



McGovern
Medical School

The University of Texas
Health Science Center at Houston

Internal Medicine Residency Training Program

Policies and Procedures Manual 2018-2019

Effective July 1, 2018

Table of Contents

- I. DEFINITIONS AND DESCRIPTIONS
- II. PROGRAM OVERVIEW
 - A. DEPARTMENT LEADERSHIP
 - 1. Chair
 - 2. Vice Chair
 - 3. Program Director
 - 4. Associate Program Directors
 - 5. Core Faculty
 - 6. Program Staff
 - B. SPONSORING INSTITUTION
 - C. AFFILIATED INSTITUTIONS
 - 1. Hospitals
 - 2. Clinics
 - D. LEVELS OF TRAINING
 - E. APPOINTMENT AND REAPPOINTMENT
 - 1. Appointment
 - 2. Reappointment and Promotion
 - F. STRUCTURE OF THE PROGRAM
 - G. SCHEDULES
 - 1. Monthly Schedules
 - 2. Vacations and Time Off
 - 3. Ready Reserve/Jeopardy Call
 - 4. Sick Leave/Leave of Absence
 - 5. Leave of Absence
 - 6. Military Leave
 - 7. Family and Medical Leave (FMLA)
 - 8. Holidays
 - 9. Reporting Time-Off
 - H. SUPERVISION POLICY
 - 1. General
 - 2. Inpatient Services
 - 3. Outpatient Services
 - 4. Procedures Performed by the Resident
 - I. ROLES AND RESPONSIBILITIES OF RESIDENTS
 - 1. Medical Records and Clinical Documentation
 - J. EXPOSURE TO INFECTIOUS DISEASES
 - K. EVALUATION AND ADVANCEMENT
 - 1. Resident Evaluations
 - 2. Rotation Evaluations
 - 3. Peer Evaluations
 - 4. Attending Evaluations

- 5. [Resident Self-Evaluations](#)
- 6. [Six Month Evaluations](#)
- 7. [Clinical Evaluation Exercise](#)
- 8. [In-Training Exam](#)
- 9. [Pre and Post Tests](#)
- 10. [Evaluation Criteria](#)
- 11. [Problems and Complaints about Evaluation](#)
- 12. [Retaliation](#)
- L. [Medical Licensure](#)
 - 1. [DEA AND DPS NUMBERS](#)
- M. [EDUCATIONAL MEETINGS AND CONFERENCES](#)
 - 1. [Resident Case Conferences](#)
 - 2. [Core Curriculum Lectures](#)
 - 3. [Grand Rounds](#)
 - 4. [Senior Seminar](#)
 - 5. [Board Review Conference](#)
 - 6. [Multidisciplinary Week](#)
- N. [PROFESSIONAL ATTIRE AND ETIQUETTE](#)
- O. [MOONLIGHTING](#)
- P. [DUTY HOURS](#)
 - 1. [Policy](#)
 - 2. [On-Call Activities](#)
 - 3. [Subspecialty Program Requirements](#)
 - 4. [Professionalism, Personal Responsibility, and Patient Safety](#)
- Q. [GRIEVANCES](#)
- R. [CORRECTIVE AND/OR ADVERSE ACTIONS](#)
 - 1. [Summary Actions when Resident May Pose a Threat to Patient Safety](#)
 - 2. [Academic Actions](#)
 - 3. [Non-Academic Actions](#)
 - 4. [Duty to Report](#)
- S. [CONDITIONS OF SEPARATION](#)
 - 1. [Resignation](#)
 - 2. [Separation](#)
 - 3. [Termination](#)
- T. [PAGERS](#)
- U. [EMAIL](#)
- V. [LAB COATS](#)
- W. [PARKING](#)
- X. [HIPAA](#)
- Y. [DISASTER PREPAREDNESS PLAN](#)
- Z. [Conclusion](#)

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 2nd year of training to their 3rd year for Categorical and additionally 4th year for Internal Medicine Pediatrics Residents.

Program: The term “Program” refers to the Internal Medicine Residency and/or the combined Internal Medicine and Pediatrics training program(s).

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

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

II. PROGRAM OVERVIEW

The mission of the University of Texas Houston Internal Medicine Program is to prepare each Resident for a successful career as a general internal medicine physician. We strive to provide an excellent foundation for each Resident so that no matter the career path that is chosen, he/she will have the ability to excel. Training encompasses 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. Internal Medicine is a discipline encompassing the study of health promotion, disease prevention, diagnosis, care, and treatment of men and women from adolescence to old age, during health and all stages of illness. Intrinsic to the discipline are scientific knowledge, the scientific method of problem solving, evidence based decision making, a commitment to lifelong learning, and an attitude of caring that is derived from humanistic and professional values.

One of the fundamental principles of Internal Medicine training is the progressively increasing degree of responsibility that Residents are given for the care of patients. The principles of patient care demand that the attending physician retain ultimate responsibility for the welfare of his or her patients, however, this rule allows delegation of authority to the Residents for management of patients on a day to day basis. Attending physicians will delegate progressively more and more authority to the house officer as he or she progresses through the training program. Acceptance of this responsibility requires that the Housestaff have time to assess the patient, to develop a reasonable formulation of the patient’s problems, and to propose a plan of management. With the concurrence of the attending physician, the plan of management may then be undertaken by the Resident. Additionally,

the attending physician has an obligation to teach general and/or subspecialty internal medicine to the Residents. This teaching is best carried out in the context of the immediate clinical situation. The attending physician and Residents should work together for the benefit of the patient.

Throughout their training, Residents are exposed to several different kinds of clinical experiences. At Memorial Hermann Hospital, M.D. Anderson Cancer Center, the Michael E. DeBakey VA Medical Center, and Lyndon B. Johnson General Hospital, there are inpatient services staffed by full time faculty. At Memorial Hermann there are also patients under the care of voluntary faculties of the University of Texas McGovern Medical School. There are rotations through general and subspecialty inpatient services and outpatient clinics, medical intensive care, coronary care units and emergency rooms.

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

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

A. DEPARTMENT 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



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. Executive Vice Chair

Dr. Kevin Finkel is Executive Vice Chair of Medicine, professor and director of the Renal Disease and Hypertension division at the McGovern Medical School at The University of Texas Medical Houston Health Science Center (UTHealth). Dr. Finkel is a 1990 graduate of Northwestern University-Feinberg School of Medicine in Chicago, Illinois where he completed his Internal Medicine residency. In 1994, Dr. Finkel completed his Renal Disease fellowship at Barnes Hospital/Washington University School of Medicine in St. Louis Missouri. Dr. Finkel has been awarded the Dean's Teaching Excellence Award multiple times and is active in the education of student, residents, and fellows at McGovern Medical School.



3. Vice Chair for Education

The ultimate responsibility for administration of the educational programs in Internal Medicine rests with the Vice Chair of Medicine for Education, Dr. Philip R. Orlander. 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. 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 Texas with Medical Staff appointment at the McGovern Medical School at The University of Texas Medical Houston Health Science Center (UTHealth).

Dr. Orlander has been instrumental in the education of the Internal Medicine Residents since his appointment as Assistant Professor with the McGovern Medical School at the University of Texas Medical Houston Health Science Center (UTHealth) in 1983. In 1991, he was promoted to Associate Professor and became the program director for the Endocrinology, Diabetes and Metabolism fellowship. He was promoted to Professor in 1997, and Division Director of Endocrinology, Diabetes, and Metabolism in 1993. In 2005, 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. 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.

4. Program Director



Dr. Jennifer L. Swails is the GMEC approved Program Director for Internal Medicine. Dr. Swails received her bachelor in science degree in biology from Davidson College and her doctorate in medicine from Weill Cornell Medical College. She completed residency training in Internal Medicine and primary care and Brigham and Women's hospital and then joined the faculty of the McGovern Medical School at The University of Texas Health Science Center at Houston in 2012. Her role involves direct patient care in both the inpatient and outpatient settings, as well as quality improvement and medical education. Dr. Swails is board certified in internal medicine (2012) and medical quality (2017). She is a member of Phi Beta Kappa and Alpha Omega Alpha honor societies, and was inducted into the Academy of Master Educators in 2015. In 2016, Dr. Swails received a UT system patient safety grant to develop a curriculum to teach team work skills to students throughout the health sciences. She was chosen by the medical school class of 2017 to be the commencement speaker, at which time she received the McGovern award for outstanding clinical teacher.

Responsibilities of the Program Director

The Program Director administers and maintains an educational environment conducive to educating the Housestaff 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 Housestaff. Faculty are reviewed annually and given a summary review of their performance for the preceding year based on the confidential and anonymous resident evaluations and comments.

5. Associate Program Directors

The Program Director is aided in the administrative and clinical oversight of the educational program by 7 Associate Program Directors as follows:



Gabriel Aisenberg, MD

Associate Program Director
Program Site Director, LBJ Hospital
Assistant Professor of Medicine
Division of General Medicine



Jammie Barnes, MD

Associate Program Director
Assistant Professor of Medicine
Division of Rheumatology



Robby Wesley, DO

Associate Program Director
Assistant Professor of Medicine
Division of General Medicine



Renee Flores, MD

Associate Program Director
Assistant Professor of Medicine
Division of Geriatrics and Palliative care



Philip Orlander, MD

Associate Program Director
Vice Chair for Education
Professor of Medicine
Division of Endocrinology



Katie B. Guttenberg,
MD

Associate Program Director
Assistant Professor of Medicine
Division of Endocrinology



Mark A. Farnie, MD

Associate Program Director
Internal Medicine/Pediatrics Program Director
Professor of Medicine
Division of General Medicine

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.

6. Core Faculty

The residents in the Internal Medicine Residency enjoy the expertise of 14 institutionally based core faculty members 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 Housestaff. 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 Housestaff as a whole, about career and educational goals.

Core Faculty

Amee Amin, MD Division of Emergency Medicine- Hospitalist	Cesar Arias, MD Division of Infectious Disease	Anneliese Gonzalez, MD Division of Oncology
Omowunmi Aibana, MD Division of General Medicine	Ricardo Badillo, MD Division of Gastroenterology, Hepatology and Nutrition	Brandy McKelvy, MD Division of Pulmonary and Critical Care
Jane Andrews, MD Division of General Medicine	Sujith Cherian, MD Division of Pulmonary and Critical Care	Saher Rabadi, MD Division of General Medicine
Effrosyni Apostolidou, MD Division of Hematology	Abhijeet Dhoble, MD Division of Cardiology	Neel Shah, MD Division of Endocrinology
	Rodrigo Hasbun, MD Division of Infectious Disease	Jade Teakell, MD Division of Renal Disease and Hypertension

7. Program Staff

The main Housestaff office is located in the Medical School Building, MSB 1.134 and houses the clerical staff responsible for the operation of the program.

Melanie J. Carver
Program Coordinator
Internal Medicine Residency Program
UT Houston Medical School
6431 Fannin, MSB 1.134
Houston, Texas 77030
Ph (713) 500-6526

Melanie.J.Carver@uth.tmc.edu

Diana Hernandez
Program Coordinator
Internal Medicine Residency Program
UT Houston Medical School
6431 Fannin, MSB 1.134
Houston, Texas 77030
Ph (713) 500-6536

Diana.Hernandez@uth.tmc.edu

Dana L. Foster
Program Coordinator
Internal Medicine Residency Program
UT Houston Medical School
6431 Fannin, MSB 1.134
Houston, Texas 77030
Ph (713) 500-6522

Dana.Foster@uth.tmc.edu

Phyllis Martin
Program Coordinator
Internal Medicine and Pediatrics Residency Program
UT Houston Medical School
6431 Fannin, MSB 1.126
Houston, Texas 77030
Ph (713) 500-6525

Phyllis.Martin@uth.tmc.edu

B. SPONSORING INSTITUTION

The Internal Medicine Residency Program is sponsored by UT Health and established under the department of Internal Medicine. The Sponsoring Institution provides technical and professional personnel as required by Housestaff and as delegated by McGovern Medical School at the University of Texas Health Science Center at Houston's Handbook of Operating Procedures <https://www.uth.edu/hoop/>.

The mission of McGovern Medical School 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 McGovern Medical School 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 UT Health for the purpose of the Internal Medicine Residency Training Program includes:

- a. Memorial Hermann Hospital-TMC
- b. Lyndon B. Johnson General Hospital (Harris County Hospital District)
- c. The University of Texas M.D. Anderson Cancer Center
- d. The Michael A. DeBakey VA Medical Center

2. Clinics

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

- a. University of Texas Professional Building (UT Physicians)

- b. UTHSC-H Center (West Loop Bellaire Clinic)
- c. Thomas Street Clinic (Harris County Hospital District)
- d. Lyndon B Johnson Hospital Clinic (Harris County Hospital District)
- e. The Michael A. DeBakey VA Medical Center

D. LEVELS OF TRAINING

Progressive levels of training in the Program are designated as Post Graduate Year (“PGY”) 1 through 3 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 Graduate Medical Education office and Clinical Competency Committee, based on the Resident’s level of education, experience, demonstrated ability, clinical performance, and professionalism. Each resident will be expected to excel in the competency based medical curriculum.

Each Resident is expected to advance in competency as they progress in PGY level with the intern beginning at the level of a novice. The intern is not expected to exercise discretionary judgment in the first 4 – 6 months of residency. The novice intern should adhere to standard rules and begin to master the very basic part of treatment and diagnosis. This stage will require extensive supervision by attendings and upper level residents. As the intern progresses to the last six months of the intern year, he/she should be at the level of an advanced beginner. Here the intern should be able to make connections to the bigger picture by using attributes or aspects as guidelines in lieu of strict adherence to rules. The advanced beginner will look at aspects separately and treat as such. During the first six months as a PGY 2 a resident begins to exhibit competence in clinical acumen and practice. The PGY 2 Resident should be able to conduct his/her actions in the context of a long term goal instead of as a separate part of the puzzle. The Resident should be able to achieve efficiency and organization with his/her plans and execute them with limited supervision. By the end of the PGY 2 Year, beginning of PGY 3 level, the Resident should be conducting himself/herself at a proficient level, where the situations encountered are perceived as wholes, rather than parts to be tackled one at a time. The PGY 2 in the final months of his/her training should be able to treat under standard circumstances and adjust as appropriate. In the final months of the PGY 3 level, the resident should be operating at the level of an expert. Treatment of a patient should now be intuitive to the Resident with standard rules and maxims used in treatment, but more than rules, an implicit understanding of treatment.

E. APPOINTMENT AND REAPPOINTMENT

1. Appointment

Applicants to the Internal Medicine Program must meet one of the following minimum 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.

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

** Only J-1 Visas are issued.

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 will be based on performance evaluations and an assessment of the Resident’s competence and 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, a Resident must actively participate in at least two (2) weeks of the month. Credit for a rotation will only be given to those Residents who successfully pass the month. Any rotations where a resident received an overall rating below their expected performance level will need to be repeated. An intern who, in the opinion of the Program Director and Chairman or other pertinent faculty is not prepared for the responsibilities of an upper level resident, *may*, at the discretion of the Program Director, 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 Residency Program values education of our Residents above all and the policies of the Program have been developed to reflect this. Educational experiences of the program include interactions with students, residents, fellows and attending physicians, as well as other members of disciplinary teams including Nurses, Physician Assistants and administrative personnel.

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

Intensive Care Unit MHH/LBJ *	Geriatric and Palliative Care MHH/LBJ
Ambulatory MHH/LBJ	Gastroenterology Consults MHH/LBJ
General Medicine Wards MHH/LBJ/VA	Hematology Consults MHH/LBJ/MDA
Emergency Room LBJ *	Infectious Diseases Consult MHH
Coronary Care Unit MHH *	Pulmonary Consults MHH/LBJ/SLEH
Hepatology Wards MHH	Renal Consults MHH/LBJ
Oncology Consults MHH/LBJ	Rheumatology Consults MHH/LBJ
Cardiology Consults MHH/LBJ/SLEH	
Endocrinology Consults MHH	

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

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

G. SCHEDULES

1. Monthly Schedules

Each Residents schedule is formulated so that by the end of training, the Resident will have completed 36 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*) and updated as needed. Changes should be requested 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 requests for 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, a request must be made *in writing* to the scheduling chief. All changes are reviewed by the Assistant Chiefs of Service and the Program Director because of the needs for staffing of services, and the requirements of the American Board of Internal Medicine and the ACGME.

2. Vacations and Time Off

Residents are permitted the equivalent of three (3) calendar weeks of vacation each 12 month appointment term. In addition to these allotted days the Program allows each Resident 2 days administrative days (once a year) around an Ambulatory rotation weekend. These 2 days are given on a first come, first serve basis.

Resident's must coordinate vacation scheduling with the Internal Medicine Residency Program, as well as with the Assistant Chief of Service in charge of scheduling to ensure adequate coverage of services. No more than two (2) consecutive weeks of vacation may be taken without permission from the Program Director. The vacation schedule is incorporated into the yearly master schedule. Residents 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.

Residents are provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period. This is not included in reported vacation. 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 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.

The Internal Medicine Residency Program Administration supports PGY 3 Residents in their endeavors to find opportunities to interview for fellowships/job positions. This support must be balanced with the need to comply with educational requirements of the Program. During the recruitment months for fellowships, Residents will be allowed to take off time from their scheduled rotations for a maximum of 7 days total, with advanced notice to the chief residents which *must* include the dates requested and the name of the individual secured to cover the requested time off. Each Resident requesting time off for interviews is responsible for arranging coverage for the time he/she will be off. Chiefs will not be responsible for arranging coverage. The requested time off should not be contiguous with each other. Residents will be expected to use any scheduled days off to cover the time requested.

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 3 Upper Levels and 2 Interns that are on a designated Jeopardy rotation for a two week period. If a Resident has an emergency situation where he/she cannot take call, the appropriate chief will pull someone from the Ready Reserve rotation. As soon as it is known that a resident will not make it to work, the Chief Resident must be informed by paging them at 22001. No other mode of communication is acceptable other than telephone conversation (i.e., texting, emailing, and voicemails are not appropriate forms of communication). 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 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 UT Health “sick leave pool” leave. The program is responsible for tracking Residents' sick leave through the Residency Management 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

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 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 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 policy and therefore no make-up rotations are required. The ABIM allows up to 3 months leave for vacation time, parental leave, or illness in a 36 month training period. 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 UT Health 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.

9. Reporting Time-Off

Residents will be required to report time off in New Innovations as part of their Duty Hours. This includes scheduled vacations and sick time. Reporting of time off in New Innovations does not negate the obligations set forth above in section G, subsection 1-8. Chief Residents must always be notified of scheduling issues.

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 Housestaff 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 so that attendings have adequate time to effectively teach the Housestaff. Residents are provided with rapid reliable systems for communication with supervising faculty. Faculty scheduled to supervise on a rotation are required to provide residents with continuous supervision and consultation.

Over the course of the 36 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. 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 New Innovations system. 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 may 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 may 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 (Cardiac arrest, rapid response, etc.). Housestaff 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. The following are inpatient rotations:

● General Medicine Ward Team (MHH;LBJ; VA)	● Cardiology Consults or Inpatient Ward Service (MHH; LBJ)
● Coronary Care Unit (CCU MHH)	● Endocrinology Consults
● Intensive Care Unit (ICU MHH; LBJ)	● Gastroenterology Consults (MHH; LBJ)
● Renal Consults (MHH, LBJ)	● Hematology/Oncology Consults (MDA;MHH;LBJ)\
● Hepatology (MHH)	● Pulmonary Consults (MHH; LBJ)
● Emergency Room (LBJ)	● Rheumatology Consults (MHH; LBJ)

- | | |
|-------------------------------|--|
| ● Stroke Service (MHH) | ● General Medicine Consults (LBJ) |
|-------------------------------|--|

3. Outpatient Services

The following is a list of outpatient services:

- **Neurology**
- **Geriatrics**
- **Oncology at MDA**
- **Allergy and Immunology**
- **Ambulatory**
- **Continuity Clinics**

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 (Current ACLS Certification)
 - Drawing venous blood (Central Line)
 - Drawing arterial blood (Arterial Line)
 - Pap smear and endocervical culture
 - Placing a peripheral venous line
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

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 and the ACGME Milestones;
- 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 UT Health policies as set out in the GME Handbook of Operating Procedures (HOOP) (which may be found at <https://www.uth.edu/hoop/>, 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 Policies and Procedures 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 in a positive learning environment
- 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
- 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.

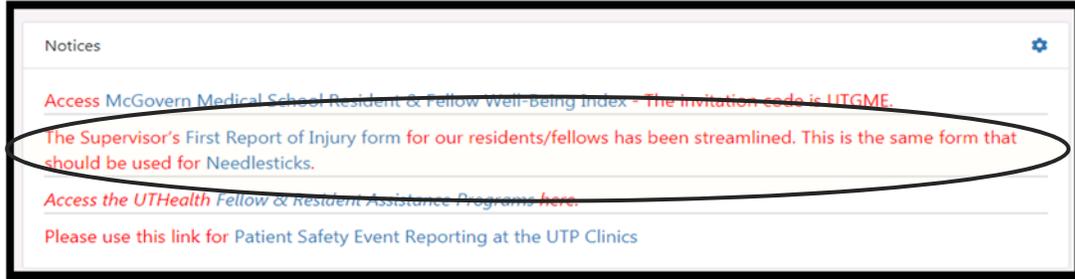
1. MEDICAL RECORDS AND CLINICAL DOCUMENTATION

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.

J. EXPOSURE TO INFECTIOUS DISEASES
Needle Stick and Other Exposures – Including Body Fluids

Directions and forms are available on New Innovations under the Notices section and at the following link: <https://med.uth.edu/oep/files/2017/02/BBP-Exposure-quick-reference-12-2016.pdf>



K. 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 4 week block, 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. After 2 weeks on the rotation, each resident shall meet with their attending physicians to review his/her progress. At the end of the 4 week block, 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, New Innovations. Before an evaluation is considered complete, it must be acknowledged or protested on-line by the resident.

Resident evaluations are available online by the end of the rotation 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.

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

The online evaluation system developed by UT Health can be found at: www.new-innov.com/uth

Evaluation of advancement of the Residents is performed by the Chairman and Program Directors, with the advice of the Clinical Competency Committee. These reports 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 will be assigned for each 4 week block and are completed by the appropriate attending. The evaluations are an analysis of the Residents performance during the month based on the milestones in each of the 6 ACGME core competencies. These evaluations are assigned 7 days after 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 for each 4 week block 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 for each 4 week block and completed by the Resident on his/her peers conduct throughout the rotation. It is completed and submitted by team members that rotated with the resident for the rotation and can be submitted confidentially. These evaluations are reviewable by the individual being evaluated however, if it is submitted anonymously, 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 for each block. Residents will evaluate their attending for the time period 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, and 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 resident's progress over the previous six month period, most especially in regards to the Policies and Procedures Manual

ACGME milestones. Career counseling is also discussed in this meeting. This meeting is documented in the ACGME system, and a copy of the meeting details are placed in the Resident's 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.

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 Coordinators.

8. In-Training Exam

The In-Training Examination by the American College of Physicians is mandatory for all residents. It is administered in August/September of every year, and all categorical residents will sit for the exam each year. You will be excused from clinical duties on that day and you will take the 9 hour exam in a full day session (with scheduled breaks).

9. MKSAP

Residents are required to complete MKSAP assignments during each ambulatory block, which must be uploaded to Blackboard or Canvas (Education Management Software). Completion of these tests is mandatory as a part of the Ambulatory Curriculum.

10. Evaluation Criteria

A number of factors are considered when assessing residents. Evaluations are based on the 6 ACGME core competencies: patient care, medical knowledge, system based practice, practice based learning and improvement, professionalism, and interpersonal and communication skills. The following tools are utilized when assessing a resident.

Patient Care

Competency	Milestone	Evaluation Tool
Gathers and synthesizes essential and accurate information to define each patient's clinical problem(s).	PC-A1-4 PC-B1-4 PC-C1	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations

<ul style="list-style-type: none"> ➤ <i>Manages patients using clinical skills of interviewing and physical examination.</i> ➤ <i>Appropriately uses laboratory and imaging techniques.</i> 		<ul style="list-style-type: none"> ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations ● CEX
<p>Develops and achieves comprehensive management plan for each patient.</p> <ul style="list-style-type: none"> ➤ <i>Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem.</i> ➤ <i>Develop prioritized differential diagnosis, evidence based diagnostic and therapeutic plan for common inpatient and ambulatory conditions.</i> ➤ <i>Modify differential diagnosis and care plan based on clinical course and data as appropriate.</i> 	PC-C1-3	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations ● CEX
<p>Manages patients with progressive responsibility and independence.</p> <ul style="list-style-type: none"> ➤ <i>Manage patients in a variety of health care settings to include the inpatient ward, critical care units, the ambulatory setting and emergency setting.</i> ➤ <i>Manage undifferentiated acutely ill and severely ill patients.</i> 	PC-F1-10	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations
<p>Skill in performing procedures.</p> <ul style="list-style-type: none"> ➤ <i>Demonstrates competence in the performance of procedures mandated by the ABIM.</i> 	PC-D1	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Continuity Clinic Evaluations ● Procedure Logs
<p>Requests and provides consultative care.</p> <ul style="list-style-type: none"> ➤ <i>Patient Care</i> <ul style="list-style-type: none"> ○ <i>Recognize when to seek additional guidance.</i> ○ <i>Manage patients as a consultant to other physicians.</i> 	PC-G1-2	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations

Medical Knowledge

Competency	Milestone	Evaluation Tool
<p>Clinical Knowledge.</p> <ul style="list-style-type: none"> ➤ <i>Core knowledge of General Internal Medicine and its subspecialties.</i> <ul style="list-style-type: none"> ○ <i>Demonstrate a level of expertise in the knowledge of those areas appropriate for an internal medicine specialist.</i> 	MK1	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations

<ul style="list-style-type: none"> ○ <i>Demonstrate sufficient sufficient knowledge to treat medical conditions commonly managed by internists, provide basic preventative care and recognize and provide initial management of emergency medical problems.</i> 		<ul style="list-style-type: none"> ● 360 Summary ● Continuity Clinic Evaluations ● CEX ● Pre and Post Tests ● ACP Grades
<p>Knowledge of diagnostic testing and procedures.</p> <ul style="list-style-type: none"> ➤ <i>Common modalities utilized in the practice of Internal Medicine.</i> <ul style="list-style-type: none"> ○ <i>Demonstrates sufficient knowledge to interpret basic clinical tests and images, use common pharmacotherapy and appropriately use and perform diagnostic and therapeutic procedures.</i> 	MK2	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations ● CEX ● Pre and Post Tests ● ACP Grades ● Procedure Logs

System Based Practice

Competency	Milestone	Evaluation Tool
<p>Works effectively within an interprofessional team (e.g. peers, consultants, nursing ancillary professionals, and other support personnel).</p> <ul style="list-style-type: none"> ➤ <i>Work in interprofessional teams to enhance patient safety and improve patient care quality.</i> 	SBP-B1-4	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations
<p>Recognizes system error and advocates for system improvement.</p> <ul style="list-style-type: none"> ➤ <i>Improving healthcare delivery.</i> <ul style="list-style-type: none"> ○ <i>Advocate for quality patient care and optimal patient care systems.</i> ○ <i>Participate in identifying system errors and implementing potential system solutions.</i> ○ <i>Recognize and function effectively in high quality care system.</i> 	SBP-C1-5	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Conference Evaluations ● QI Project
<p>Identifies forces that impact the cost of healthcare, advocates for and practices cost effective care.</p> <ul style="list-style-type: none"> ➤ <i>Cost effective care for patients and populations.</i> 	SBP-D1-4 SBP-E1-4	<ul style="list-style-type: none"> ● Journal Club ● Morning Report Evaluations

<ul style="list-style-type: none"> ○ <i>Incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care as appropriate.</i> 		<ul style="list-style-type: none"> ● Conference Evaluations
<p>Transitions patients effectively within and across health delivery systems.</p> <ul style="list-style-type: none"> ➤ <i>Work in teams and effectively transmit necessary clinical information to ensure safe and proper care of patients including the transition of care between settings.</i> 	SBP-A1-3	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations

Practice based Learning and Improvement

Competency	Milestone	Evaluation Tool
<p>Monitors practice with a goal for improvement.</p> <ul style="list-style-type: none"> ➤ <i>Identify strengths, deficiencies, and limits in one's knowledge and expertise.</i> ➤ <i>Set learning and improvement goals.</i> 	PBLI-G1	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Resident Self-Assessment
<p>Learns and improves via performance audit.</p> <ul style="list-style-type: none"> ➤ <i>Systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement.</i> 	PBLI-F4	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Resident Self-Assessment
<p>Learns and improves via feedback.</p> <ul style="list-style-type: none"> ➤ <i>Incorporate formative evaluation feedback into daily practice.</i> 	PBLI-F1	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Resident Self-Assessment

Professionalism

Competency	Milestone	Evaluation Tool
<p>Has professional and respectful interactions with patients, caregivers and members of the interprofessional team (e.g. peers, consultants, nursing, ancillary professionals and support personnel)</p> <ul style="list-style-type: none"> ➤ <i>Provide timely, constructive feedback to colleagues.</i> <ul style="list-style-type: none"> ○ <i>Communicate constructive feedback to other members of the healthcare team.</i> 	P-C1-2 P-F6 P-F7	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary

<ul style="list-style-type: none"> ○ <i>Recognize, respond to, and report impairment in colleagues or substandard care via peer review process.</i> ➤ <i>Serve as a professional role model for more junior colleagues (e.g. students, interns, etc.).</i> ➤ <i>Recognize the need to assist colleagues in the provision of duties.</i> 		
<p>Accepts responsibility and follows through on tasks.</p> <ul style="list-style-type: none"> ➤ <i>Maintain accessibility.</i> <ul style="list-style-type: none"> ○ <i>Respond promptly and appropriately to clinical responsibilities including but not limited to calls and pages.</i> ○ <i>Carryout timely interactions with colleagues, patients, and their designated caregivers.</i> ➤ <i>Demonstrate personal accountability.</i> <ul style="list-style-type: none"> ○ <i>Ensure prompt completion of clinical, administrative, and curricular tasks.</i> 	P-D1-2 P-F3	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Coordinator Evaluation ● Conference Evaluations and Attendance
<p>Responds to each patient's unique characteristics and needs</p> <ul style="list-style-type: none"> ➤ <i>Patient Centeredness</i> <ul style="list-style-type: none"> ○ <i>Respect for patient privacy and autonomy.</i> ○ <i>Sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.</i> 	P-I1-2 P-J1-2	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Patient Evaluations
<p>Exhibits integrity and ethical behavior in professional conduct.</p> <ul style="list-style-type: none"> ➤ <i>Physicianship</i> <ul style="list-style-type: none"> ○ <i>Demonstrate compassion, integrity, and respect for others.</i> ○ <i>Responsiveness to patient needs that supersedes self-interests.</i> ○ <i>Accountability to patients, society, and the profession.</i> 	P-A1-4 P-B1-4	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Coordinator Evaluation

Interpersonal and Communication Skills

Competency	Milestone	Evaluation Tool
<p>Communicates effectively with patients and caregivers.</p> <ul style="list-style-type: none"> ➤ <i>Communicate effectively with patients, family, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds.</i> 	ICS-A1-8 ICS-B1-3	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary

		<ul style="list-style-type: none"> ● Continuity Clinic Evaluations
<p>Communicates effectively in interprofessional teams (e.g. peers, consultants, nursing, ancillary professionals and other support personnel).</p> <ul style="list-style-type: none"> ➤ <i>Works effectively as a member or leader of a healthcare team or other professional group.</i> ➤ <i>Act in a consultative role to other physicians and health professionals.</i> 	ICS-C1-2 ICS-D1-3 ICS-E1-3	<ul style="list-style-type: none"> ● Monthly Resident Evaluations ● Peer Evaluations ● Student Evaluations ● 360 Summary ● Continuity Clinic Evaluations
<p>Appropriate utilization and completion of health records.</p> <ul style="list-style-type: none"> ➤ <i>Maintain comprehensive, timely, and legible medical records.</i> 	ICS-F1 ICS-F2	<ul style="list-style-type: none"> ● Monthly Resident Evaluations

11. 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.

12. Retaliation

The Program encourages Residents and Attendings to open and honestly evaluate as is appropriate in the spirit of constructive evaluation. This program does not 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.

L. 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. Licensure information may be obtained from the house staff office. Complete information about licensure can be found on the [Texas Medical Board webpage](#). Housestaff should obtain a valid Texas Medical License as soon as possible.

Requirements include:

- Completion of 12 months of Internal Medicine Internship for US or Canadian Medical School Graduates, or completion of 24 months of Internal Medicine for all others.
- Completion and Mastery of [USMLE Step 3](#)
- Completion and Mastery of [Jurisprudence Exam](#)
- Completion of [Form L](#) by the program

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

M. EDUCATIONAL MEETINGS AND CONFERENCES

The Program has taken great care in putting together a comprehensive list of didactic lectures and conferences to help you in your studies. 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 and is limited to two days. The Assistant Chiefs of Service will not pull residents from the Jeopardy Call Rotation to provide coverage for a resident's duties while they are away.

There are several Internal Medicine conferences held weekly. Attendance by Residents is mandatory and will be monitored with sign-in sheets. 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 exact same time with documentation) will result in punitive action.

Conference attendance will be tallied from the first of each block to the last day of each block. Cumulative attendance rate will be available on the 5th day of the following block. Any housestaff with less than 80% attendance rate will be subject to a call from the program director, and this violation will be documented in the resident's milestone performance assessment of professionalism.

These mandatory conferences are as follows:

1. Resident Case Conferences

These conferences include intern conference, sub-specialty conference, post-call morning reports, and morning case conference. Conferences occur at all 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 block. 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.

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 these presentations are designed to prepare Residents for practice as well as for the American Board of Internal Medicine Certifying Examination. These structured conferences along with consistent reading, attendance at other conferences and patient care help prepare Residents for the Board examination.

3. Grand Rounds

Internal Medicine Grand Rounds are held on Thursdays at 12pm in the Medical School, room 2.103. These presentations are given by members of UT Health faculty or by visiting professors, concerning important and relevant topics in Internal Medicine. This conference is simultaneously broadcast to LBJ hospital.

4. Board Review Conference

The program has set up this lecture series to include high yield board review topics and board review questions to facilitate studying and mastery of the American Board of Internal Medicine Certification Exam.

N. 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 well-fitting professional attire and to demonstrate good personal hygiene and cleanliness. Scrubs may be worn on weekends and “after hours” during on call shifts.

O. MOONLIGHTING

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

P. 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. There is no call, either inpatient or at-home, during this residency program.

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 post-float daytime assignments. Rotations 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

Clinical and educational work hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. Residents should have eight hours off between scheduled clinical work and education periods.

- (i) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. Residents may be allowed to remain on site in order to ensure that effective transitions occur and/or resident education, however this period of time must be no longer than an additional four hours. Additional patient care responsibilities must not be assigned to a resident during this time.
- (ii) In unusual circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site to continue to provide care to a single severely ill or an unstable patient; humanistic attention to the needs of a patient or family; or to attend unique educational events.
 - 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 in seven free of clinical work and required education (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.

Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. Circumstances of return-to-hospital activities with fewer than eight hours free

of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off –in-seven requirements.

Duty Hours are formally monitored through the institutional New Innovations 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 Medicine 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 23 four-week period. Continuous on-site duty, including in-house call, will not exceed 24 consecutive hours however Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care as 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 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 your job but also to ensure patient safety while you are practicing patient care. The **S.A.F.E.R program**, provided by the GME office, is a required presentation that each Housestaff 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.

5. Reporting Duty Hours

All residents must report their duty hours monthly. Residents will report duty hours by logging into New Innovations and entering the time worked. Duty hours will be considered late by the 5th day of the following month. (Example: Duty hours for July will need to be submitted no later than August 5th.) A resident will be considered to be not compliant in the program if duty hours are delinquent. Should resident become routinely delinquent the associate program director and/or program director will be notified and further disciplinary action may be pursued.

Q. GRIEVANCES

The Program Director is responsible for ensuring compliance with the grievance and due 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.

R. 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 UT Health, 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.

S. 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.

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.

T. PAGERS

Residents are issued a personal pager, for which they are financially responsible for the loss or damage of. In addition to the pager issued by the Program, Housestaff may be issued a hospital pager during rotations at MD Anderson. 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 713-704-4000.

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

U. 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 UT Health e-mail address and allowed permitted use of UT Health 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 UT Health HOOP (see, e.g., HOOP Policies 98, 132, 175-181, and 198). All use of the UT Health information technology network, including access to and use

Policies and Procedures Manual Last Update 5/24/2019 12:00 PM Page 40

of the internet and UT Health 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 UT Health 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 UT Health 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 UT Health 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 UT Health Help Desk at 713-486-4848.

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

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

V. LAB COATS

Two 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 Housestaff Office located at MSB 1.134.

W. 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 Housestaff. However, you will still need to be identified with a UT ID Badge and your vehicle will need to be identified with a decal.

The security office will maintain the decals. When a UT HEALTH Housestaff presents their ID Badge, the appropriate decal will be issued and the badge will be coded with access to

the applicable parking lots. Each UT HEALTH Housestaff will be issued a decal based upon their work classification.

X. 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.

Y. DISASTER PREPAREDNESS PLAN

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

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

Disaster Preparedness Plan:

There will be four levels of readiness + action statuses during the severe weather threat:

Green, **Yellow**, **Orange**, and **Red**

- **Green** – Normal Daily Operations – Monitoring - Be on High Alert for Updates via email and pages
- **Yellow** – Essential residents (see below) should pack and prepare to stay in the hospital for at least 5 days
- **Orange** – Essential residents should not leave the hospital unless relieved or if status de-escalates; non-essential staff leave hospital
- **Red** – Essential Residents/Ride Out Team Stays in the hospital until further notice, non-essential staff stay off roads

Essential Residents =

LBJ Wards: Pre-Short team and Pre-Off team (2) and Intern (4); Nocturnists (2) and Night Interns (2); Float Intern (1)

LBJ MICU: Long-Call resident (1) and Intern (1); Night Resident (1) and Intern (1)

MHH: Short-Call and Long-Call Day Resident (2) and Intern (2); Night Float Resident (1) and Long-call Night Intern (1)

MHH MICU: Long-Call Resident (1) and Intern (1); Night Resident (1) and Intern (1)

CCU/CIMU: CCU Long Call resident (1) and intern (1), CIMU Resident (1) and Intern (1); CCU Night Resident (1) and Night Intern (1)

In the event of a severe weather threat, there will be an excel sheet to reference for call room assignments based on coverage for each hospital.

If you feel you cannot stay due to personal or family concerns you need to find coverage for your assigned duty. Your coverage needs to be approved by the Assistant Chiefs of Service prior to your being excused.

Z. 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.

