivation, educate in alertness management and fatigue mitigation processes, helps with ideas on how to mitigate patient care problems that stem from fatigue. Residents and interns are strongly encouraged to notify the attending and/or Program Director of issues with fatigue while completing patient care responsibilities and encourages the use of strategic napping to fight the effects of fatigue on Patient Care. Sleep facilities are provided at all sites where a resident or intern rotates and may find themselves in a situation where the patient care quality is compromised by excessive sleepiness. If a resident feels he/ she is unable to drive home safely after being on call, they must call the Program Director or Program Coordinator for them to facilitate transportation.

5. Transfer Protocols and Hand-over of Patient Care

- Checkout is to be given verbally in person as well as in written form as explained below.
 - Checkout may not be given with only one form of communication
 - Checkout may not be given over the phone
- For the non-call teams, ACE resident, Med-Peds resident/Intern:
 - Weekdays may checkout to the float resident at 5pm.
 - Weekends may checkout to the on-call resident at 12pm
- For the post-call team:
 - The resident should run the list with the post-call cover intern. The resident on-call will be the interns backup as needed.
 - May checkout the float resident at 5pm on weekdays or 12pm on weekends.
- SECURE 1 CHECKOUT SHEET
 - <https://secure1.mhhs.org/checkout/>
 - Secure, web-based form to collect pertinent information which can then be handed off between residents, and can be altered by anyone on service
 - Includes current information, room numbers, medication lists, medical record numbers, and code status
 - Includes important team contact information including cell phones and pagers of all team member and the attending in case of emergency
 - It is managed only by interns and residents; Medical Students are not allowed to update the list.
 - The secure one checkout list is to be printed and given to the covering resident or intern at the time of verbal checkout
- Each year at the beginning of the year the program is to have a formal, interactive teaching session regarding checkout procedures, protocols, and how to give effective, appropriate checkout
- Each month check procedures and protocols are to be reviewed during the monthly on-site orientation

- DNR decisions should be made by the PGY-2 resident and above. PGY-1 residents need to be supervised for all aspects of their care provided including but not limited to transfer of a patient to an intensive care unit, or end-of-life decisions. PGY-2 and above residents may be directly or indirectly supervised for the items.

S. GRIEVANCES

The Program Director is responsible for ensuring compliance with this grievance and dues process procedure as well as the institutional requirements found in the GME Resident Handbook. 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 Program.

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

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

T. CORRECTIVE AND/OR ADVERSE ACTIONS

1. Summary Actions when Resident May Pose 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 and/or any conduct of a resident may constitute an immediate threat to patient safety, the Program Director may reassign or suspend the resident pending a determination by the Program Director regarding the ability of the resident to continue in the Program. If the Program Director's determination regarding whether the Resident is able to continue in the Program is appealed, the appeal shall be conducted under the provisions for "Academic Actions" below, except that the resident need not have been provided prior "notice and guidance" regarding the conduct prompting the summary suspension.

2. Academic Actions

In the event a resident encounters difficulty meeting and/or maintaining performance standards as they pertain to the ACGME Competencies, as well as/or professional behavior standards ("academic difficulty"), the Program Director will notify the resident that his/her performance is unsatisfactory. Likewise, if a resident is having academic difficulty, he/she should seek the guidance and advice of the Program Director.

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

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

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

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

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

3. Non-Academic Actions

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

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

Upon receipt of a notice of allegations from a Program Director, the GME office will promptly provide a copy of the following procedures to the Resident. If the resident does not dispute the allegations, he or she will be asked to sign a Waiver of Hearing and a disciplinary penalty may be assessed by the Program Director or Department Chairperson. If the resident disputes the allegations, or if the resident admits the allegations but contests the penalty to be assessed, he or she may request a hearing before a Discipline Committee appointed by the DIO. The Discipline Committee will consist of three members, one of

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

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

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

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

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

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

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

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

4. Duty to Report

The TMB requires all Residents with PIT permits to report, in writing, the following circumstances to the Executive Director of the Board 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 \$250), charge or conviction of a crime, indictment, imprisonment,
- placement on probation or receipt of deferred adjudication; or
- diagnosis or treatment of a physical, mental or emotional condition which has impaired or could impair the PIT permit holder's 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 corrective action, including disciplinary action.

U. CONDITIONS OF SEPARATION

1. Resignation

A resident may resign from a Program by providing at least 30 days' written notice of his/her intent to resign. The resident's resignation must be submitted to the Program Director. 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.

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.

a. 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.

Academic Year 2011-2012

(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).

3. Termination

A resident's appointment may be terminated prior to the end of the appointment term. A Resident so terminated will generally receive compensation equivalent to 90 days' salary.

V. PAGERS

Residents are issued a personal pager, for which they are financially responsible for the loss or damage of. In addition to the pager issued by the Program, House staff may be issued a

hospital pager during rotations at MD Anderson or St. Luke's Episcopal Hospital. Residents are **required** to wear your UT pager and leave it on at all times unless on vacation or your day off.

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

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

The pager systems are as follows for each hospital:

Memorial Hermann and LBJ Pagers:

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

M.D. Anderson Pagers:

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

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

When instructed, enter the call back number.

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

St. Luke's Pagers:

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

W. EMAIL

After satisfying all prerequisites, completing all paperwork relevant to appointment and signing the *User Responsibilities & Accountability Acknowledgment Form*, a resident will be assigned a UTHealth e-mail address and allowed permitted use of UTHealth computer resources, particularly e-mail, during the duration of their appointment. Residents are subject to and shall abide by the terms of all applicable information technology policies and guidelines contained in the UTHealth HOOP (see, e.g., HOOP Policies 98, 132, 175-181, and 198). All use of the UTHealth information technology network, including access to and use of the internet and UTHealth email is a privilege that must not be abused. Any prohibited or inappropriate use of the network and/or the e-mail system may result in the withdrawal of such privilege, and may be grounds for additional adverse action, up to and including dismissal from the Program.

The UTHealth email will be the only email address that the Program will disseminate information to and through. It is the resident's responsibility to check his/her UTHealth account on a regular basis with the recommendation being daily. Residents will be held responsible for any information disseminated via email, regardless of whether it is checked frequently or infrequently. The UTHealth e-mail is web-based and can be reached by any computer connected to the internet at the following URL: <https://webmail.uth.tmc.edu/>. If you experience problems with your account or password, please contact the UTHealth Help Desk at 713-486-4848.

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

X. LAB COATS

Four three-quarter length coats are supplied to each resident through the Program in the first appointment year, and one additional coat is supplied in each subsequent year of training. Information about laundry services is available from the House staff Office located at MSB 1.126.

Y. PARKING

Subsidized parking is available to residents in the UT Professional Building and Prairie View A&M parking garages. All residents will be given an opportunity to sign up for parking at resident orientation; a copy of the parking policy and rules will be provided at that time. Residents who sign up for parking must do so for the entire academic year. Residents who cancel parking during the academic year are not eligible to re-enroll until the following open enrollment period and are not entitled to any refunds. Residents who permit use of their parking card by any other individual(s) or otherwise attempt to circumvent the parking system will lose all parking privileges for the duration of their residency/fellowship.

Parking at LBJ will be provided at no cost to UT House staff. 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 UTHEALTH House staff presents their ID Badge, the appropriate decal will be issued and the badge will be coded with access to the applicable parking lots. Each UTHEALTH House staff will be issued a decal based upon their work classification.

Z. HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) was enacted in an effort to protect patients from unauthorized disclosure of their protected health information. Residents in the Program are charged with knowing the information covered under the Act as well as complying with the rules and regulations. HIPAA violations are prohibited. Each resident may only utilize patient information within the guidelines of the Act.

AA. DISASTER PREPAREDNESS PLAN

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

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

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

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

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

1. All residents and interns **ON-CALL and PRE-CALL** on the day the disaster plan is activated are required to report to their assigned duties immediately.
2. Residents and interns will rotate working 12 hour shifts until the disaster plan is no longer in effect.
3. For Ward Teams - there will be two Ward Teams on duty at a time in each hospital. Ward teams must divide the patients from ALL ward services equally and round on them on them on a daily basis. The cross-cover and admitting duties will then be divided amongst the two ward teams on duty in 12 hour shifts.
4. Renal Wards at Hermann and LBJ will be covered by the Renal Fellow.
5. The ER at LBJ will be covered by all of the residents and interns scheduled for the day and night shifts on the day the disaster plan is activated. They will rotate duties in 12 hour shifts.
6. CCU/Cardiology at Hermann will function similar to the Ward Teams (see number 3).
7. MICU at Hermann and LBJ will rotate duties in 12 hour shifts.

BB. Conclusion

Each resident shall review this Policy and Procedure Manual and comply with all provisions. Should a resident have any questions about this Manual, please contact the Program Director immediately. Each resident is presumed to have read and understood this Policy and Procedure manual, in conjunction with the GME Handbook, unless he/she schedules a meeting with the Program Director to discuss any questions or concerns.