

## Residency Policies & Procedures

### I. Introduction

These policies and procedures apply to house staff participating in the University of California Irvine School of Medicine Residency Training Program in Internal Medicine. These policies are supplemented by broader policies of the University. It is the responsibility of the individual house officer to review and to become familiar with this policy manual and its contents. "House staff" or "House officer" or "GME trainee" or "Resident" refers to individuals who have received their M.D. or D.O. degree and have been accepted into the Internal Medicine Training Program with either the goal of completing a single year of training (Preliminary Year) or of completing requirements for eligibility to take the American Board of Internal Medicine (ABIM) Certification Exam.

#### A. Mission Statement

Our training imbues the highest respect for intellectual integrity, curiosity and humanism to prepare our residents for any career path in internal medicine.

#### B. Vision

We seek to create the physician leaders and innovators of tomorrow. By providing the strongest academic and clinical training, we strive to foster enduring scholarship, physician wellness, and dedication to our patients and communities.

#### C. Values

1. Scholarship
2. Patient Care
3. Humanism
4. Personal & Professional Growth
5. Collegiality

#### D. Educational Goals and Objectives with Respect to the Competencies of Residents at Each Level of Training

1. **Level I:** Non-supervisory (PGY1 or as defined by the Program Evaluation Committee- PEC). Before the house officer can move into a supervisory role, he or she must demonstrate attainment of the competencies represented in the following objectives:

This house officer must achieve the role of **reporter and interpreter**, and demonstrate a capacity to become an excellent manager.

- A. Patient Care: The house officer must:

- i. be able to carry out all assignments agreed to in consultation with senior residents and faculty.
- ii. be able to provide clinical care in all settings in a relatively independent manner for most common internal medicine problems with only moderate supervision from senior house officers and faculty.
- iii. demonstrate appropriate awareness of his or her limitations.
- iv. demonstrate the ability to conduct competent medical interviews and physical examinations.
- v. demonstrate the ability to engage in informed discussions of clinical options for evaluation and treatment.
- vi. demonstrate the ability to identify key clinical factors and pattern groupings in the process of medical decision making.
- vii. demonstrate a willingness to consider cost and social issues in the process of medical decision making and patient care.
- viii. demonstrate the ability to perform all basic required procedures (including ACLS), to provide informed consent for those procedures and to interpret the results of those procedures.
- ix. demonstrate the ability to document patient care in an effective and competent manner

B. Medical Knowledge: The house officer must:

- i. demonstrate appropriate knowledge of basic and clinical science.
- ii. demonstrate commitment to learning and to the educational process.

C. Practice-based Learning Improvement: The house officer must:

- i. demonstrate insight into his or her own knowledge deficiencies.
- ii. be able to define the concept of practice-based learning.
- iii. be able to define methods for incorporating practice-based learning into his or her educational strategies.
- iv. demonstrate commitment to the process of practice-based learning.
- v. demonstrate command of medical knowledge management including information resources and retrieval, critical appraisal, and practice application.

- D. Interpersonal & Communication Skills: The house officer must:
- i. demonstrate knowledge of the importance of highly developed interpersonal and communication skills to the provision of competent and compassionate medical care.
  - ii. demonstrate the ability to develop effective therapeutic relationships with patients, their families, and their significant others or designated representatives for making health care decisions.
  - iii. demonstrate appropriate flexibility and the ability to understand and incorporate formative feedback.
  - iv. demonstrate incorporation of the 5E's of communication into interaction with both patients and colleagues.
  - v. understand the role of consultants and the importance of effective and personal communication.
  - vi. demonstrate the ability to communicate effectively with colleagues and other members of the health care team.
- E. Professionalism: The house officer must:
- i. demonstrate understanding of the broad definitions of professionalism, including altruism, medical ethics, and the professional role.
  - ii. act in a professional manner in relations with patients, colleagues, related health professionals and all others involved in the provision or process of care.
  - iii. demonstrate the importance of confidentiality and of patients' rights.
  - iv. demonstrate circumspection in word and deed.
  - v. demonstrate commitment to learning from mistakes, honesty, compassion, and commitment to quality.
  - vi. demonstrate the ability to recognize deficiencies in peers and provide formative feedback.
- F. Systems-based Practice : The House officer must :
- i. demonstrate an understanding of the contexts and constraints of the health care delivery system.

- ii. demonstrate the ability to apply knowledge of the health care delivery system to improve individual and community health.

G. Teaching: The house officer must :

- i. demonstrate knowledge of the importance of the teaching role of the physician.
- ii. demonstrate a willingness to engage in teaching.

H. Organizational Skills: The house officer must:

- i. demonstrate the ability to work in an effective, comprehensive and time-sensitive manner.

2. **Level II** (PGY2 through PGY3 as defined by the PEC) Level II assumes achievement of all Level I Competencies in addition to the following. This resident should achieve the roles of manager and educator.

A. Patient Care: The house officer must:

- i. demonstrate the ability to move from identifying key clinical factors and patterns to consistently making accurate and rationale differential diagnoses and plans.
- ii. be able to consistently make appropriate decisions under the supervision of faculty.
- iii. be able to teach procedures to those medical learners under his or her supervision.
- iv. demonstrate the ability to provide compassionate and competent end-of-life care or treatment of pain.
- v. demonstrate the ability to identify and address opportunities for disease prevention and health promotion.

B. Practice-based Learning Improvement: The house officer must:

- i. demonstrate commitment to enhancing the learning of colleagues and patients through practice-based learning strategies.
- ii. demonstrate skill at identifying appropriate practice-based learning opportunities and at identifying appropriate resources and questions.

C. Interpersonal and Communication Skills: The house officer must :

- i. demonstrate the ability to lead effectively and to assume responsibility.

- ii. demonstrate ability to create an environment which fosters respect for patients, colleagues, and the educational process.

D. Systems-based Practice: The house officer must:

- i. demonstrate an ability to work within and lead a health care team
- ii. demonstrate understanding and the ability to implement process improvement, FOCUS-PDCA, root cause analysis and quality measures.

E. Teaching: The house officer must :

- i. demonstrate effective clinical teaching skills with special respect to the Microskills of clinical teaching.
- ii. create a nurturing environment which emphasizes the importance of learning and is conducive to learning.

F. Organization Skills : The house officer must:

- i. demonstrate commitment to the process of team orientation and management.
- ii. demonstrate commitment to an organizational process which places appropriate emphasis on time commitments to patient care, education and personal time as well as equity in the team setting for distribution of assignments, patient care, learning and personal time.
- iii. ensure adherence to work hours regulations and the policies and procedures of the Program.

3. **Level III.** (Prepared to Practice Independently) The house officer is ready for graduation and has consistently demonstrated competence in all areas. The house officer can practice independently and has demonstrated the requisite knowledge, skills and attitudes required to perform as an independent practitioner of Internal Medicine. This house officer must be an excellent **manager**.

## II. **General House Staff Responsibilities & Licensing Requirements**

- A. **Teaching** - Each house officer shall fulfill the clinical and educational requirements of the Program. Such requirements include the teaching of medical students and other house officers. **Teaching is a crucial role of the house officer and the evaluation process shall include assessment of the house officers teaching**

**effort.** Teaching will be considered in the overall evaluation of the house officer for promotion to the next post-graduate level.

**B. Dress & Attire** - House officers shall act and dress professionally at all times. They shall comply with the professional and dress codes of the American College of Physicians and the American Medical Association. The purpose of this dress code is not to inhibit personal freedom, but to acknowledge the unique role that physicians play in patient care. Multiple studies have shown that physical appearance impacts the comfort level of the patient. The more comfortable the patient, the more likely they will provide accurate information. Characteristics deemed undesirable to wear include blue jeans, clogs, sandals and tennis shoes. Characteristics found desirable were an ID badge, white coat, dress shoes and good physical grooming.

1. House staff should wear white coats and ID's at all times when interacting with patients. The white coat should be kept clean without any stains or holes.
2. On non-call days and short call days during the week, including clinical electives the minimum dress requirement is:

**Men:**

Collared shirts  
Slacks, khakis or chinos  
Dress shoes/clogs  
Ties are optional  
No denim

**Women:**

Blouses, professional dress shirts  
Slacks, khakis or chinos  
Dress shoes/clogs  
Skirts of medium length - no minis  
No plunging necklines  
No open-toed shoes  
No denim  
Well-groomed fingernails, muted nail polish allowed

**For all the house staff:**

Please maintain good personal hygiene - this includes bathing/deodorants/regular dental hygiene  
Avoid distracting colognes or perfumes as they may prompt allergies  
Please keep hair neat and clean, trim beards or mustaches  
Keep jewelry at a minimum - a watch, up to four rings, small earrings, modest bracelet or necklace as it may be distracting to the patient  
No open toed shoes

3. Overnight shifts  
Scrubs and comfortable shoes/sneakers are ok  
Clean T shirts or polo shirts are ok instead of scrub tops

Please wear your white coat  
Please attempt to wear non call attire if post call especially on the ward teams  
Personal grooming is expected post call

4. ICU/CCU

Scrubs and comfortable shoes/sneakers are ok  
Clean T shirts or polo shirts are ok instead of scrub tops  
If leaving the ICU to other patient areas, the scrubs must be clean and be covered with a white coat  
Please change stained or soiled scrub suits as soon as possible

5. Weekends

Wearing non-call attire is optional on the weekends  
Scrubs are permitted with white coat

- C. **Professional Behavior** - Each house officer shall act in a professional manner. Professionalism includes an altruistic commitment to one's patients and to one's colleagues and co-workers. The house officer is expected to place the delivery of medical care and the support of others above personal interests. Professionalism also includes respect for one's teachers and for one's institution: timeliness; attendance; commitment to one's own education and the education of others; completion of duties and assignments; adherence to Program policies and procedures; completion of medical records; upholding confidentiality; commitment to teaching and lifelong learning; circumspection in thought and action; a civil tongue; and upholding one's oath.

Each house officer shall comply with the American College of Physicians Ethics Manual and the bylaws and regulations of the institutions to which they are assigned.

- D. **Medical License** - Each house officer shall obtain a California medical license at the earliest possible and practical time.

House officers must take the USMLE Step 3 by **April 1** of the PGY-1 year. House Officers must obtain a license by **June 1** of their PGY-2 year.

The Program will consider any house officer delinquent if they have not obtained a license by June 1 of their PGY-2 year. ***In that case, the house officer may receive administrative penalties or probation for lack of compliance with this policy.***

Under California state law, a house officer who attended medical school at an allopathic school accredited by the LCME or an osteopathic school accredited by the AOA may not engage in patient care activities if they have not obtained their medical license by the first day of their third year of training. ***Such a house officer who is not licensed by the first day of his or her third year of training by law must be placed on suspension and will not receive academic credit for the period on suspension.*** "Training"\* includes any time in any discipline under ACGME accreditation. The first day of the third year of training is two years after the first day of orientation, generally around the 22<sup>nd</sup> or 23<sup>rd</sup> of June.

House officers who are international graduates must complete 12 additional months of graduate medical education training before they become eligible for a medical license in California.

If a house officer is terminated from the Program for failure to obtain a license, reappointment after the house officer attains licensure will be contingent upon Departmental resources in addition to the usual criteria for reappointment. The Department may choose to fill the house officer's position with another house officer. This may make it impossible for the house officer to return to the Program.

\*(For example, a house officer who completes a year of training in an unrelated discipline such as surgery and then starts over as an intern in internal medicine must have a California license by the end of his or her PGY1 year in medicine because he or she would have completed 2 full years in an ACGME-accredited training program, even though one of those years was in a discipline unrelated to internal medicine.)

- E. **DEA License** - House officers must assume the fullest responsibility for the care of their patients. The ability to prescribe appropriate pain relief is central to that responsibility. In addition, house officers must understand the principles of pain control and of palliation. Therefore, house officers must obtain their **DEA license and controlled substance prescription forms** as soon as possible, and in any case, no later the first day of the third month of their PGY 3 year. Failure to do so may result in disciplinary action.
- F. **Medical Records** - Each house officer must maintain patient medical records in a competent and timely manner, in all cases complying with the time and procedural requirements of the institutions to which they are assigned. House officers on Medical Record suspension for 4 weeks or more will be proposed for probation by the ROC.
- G. **Compliance** - Each house officer must comply with the specific policies and procedures set forth in this document.

### III. **Duty Hours, Caps, Admissions, the Work Environment, and Supervision**

#### A. Application of these Policies

The UC Irvine Internal Medicine Residency Training Program fully endorses the ACGME and UC Irvine Institutional Supervision Policies. In addition, the following program supervision policy applies to internal medicine residents.

Furthermore, the Program and its institutions will not place excessive reliance on residents to meet the service needs of the participating training sites. To this end the program's policies with regard to work hours and all other educational and work environment issues will apply to all training sites.

As defined by the ACGME RRC for Internal Medicine, "PGY2 and PGY3 residents are considered to be in the final years of training" for purposes of defining supervision responsibilities.



## B. Backup Policy

Adequate back up will be available at all times for house officers with patient care responsibilities. Back up will be regularly available and will comply with work hours requirements. Back up will be called whenever patient care caps are exceeded or whenever the burden of work would endanger patients or house officers.

## C. Admissions and Admissions Cap Policy

For the purposes of the admissions cap, an admission or unit transfer is counted under the cap if the resident has physically taken responsibility for the patient. Anticipated ED admissions, transfer patients who have not yet arrived at the facility, clinic patients waiting for beds, admissions from home not yet at the hospital do **not** count towards the admissions cap until they arrive and become the responsibility of the admitting resident.

On inpatient rotations or during float:

1. A first-year resident must not be responsible for more than five new patients per admitting day. (The first 2 unit transfers to a ward team do not constitute a "new" admission.)
2. A first-year resident must not be assigned more than eight new patient admissions in a 48-hour period.
3. The second- or third-year resident must not be responsible for admitting more than a total of 10 new patients per admitting day or more than 16 new patients in a 48-hour period, which includes the first-year resident's patients being supervised, plus 2 or more ICU transfer patients.

## D. Ongoing Care

1. UCI IM residency general medicine ward teams will be capped at 15 patients with the option to flex to 20 total patients in extreme circumstances as defined by the program directors or chief residents.
2. A first-year resident must not be responsible for the ongoing care of more than 8 patients and generally not more than 6 patients.
3. When supervising one first-year resident, the second- or third-year resident must not be responsible for the ongoing care of more than 12 patients
4. When supervising more than one first-year resident, (or one first-year resident and two sub-interns) a second- or third-year resident must not be responsible for the ongoing care of more than 16 patients.
5. A first-year resident stationed in an intensive care unit must not be responsible for the ongoing care of more than 6 patients.

## E. Duty Hours, the Work Environment & Supervision

1. Residents must not be routinely required to provide intravenous, phlebotomy, or messenger/transporter services. Inpatient support services must be available on a 24-hour basis to meet reasonable and expected demands, including intravenous services, phlebotomy services, messenger/transporter services and laboratory and radiological information retrieval systems that allow prompt access to all results.
  2. Residents' service responsibilities must be limited to patients for whom the training program bears major diagnostic and therapeutic responsibility.
  3. Residents will have no direct responsibility for non-teaching patients and will provide care for non-teaching patients only in the event of an emergency during which the resident is the only or best individual available to provide care.
  4. On non-float inpatient rotations residents must have continuing responsibility for most of the patients they admit, and most patients must be cared for by the residents who admitted them.
  5. Supervision by faculty members must be provided for all patient care activities in which residents are engaged and in accordance with ACGME requirements for supervision. Supervision must be continuous and direct with reliable systems for communication.
- F. In the continuity clinic, continuity faculty will review each case on a real-time basis for residents at all levels. Faculty will generally be responsible for the supervision of 2 residents and never more than 3 residents plus one student. Faculty will not regularly care for their own patients independently when supervising 2 or more residents.
- G. On the inpatient services:
1. Senior residents (residents in the final years of training), fellows, or faculty members will be physically present at all times to supervise PGY1 residents, or as defined by the ACGME, "direct supervision (will be) immediately available in-house"
  2. Faculty members will see all patients every day and as often as needed to ensure the highest quality patient care and education.]
  3. Attendings of record or an alternative and informed faculty member will be immediately available at all times to assist in the care of patients. Attendings of record will be immediately available by phone if they are not physically present in the hospital or as defined by the ACGME, "direct supervision (will be) immediately available".
  4. The program will maintain mechanisms to ensure that faculty is available and that in the event faculty cannot be reached, chief residents are continuously available.

5. Attendings of record will not be assigned duties which would prevent their presence or attention during the time of their attending assignments.
6. In-house attendings will be provided at each institution at all times.
7. Residents will be regularly reminded of the importance of daily interactions and supervision by faculty and being continually aware of their limitations and the professional responsibility to seek help from more senior residents, fellows, or faculty members. They will be required to inform their attending of any changes in status or consents required such as:
  - i. Significant changes in patient clinical status
  - ii. Changes in code status
  - iii. Procedures requiring consent including code status, blood product administration, invasive procedures that require written consent.
8. Faculty and residents will be educated to recognize the signs of fatigue or other impairments. Reporting systems will be maintained and publicized to assure confidential support and sufficient back up.
9. Educational experiences must include interactions with attending physicians and other residents, as well as teaching rounds, conferences, evaluation, and formative feedback.
10. For each rotation or major clinical assignment, the teaching ratio will not exceed a total of 8 residents or students to one teaching attending.
11. Total required emergency medicine experience will not exceed 2 months in 3 years of training for a house officer.
12. Total required critical care experience will not exceed 6 months in 3 years of training for an individual resident. (NOTE: When elective experience is added in the critical care unit, it must not result in more than a total of 8 months in 3 years of training for any resident.)
13. When averaged over any unique rotation or assignment, duty hours must not exceed 80 hours per week. Duty hours include all activities related to the residency program including patient care, education, medical records completion, required research during the body of the residency (but not additional research years outside of the ACGME requirement or research conducted on personal time as a personal activity) and administration, but do not include reading and preparation time spent away from the duty sites.
14. Except under extraordinary circumstances, residents must not be assigned on-call in-house duty more often than every fourth night and never more often than every third night.

15. When averaged over any specific rotation or assignment of any duration, residents must have at least one day (full 24 continuous hours) out of 7 free of patient care duties. This includes being free from back up responsibilities and from responding to pages.
16. Duty periods of PGY1 residents must not exceed 16 hours in duration.
17. Duty periods of PGY2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
18. Residents are encouraged to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
19. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
20. Senior residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
21. In unusual circumstances, senior residents (not interns), on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

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.
  - iii. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.
22. PGY1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
  23. Residents in the final years of education (PGY 2-3) must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

- a. This preparation must occur within the context of the 80- hour, maximum duty period length, and one-day-off-in seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
  - b. Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.
24. Residents must not be scheduled for more than six consecutive nights of night float.
- a. The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the GMEC governing the SOM's residency programs and will be applied to SOM's residents appointed to those residencies.
25. PGY2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).
26. Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at home call is not subject to the every-third night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four week.
- a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
27. 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".
28. Adequate time for rest and personal activities will be provided between duty periods. This should generally be a minimum of ten hours off from responsibilities and no less than eight hours off in any case.
29. Emergency Medicine shifts must not exceed 12 hours per shift.
30. Emergency medicine assignments must be separated by at least 12 hours of non-patient care duties.
31. Residents taking at-home call must be provided one 24-hour period in 7 averaged over 4 weeks completely free of educational and clinical responsibilities.

32. Moonlighting must be counted toward the 80-hour limit (See the Policy on Resident Moonlighting.) All moonlighting, in house or external must be counted in the Duty Hours limits.
33. Interns (PGY1 residents) must not work longer than 16 continuous hours and must leave the hospital after 16 hours without further time for transition, completion of work or handoffs. Interns cannot take call from home although they can take back-up call from home. Interns must not provide unsupervised care, either in-house or from home.
34. Senior residents (PGY2 or PGY3) must not work longer than 24 continuous hours with 4 additional hours allowable for hand-offs and transition, but not for the admission of new patients or ongoing patient care activities. Senior residents can take at home call, but must receive one day out of seven free from call. Senior residents may return to the hospital after less than 8 hours off between duty periods. This activity must be monitored by the program director.
35. Residents must attend a minimum of 130 continuity clinics over the 36 months of training. Residents must not attend continuity clinic after 24 hours on continuous in-house duty.
36. During ambulatory assignments and in continuity clinic, when averaged over the course of a year, a first-year resident's patient load must be 3-5 patients per half-day session, a second-year residents 4-6 patients, and a third year 4 or greater.
37. The Program will abide by all work hours regulations as prescribed in the General Program Requirements of the ACGME.
38. However, it is the responsibility of the house officer to decide ultimately when further patients would impair the provision of safe and comprehensive patient care. Back up should be called at any time if patient care is affected. Furthermore, if the number of patients on any given team becomes too large for good patient care, the senior resident or attending on a team must report this to the Chief Resident who will evaluate the situation and make any necessary arrangements to stabilize the situation. The Chief Residents shall monitor this and shall be available to the house staff at all times for consultation and assistance.

#### **IV. Bouncebacks and Transitions in Care**

##### **A. UCI Bounceback Policy**

A "bounceback" is a patient who was discharged from the hospital during the same block and whose senior resident during the prior admission is currently Senior resident on the ward service when the patient is readmitted to the hospital. If the senior resident is off the day of readmission, the on call team will admit the patient and transfer the patient back on the following day.

## B. VA Bounceback Policy

A “bounceback” is a patient who returns to the hospital during the same time period that the senior resident who took care of him/her is still on a ward service at the same site. This includes the situation in which the resident is at the same site for two consecutive months, even if the resident switches teams.

1. If the senior resident of the primary team is present when a bounceback returns, the patient must be admitted by the primary team until 4pm on weekdays and until 12pm on weekends.
2. If the senior of the primary team is off for the day, the on-call team must admit the patient & count it toward their cap. The following day, the patient shall be transferred to the primary team only if the senior resident is present. This counts as a *transfer* if the receiving team is on short or long call.
3. If a bounceback patient is admitted by the backup or night float senior, care of this patient must be assumed by the primary team the following day only if the senior resident is present.
4. Bouncebacks can only be transferred to the primary team when the senior resident of that team is present.

If a patient is seen or accepted by a ward team on-call, **that patient is immediately and irreversibly assigned to that ward team**. If the patient becomes unstable and is transferred to the MICU/CCU prior to being staffed by the ward attending, the patient will return to the ward team that originally admitted him/her when s/he is ready to leave the MICU/CCU team. Bounceback status of admissions will be one criteria utilized by the admitting resident (e.g. nocturnist, ED triage, or chief resident) to decide which team accepts responsibility for the patient. The individual responsible for admissions has final responsibility for that decision and may use team caps, team size and other relevant criteria in addition to bounceback status.

Any concerns regarding this policy should be directed to the on-call chief resident at the site. The chief resident has the authority to make exceptions to this policy as s/he sees fit according to the circumstances.

## B. Hand-Offs

1. The hand-off process for changes in clinical rotations should begin the day prior to the first day of the new block. Residents need to communicate verbally about patients as well as the logistics of team function. If the resident coming on service does not hear from the resident coming off service then the former must take responsibility to contact the latter.
2. There must be an off service note written for every patient. The most crucial element of the off-service note is a description of the patient's

hospital course. Key information to include (in addition to a succinct retelling of the patient's hospitalization) would be a list of any pending lab and imaging results, disposition, and identification of any of the patient's significant others as well as the patient's Primary Care Provider.

3. Residents are expected to be able to assume full care for their assigned patients from the first day of the rotation.
4. Pagers must be handed off person-to-person.
5. At UCIMC, verbal sign-out to the UCIMC Team H resident must be given on any Internal Medicine consultations done overnight. It is preferred that this sign-out take place in person; however, in the event that the Team H resident is running late then it is acceptable to do this sign-out over the telephone. It is not acceptable to just leave a consultation on a table as the sole means of communication.
6. Handoffs from Float or bouncebacks must be verbal, preferably face-to face.

#### C. MICU Transfers

1. The MICU senior should verbally sign-out to the Ward On-Call senior about the patients who are being transferred out each day. This interaction needs to be direct, preferably face-to-face and not through email or text message.
2. The MICU senior cannot sign-out any patients to the Ward On-Call Senior that are "potential" transfers, i.e., those patients who could be transferred later in the day pending extubation or pending "improvement in clinical status." MICU seniors can only sign out patients who are ready for transfer.

#### D. Outside Patient Transfers (UCI)

1. UCI Transfer Center receives a call to transfer patient to UCI and calls the accepting Attending on-call at that time.
2. The accepting Attending notifies the accepting Resident at that time.
3. If the patient does not arrive to UCI by the end of the call shift, the accepting day time Resident needs to pass on the name of the pending admission and the history to the Night Float Resident and should include the name of her or his accepting Attending, so at least someone who knows about the patient can be contacted if needed.
4. If the Night Float Resident does not get the admission by the end of her or his shift, then she or he needs to pass the pending admission on to the new on-call day Resident and team.



5. The Attending for the new on-call team needs to contact the UCI Transfer Center to follow-up on the status of the transfer and determine if the patient's status has changed.
6. The patient is counted as an admission to the team that is accepting admissions when the patient actually arrives to UCI.
7. The resident must also create an entry in the sign-out system in the "pending" category. This entry must include all available data.

## **V. Confidentiality**

- A. House officers will respect and honor the confidentiality of all information obtained from any source, including computerized medical records, in the course of providing medical care. This confidentiality applies to the medical records and histories of patients being cared for by the house officer, patients of colleagues, and colleagues themselves.
- B. Patients should not be discussed in public areas. Even in professional activities, patient confidentiality should be maintained with identities revealed only when absolutely necessary for the care of the patient.

## **VI. Evaluation, Performance, and Discipline**

### **A. Evaluation**

1. House officers will be formally reviewed on a quarterly basis by the Clinical Competency Committee (CCC) of the Program Evaluation Committee (PEC). In its standard review process, the Committee will consider performance evaluations, letters or memos, performance on the in-training exam, conference attendance records, proceedings of the PEC, and any other pertinent data or input which may relate to all categories of evaluation. In pursuing its charge, the Committee will be guided by University policy and the policies specified by the Residency Review Committee of the Accreditation Council for Graduate Medical Education, the Special Requirements for Training in Internal Medicine, and the American Board of Internal Medicine.
2. If problems are suspected or identified in any category of evaluation during the course of the regular review process or if potential problems are brought to the Committee from a source outside the usual review process, the Committee may monitor the resident more closely than called for in the regular evaluation process. This monitoring may occur within the usual time frame and evaluation process or the Committee may pursue a more intensive review. For instance, the Committee may choose to investigate issues by soliciting comment from others (either verbally or in writing) or by arranging special tutorials, evaluations, examinations, or observations not required for other house officers about whom the usual evaluation process has not raised concern.
3. If problems are identified or are brought to the attention of the Committee, the Committee will decide upon the significance of the problems and define a course of further evaluation, remediation, probation, or censure, or even upon an action of dismissal if justified. All decisions of the Committee are subject to the

concurrence of the Chair, Department of Medicine, and ultimately the Dean, School of Medicine, as prescribed by U.C. due process.

4. Routine evaluations shall be obtained on a monthly basis and reviewed by the Competence Committee (CC). Overall performance shall be reviewed with each house officer every 6 months in a meeting with the Program Director or his or her designee. Written evaluations for each rotation shall be included in the house officer's file. In addition, the CCC may consider results of the In-Training Exam, input from patients or allied health professionals, and any other pertinent source of information in the evaluation of the house officer. The house officer's file must contain any written transmission used in evaluating the house officer. Minutes of the CCC meetings, which concern the house officer, may also be placed in the house officer's file and should represent in detail complaints or information entered into the record. Evidence of deficiency or assignment to any status less than Satisfactory should be transmitted to the house office in writing.

#### B. Promotion, Performance and Status

1. On at least a quarterly basis (and more frequently in necessary), the Clinical Competence Committee will review the status of each resident in the Program. Promotion and performance will be evaluated based upon the Program's established standards as stated in '**Educational Goals and Objectives with Respect to the Competencies of Residents at Each Level of Training**'.
2. House officers who are performing well receive a "Satisfactory" status.
3. House officers will receive letters of commendation for exemplary service.
4. House officers for whom problems are identified will be proposed for one of the following levels of status at the discretion of the Program Director after recommendation of the CCC.
5. The house officer will receive notice in writing of the proposed action. A copy of the notice of the proposed action will be sent to the Chair, Department of Medicine, the Associate Dean for Graduate Medical Education, the Director of Postgraduate Programs, and the house officer's file.
6. The house officer will have the right to appeal the proposed action as outlined in Section IV.F. The Committee will vote on a final decision at the time of its first meeting following the proposed action. At that time, a final notification letter will be sent to the house officer, the Chair, Department of Medicine, the Associate Dean for Graduate Medical Education, the Director of Postgraduate Programs, and the house officer's file.
  - a. **Counseling Letter:** A counseling letter may be issued by the Program Director to a GME Trainee to address an **academic or professional** deficiency that needs to be remedied or improved. A counseling letter must be in writing and should describe the nature of the deficiency and any necessary remedial actions required on the part of the GME Trainee. The Program Director will review the counseling letter with the GME Trainee. Failure to achieve immediate and/or sustained improvement or a repetition of the conduct may lead to other actions. A counseling letter

should not be used for minor, isolated problems that can be communicated and addressed less formally. **For the purposes of this policy and for responses to any inquiries, a counseling letter does not constitute a disciplinary action.**

- b. **Advisory Status:** minor issues exist which would probably not affect the house officer's career or ability to function as a competent internist but which may place the house officer below the expected level of performance and which can be improved. A house officer on Advisory Status may be assigned a mentor who will address the issues identified and report back to the Committee on his or her plan for remediation or on progress made. Advisory Status is an internal, residency designation and not identified in the permanent record for release to outside agencies or as a deficiency for the ABIM Resident Evaluation.
- c. **Review Status:** Significant issues exist which may affect the house officer's career or ability to function as a competent internist. A house officer on Review Status will be assigned a mentor who will address the issues identified and report back to the Committee. Review Status is an internal, residency designation, and although addressing significant issues, is not identified in the permanent record for release to outside agencies or as a deficiency for the ABIM Resident Evaluation. Review Status is not a disciplinary action.
- d. **Notice of Concern:** A notice of concern may be issued by the Program Director to a house officer who is not performing satisfactorily. Notices of concern should be in writing and should describe the nature of the deficiency and any necessary remedial actions required on the part of the house officer. The Program Director will review the notice of concern with the house officer. Failure to achieve immediate and/or sustained improvements or a repetition of the conduct may lead to additional actions.
- e. **Probation Status:** Significant and persistent issues exist which in the opinion of the Committee do affect the house officer's career or ability to function as a competent internist. These may involve knowledge base, clinical skills, professionalism, or humanistic qualities. In general, a house officer should receive a Counseling Letter before being placed on Probation. However, in certain cases where an action or deficiency clearly merits a permanent notation in the record, the house officer may be directly placed on probation or dismissed. For example, a house officer who clearly and consistently exhibits egregiously unprofessional behavior such as being absent from responsibilities for significant periods and or a house officer who in any way endangers patients may be placed immediately on Probation. **A status of Probation will be reported in response to inquiries from appropriate entities outside the university.**
- f. **Dismissal:** A house officer may be dismissed immediately from the Program for a gross and/or irremediable deficiency in knowledge base or clinical skills which would endanger patients if the house officer were to continue in the Program or if certified by graduation from the Program to

practice internal medicine. A house officer may also be dismissed from the Program for gross breaches of professionalism or humanism, especially if they endanger patients. Such an action would be recommended by the Committee to the Chair of the Department of Medicine who could then transmit that recommendation to the Dean, School of Medicine for action.

University policy states that a resident may be subject to immediate dismissal from his/her training Program during the term of appointment by the Dean, School of Medicine, for any of the following reasons:

1. Failure to rectify deficiencies of which he/she has been notified of in one or more Notice of Concern letters.
2. Performance presents a serious compromise to acceptable standards of patient care or jeopardizes patient welfare.
3. Unethical conduct
4. Illegal conduct.
5. Falsification of residency application or of any other official or medical records.

**Dismissal will be reported in response to inquiries from appropriate outside entities.**

Any house officer placed on any of the above status levels will be reviewed by the Committee at each meeting at least until such time as the status is removed.

### C. Promotion

1. Decisions on appointment to the next postgraduate level are made by the Dean, School of Medicine based upon the recommendation of the Program Director, Department of Medicine. The Competence Committee (CCC) conducts all evaluation processes and advises the Program Director. House officers, in accordance with University policy, are hired for a year at a time regardless of the total duration of their training program.
2. To graduate to the next level, house officers must at a minimum successfully complete all assigned rotations at their current level at the defined level of competency. Attending faculty will be regularly reminded of the educational goals and objectives for each rotation. Faculty will evaluate house officers on those goals and objectives to certify that the house officer meets them. In addition, the CCC will consider the input of faculty, other house officers, and medical students in evaluating the performance of the house officer. The CC members will consider any and all relevant material in deciding whether the house officer has achieved overall competence at his or her current level and should be promoted to the next level or should graduate.
3. If the CCC does not deem a house officer competent to proceed to the next level of training, the CC has three options:

The house officer may remain in the Program without advancement to the next postgraduate level for a specified period of time with criteria for advancement set forth by the CCC.

**or**

The Program may dismiss the house officer from the Residency when the house officer is judged to have irremediable deficiencies of knowledge base, clinical skills, professionalism, or humanism. This process shall proceed in accordance with applicable policies and procedures as set forth in this document and in accord with University due process.

**or**

The CCC may decide not to offer the resident a position for the upcoming academic year. (This option must be taken before the end of the 7<sup>th</sup> month of the current academic year)

4. The ultimate decision is made by the Program Director in consultation with the CCC. If the Residency Oversight Committee recommends that a house officer's appointment should not be continued at any level for the following year, written notice should be sent to the house officer at least 3 months before the end of the current year, unless serious deficiencies are discovered less than ninety days before the end of the year.

#### D. Remediation

Regardless of the house officer's current status, the Committee may require a course of remediation for a deficiency. The Committee may also appoint a mentor to supervise the remediation process. The mentor shall report to the Committee on the progress of the remediation.

#### E. Rights and Process of Appeal

1. House officers proposed for any status or for dismissal from the Program have the right to appeal that status to the Competence Committee. To appeal to the CCC, the house officer must write a letter to the Program Director stating his or her reasons for appealing the action and requesting time to appear before the Committee. The house officer has **10 days** from date of the official notice of the proposed action to respond in writing with his or her appeal. The house officer will then be scheduled to appear before the next meeting of the Committee to make a statement to the Committee. The Chair of the Committee will decide upon the length of time allotted to the house officer for a statement.

2. Further actions will be in accord with UCI Graduate Medical Education Due Process and Leave Guidelines.

#### F. Protocol for Writing and Distribution of Status and Action Letter

1. The CCC will discuss the house officer and agree upon a proposed action.
2. The CCC will specify at the time of the meeting:
  - a. The status level proposed for the house officer
  - b. The specific nature of the concern with as much detail as possible
  - c. The nature of the proposed remediation or requirements
3. Based upon the specific discussion at the CCC, the Residency Coordinator will prepare the standard letter and attachments for a PROPOSED ACTION.
4. The letter will be reviewed and signed by the Program Director and sent to:
  - a. The house officer's home address by ***certified mail***
  - b. The house officer's mailbox marked "confidential"
  - c. The house officer's file
  - d. The Director of Postgraduate Programs
  - e. The Chair, Department of Medicine
5. The house officer will have 10 days from receipt of the letter to contact the Program Coordinator in writing if he or she wishes to appeal the proposed action.
6. At the next CCC meeting (or at a special meeting which the Program Director may call if the house officer is suspended or dismissed), the CCC will discuss the proposed action again, review any written material submitted by the house officer, listen to testimony from the house officer, or others he/she may call and decide upon a final, formal action.
7. The Program Coordinator will prepare the standard letter for a FINAL ACTION, based upon the discussion at the CCC Meeting.
8. The Program Director will review and sign the letter.
9. The letter will be sent to the same distribution and with the same process as noted in VI.F.4 above.

## VII. Impaired Physicians

- A. An impairment is a substance abuse or psychiatric problem or a breach of professional conduct of such severity that it could conceivably and imminently endanger patient care.
- B. When a serious concern for physician impairment arises, the Program Director or his/her designee may suspend a resident for a period of not more than 10 days. During that time, the full CCC will meet to discuss the resident and to decide whether any further action is warranted. A 10-day suspension does not require action by the Chair or the Dean.
- C. The Program Director may require that the resident undergo a psychiatric evaluation for the use of the Program and the CCC. The evaluation will focus on impairment and will be performed on behalf of the Program. The resident will sign a release which authorizes release of a report to the Program and the results will be available to the CCC.
- D. In accordance with University policy, the suspension may be extended by the Chair for a period of not more than 60 days. A prolonged suspension is called for when a serious problem arises which may be correctable. The Program may require that a resident seek and pay for professional assistance for substance abuse or psychiatric disability. If it becomes evident that the problem is not correctable, or if it is clear that a problem is not remediable within a reasonable period of time, any and all remedies listed under Section V may be recommended by the CC and taken by the Chair and Dean.
- E. In addition, an "Intervention" may be called. An Intervention leads to the convening of a formal meeting of the Physician Advisory Committee of UCIMC, which will include members of the Medical Licensing Board of California.

## **VIII. Board Eligibility: Certification for Eligibility for the American Board of Internal Medicine**

### **A. Overall Competence**

The Program must certify that a candidate attained competence in patient care, medical knowledge, practice-based learning, communication skills, professionalism, and systems-based practice. An evaluation is sent to the American Board of Internal Medicine at the end of each year of training and at the end of the final year of training. A candidate must receive at least satisfactory ratings in all categories to be eligible to take the Board Exam. The candidate must have three years of training in an accredited Program after receiving the M.D. or D.O. degree. The following must apply:

1. The Director of the accredited internal medicine Program must have had responsibility for the educational process during all of the thirty-six months of training. The Program Director may assign up to six months of training in specialties other than internal medicine.

2. The thirty-six months of training must have included a minimum of twenty-four months of meaningful patient contact, twenty of which must have been on internal medicine inpatient or outpatient services, dermatology, or neurology. Residents must successfully complete all thirty-six months (three of these months are leave/vacation). Failure to do so may result in delay of certification or even dismissal.

#### B. Procedural Competence

The Board requires certification in all areas of evaluation and competencies including basic procedural skills. If a house officer has a disability which prevents him or her from attaining adequate procedural skill certification, the Program Director may ask the Board to waive the requirement for procedural skills certification. This must be done in written correspondence to the Board at least five months before the Board Exam. Without this waiver, a house officer who cannot perform procedures will not be able to become certified. With it, the house officer can obtain full certification.

1. If the Program asks for and receives a waiver of certification in procedural skills, this will be noted in correspondence to outside entities requesting information about certification or verification.

### IX. **Records of Employment and Performance**

- A. All house officers' educational and employment records must remain absolutely confidential. They may be utilized only for official Departmental or University business. Only one official file shall exist and all files shall be maintained in a single location.
- B. House officers must have access to their files, but only under supervision. They should review their files on a regular basis.
- C. Files will contain all the elements utilized in the evaluation process, including relevant portions of the deliberations of the Program Evaluation Committee.
- D. Only Notice of Concern, Probation, Dismissal, or a waived certification in procedural skills in a house officer's record will be reported to outside agencies or institutions as a recognized deficiency or disciplinary action.

### X. **Continuity: House Officer Responsibility to Patients, Continuity, and Clinic**

- A. Continuity of care is central to the physician-patient relationship and to quality medical care. With its frequent changes of location and responsibility, the residency training environment is not conducive to continuity. Therefore, each house officer is expected to make continuity of patient care a constant and paramount priority.
- B. Continuity clinics are a paramount priority of the internal medicine residency training program. House officers shall approach clinics with the same timeliness and respect



they would other service areas. House officers cannot cancel their clinics. Clinics may only be cancelled after approval through the process for cancellation of clinics (see section XVIII). Changes in coverage or cross coverage must be approved by the Chief Residents and the faculty responsible for the clinic. It is the responsibility of the house officer to request accommodation from all necessary parties. Accommodation is not automatic and may be denied if, in the opinion of the faculty member or the chief resident, it would significantly affect patient care.

- C. When seeing the patient of another house officer, physicians will ensure that the patient returns to their primary care physician, and that the house officer sends appropriate communication to the primary care physician.
- D. House officers will ensure that their patients know their physician's name and know how to access them for care in the continuity clinics.
- E. Whenever possible, house officers shall follow their continuity clinic patients when they are admitted to the hospital. Responsibility for inpatient care remains with the inpatient team. However, the patient's primary care physician house officer shall participate in the inpatient care of their continuity patients to the extent possible.
- F. All residents shall endeavor to ensure that primary care physicians are notified of their patients' admissions and that patients are discharged back to the care of their primary care physician.
- G. Primary Care physicians shall visit their patients and serve as an information resource.
- H. Copies of discharge summaries should be sent to the primary physician.
- I. When seeing outpatients, all house officers will either return patients to their primary care physician or assume care of the patient themselves. Patients must not be shuffled from physician to physician. It is the house officer's responsibility to ensure continuity.
- J. Continuity clinic days will be established for an entire year. House officers should arrive by 8AM for morning clinics and 1:00PM for afternoon clinics. Adjustments for specific rotations will be made at the beginning of the year by the chief residents. Any further requests for changes must be presented in writing at least **90 days** prior to the first clinic date affected by the change. House officers will not switch or trade clinic days without prior approval of chief residents and clinic directors.
- K. If a house officer is on a local externship and living in his or her usual residence, that house officer will attend their usual continuity clinic.

## XI. Code Blue Response and Code Blue Pagers

- A. Code Beepers are provided to specific on-call House Officers for emergency response to code blue on the UCIMC Campus. Response of the House Officer *carrying the Code Blue Pager* takes precedence over all other duties unless the House Officer is involved in similar, ongoing, and emergency care of another patient.
- B. The House Officer carrying the Code Blue Pager is responsible to respond to the Code Blue Page.
- C. The House Officer's responsibility to respond to code blue ends only at the end of their shift **and only after they have physically passed the Code Blue Pager to the appropriate House Officer coming on duty.** If the House Officer coming on duty is late or not available, the House Officer carrying the Code Blue Pager must continue on duty until the Code Blue Pager can be passed to an individual competent to respond to a Code Blue. In no case should the Pager be left with a student, nurse, or any personnel other than another physician competent to conduct a code and certified in ACLS. **An R2 or R3 may not pass the Code Blue Pager to an R1.** Failure to fulfill this responsibility may lead to any of the full range of disciplinary actions including Probation or Dismissal.
- D. Loss of the Code Blue Pager or the fact that the Code Blue Pager is not available must be immediately reported to the Chief Resident of the Medicine Service.
- E. Any House Officer whose responsibility it is to carry the Code Blue Pager and who should reasonably know that it is his/her responsibility to carry the Code Blue Pager and who does not report the pager missing and does not make alternative arrangements to be notified of a Code Blue will be subject to the range of disciplinary actions including Probation or Dismissal.
- F. If a Code Blue Pager is lost, payment for it becomes the responsibility of the House Officer who lost the pager. If that cannot be determined, any House Officer who should have been responsible for the pager after the time it became lost until the time it was reported lost will share equally in the cost of replacement of the pager.

## XII. Committees: Program Evaluation Committee (PEC): Structure, Function, Responsibilities

- A. Charge to the Committee – The Program Evaluation Committee (PEC) shall be charged with advising the Program Director on questions of policy and oversight for the Internal Medicine Residency Program. The Committee shall deliberate all issues having to do with the Residency Program including but not limited to:
  - 1. Evaluation of house officer's performance (the Competence Committee or CCC)
  - 2. Commendation, mentoring, remediation, and censure of residents

3. Establishment of policies regarding the general and specific operation of the residency
4. Review and certification of the activities of the Curriculum Committee
5. Evaluation of faculty with recommendation to the Chair for commendation, censure, and remediation
6. Selection of Chief Residents
7. Establishment of the priorities and goals of the Program
8. Ensuring compliance with the Special Requirements of the Residency Review Committee for Internal Medicine of the ACGME
9. Review, evaluation and implementation of the curriculum

#### B. Composition of the Committee

1. The Permanent Committee Members shall consist of the following individuals:
  - a. The Program Director
  - b. All Associate and Assistant Program Directors
  - c. Current Chief Residents and Appointed Chief Residents during the last 3 months of their residency
  - d. The Chair, Department of Medicine
  - e. The Chief, Department of Medicine, Long Beach VA Medical Center
  - f. The Residency Program Coordinators from the major training sites
  - g. Resident representatives from each class and one from the Preliminary intern group.
  - h. House officer members (other than incoming chief residents in the last 3 months of their residency) will not participate in the deliberations of the competency committee of the PEC
  - i. Ad Hoc Members

- j. From time to time, the Committee may find it necessary to expand its membership to include others for special circumstances.

### C. Meetings

1. The Committee will meet at least monthly on a schedule and at sites to be established by the Committee. The Program Director will chair the Committee and set the agenda. Special meetings of the Committee may be called to consider urgent topics or urgent problems with house staff.
2. The house staff coordinator shall compile the agenda and distribute it.
3. House staff and faculty not on the Committee may appear before the Committee if they wish to discuss a specific topic relevant to the function of the Committee or the Program. They may request an agenda item by contacting the Program Director. The Director may then direct the house staff coordinator to add the item to the agenda if it is appropriate for consideration by the Committee.

### **XIII. Advanced Cardiac Life Support Certification**

- A. All house officers must be ACLS certified at the time they enter the Program and during their entire time in the Program. Evidence of continued certification must be presented to the Program Directors at the time of each six-month review.
- B. Failure to maintain certification may result in the house officer's exclusion from clinical duties until re-certified.

### **XIV. Medical Records and Documentation**

- A. Completion of medical records in a timely and competent manner is a professional expectation of physicians. Inadequately completed or uncompleted medical records may endanger patients. Therefore, it is essential that house officers complete their medical records and not accrue medical record delinquencies or suspensions.
  1. PGY1 house officers on an inpatient service must, within 12 hours, write or type or dictate (for death summaries, depending on the site)
    - a. a comprehensive admission note including assessment and plan for each new admission to their inpatient service.
    - b. a transfer note for each patient transferred off their service.

- c. a transfer acceptance note for each patient transferred to their service.
  - d. an off service note for each patient at the end of the house officer's block of service.
  - e. an on-service note at the beginning of each block of service.
  - f. a death summary for each patient who dies under their care on the inpatient service.
2. PGY 2 or 3 house officers on an inpatient service must, within 12 hours, write, type, or dictate (for discharge summaries, depending on the site)
- a. a dictated or EMR-typed medical resident admission note for each new admission to their service. The note must include pertinent history, physical, and data with special attention to the assessment and plan. Senior admitting residents will, within 12 hours, an Admissions H&P (UCIMC) on each patient they admit. It is the responsibility of the UCIMC admitting senior ward team resident (not the float resident) to dictate admitting notes on all patients on their service. The float resident will complete the hand-written admission notes and place them in the chart for all the patients they admit. The dictated note is in addition to the float note.
  - b. a single paragraph summarizing any patient transferred to their service from another service or from the ICU.
  - c. a single paragraph summarizing any patient transferred from a to their service by the overnight float.
  - d. a discharge summary for each patient discharged from their care.
- B. The program will track the number of times a resident is cited for medical records delinquencies at any and all training sites. If the resident demonstrates a pattern of delinquencies, letters of recommendation or verification may note that as a professionalism issue. A pattern of delinquent dictations will lead to proposal for Review Status. Delinquent dictations can lead to the hospital suspending the resident. Any house officer placed on suspension as a result of an action taken by the medical records department of any Program affiliated hospital shall be immediately proposed for Probation, and a permanent notation may be placed in his or her file if that status is confirmed. The Program Director may delay Probation Status in the event of clearly extenuating circumstances. House officers shall be notified in writing of these actions and copies of these letters shall be placed in their

files.

1. Dictations and EMR Notes

a. Wards

- i. Interns are to dictate or enter into the EMR *death summaries*.
- ii. Interns are to write or enter *daily notes* on their patients.
- iii. Seniors (including float residents) are to dictate or enter into the EMR *H&Ps for all patients admitted to their service while they are on service and all discharge summaries* discharged from their service.

b. MICU/CCU

- i. Interns are to dictate *death summaries*.
- ii. Seniors are to dictate *discharge summaries*.

c. Other services

- i. Depending on the nature of the rotation, residents may be asked to dictate the following (not a comprehensive list):
  1. Inpatient consultations
  2. Outpatient consultations (including pre-operative evaluations)
  3. Outpatient progress notes

2. Documentation on Notes (UC Irvine Medical Center)

- a. House officers must **PRINT AND SIGN** their names and add the **DATE, TIME, and PAGER** to any and all documentation placed into the chart.
- b. Senior Residents must update the attending assignments for each patient.
- c. A progress note from the primary team is required for all patients every day, except for a patient who was admitted after midnight that

same day. On post-call days, the attending note may serve as the daily note for the entire team.

- d. Medication Reconciliation
- e. Greater than 90% compliance for medication reconciliation must be demonstrated. In order for a chart to be deemed “fully compliant” with least in regards to medication reconciliations, all mandatory fields need to be completed.
- f. The processes are different at UCI and at the VA, but the need for compliance is the same. This is a patient safety issue.

## **XV. In-Training Exam**

- A. The In-Training Exam in Internal Medicine is offered each year in October. House officers in the categorical track are required to take the In-Training Exam each year of their residency unless they are on their vacation month and are out of the area. Any house officer in Southern California must take the exam. Preliminary interns may take the exam if they desire.
- B. The American College of Physicians and National Board of Medical Examiners' recommend guidelines for the use of the results of the Internal Medicine In-Training Exam. The Residency Program policy regarding the exam follows these guidelines:
  - 1. The exam is to be used primarily by the individual trainee to assess his or her progress in acquiring an adequate knowledge base.
  - 2. The exam is not to be used for certification for graduation from the Program and should not in and of itself result in any disciplinary action or probation.
  - 3. Any use of the results of the exam should be in the context of the house officer's overall performance in the Program.
  - 4. The program must not release any ITE results to fellowship programs or employers.
- C. Despite the above *provisos*, the UCI Internal Medicine Residency Program does seriously review and consider the exam results. No single result will be taken out of context. However, poor performance on the exam, especially in the context of consistently poor performance on consecutive exams or on clinical services, will play a role in the overall assessment of individual residents.
- D. Residents who perform poorly will be assigned a faculty mentor to review knowledge base and study habits. In addition, results will be considered when residents submit requests for permission to moonlight. Residents who perform below the twenty-fifth percentile based upon the national sample on the exam taken in the second year of residency, will not be authorized to moonlight. The PEC may subsequently authorize

this privilege when the resident has shown significant commitment to study and improvement in knowledge base.

## **XVI. Moonlighting**

- A. The Department of Medicine does not allow house officers to moonlight at medical or other occupations outside of their responsibilities to the Program. In doing so, the Department seeks to preserve the educational process by protecting non-service time for reading, study, reflection, and personally fulfilling activities. In addition, the Department has a responsibility to ensure to the extent possible that house officers responsible for the care of patients at our hospitals and clinics are not unduly fatigued by outside work, thereby endangering their patients' welfare.
- B. Exceptions to this policy will be made on a case-by-case basis, but in all cases must meet the following conditions:
  - 1. The resident has successfully entered the PGY3 level.
  - 2. The moonlighting occurs in a Department of Medicine-sanctioned setting.
  - 3. The total number of hours worked in the Program and at the moonlighting does not exceed 80 hours per week and does not violate the work hours regulations of the ACGME.
  - 4. The Program Evaluation Committee (PEC) is aware of the nature and extent of the work and has reviewed its appropriateness.
  - 5. The house officer is not on probation or review status, has a satisfactory record of conference attendance (at least 60% averaged over the entire residency), has scored above the 30th percentile of the national sample on the In-Training Exam taken in the PGY2 year, and the resident has a strong record of professional conduct, including medical records completion, good attendance, lack of extraordinary sick days or absence from duty.
  - 6. The house officer must consistently report all moonlighting activity on an ongoing basis by submitting a Moonlighting Activities Report Form at the end of each block. This form must accurately and consistently reflect the hours worked and the sites of moonlighting for that entire block. Failure to submit the form or misrepresentation of work hours or sites may result in loss of moonlighting privileges and possibly other disciplinary actions.
- C. It is the responsibility of the resident to inform the Department of his or her intention to moonlight and to ensure that the 80 hour work week rule and other work hours regulations are adhered to.
- D. Permission may be requested by completing the Moonlighting Policy Acknowledgment / Application Form from the Residency Office and submitting it to the Chief Resident. The Program Director will review requests. The house officer may not begin to moonlight until after receiving written consent from the Program. Consent can be removed at any time if the house officer fails to maintain the standards set above in point five (5).



- E. Violations of this policy will be dealt with in the Program Evaluation Committee. Any house officer discovered to be moonlighting without permission or to be moonlighting more than the approved number of hours or at an unapproved site may be subject to disciplinary action up to and including probation and dismissal. House officers approved for moonlighting must file a Moonlighting Activity Tracking Form.
- F. The University and School of Medicine malpractice insurance does not cover moonlighting activities.

## **XVII. Schedule Changes**

Rotation Schedule changes for academic reasons will be considered only in the four (4) month period following issuance of the yearly schedules and never later than the first day of the second block, whichever is earlier. Requests must be submitted in writing and should include the reason for the request and its effect upon the house officer's educational experience. This policy includes changes in elective choices or changes of any nature in rotations.

## **XVIII. Continuity Clinic Cancellation**

Schedule changes which involve clinic cancellation for any reason (including presentation at meetings or any other academic activity) will only be considered if submitted in writing on the Clinic Cancellation Form (available on the website under "Forms"). The Form must be submitted to the Program Director **60 days prior** to the beginning of the first day of the first rotation affected by the change. The resident must find a colleague to see all scheduled patients in his or her continuity clinic and obtain the signature of that colleague and the director of the clinic affected by the change. (Patients will not be cancelled or moved.) The resident must also obtain the signature of the chief residents of the affected institution or institutions affected by the cancellation and the signature of the Program Coordinator specifying how many prior cancellations have occurred. Changes are not approved and schedule changes cannot be made until approved by the Program Director. These requests will be considered on an individual basis, taking into account the merit of the request and its effect on the program.

## **XIX. Order Writing Policy**

- A. Order writing protocols will adhere to the policy and procedures of the hospital or clinical site at which the house officer is working. This policy applies to written and computer entered orders. Lines of responsibility will be reflected in the rotation curricula. House officers will bear first responsibility for all patients. PGY1 residents will report to senior residents. Attendings are ultimately responsible for the care of all patients. Except in immediate emergencies such as code blue, house officers will not bear responsibility for patients on nonteaching services. At UCIMC, Long Beach Memorial Medical Center and the LBVAMC, all internal medicine patients will be teaching patients.
- B. In general, order writing is the responsibility of the PGY1 house officer who is responsible for the care of the patient. The exception to this would be outpatients who are under the primary care of a physician at another level. Except on hospitalist or oncology services, all inpatients will be under the direct care of a PGY1 house officer who is supervised by an attending. The attending is ultimately responsible for

all orders which are written.

- C. Orders may be written or entered by medical students, but they must be immediately co-signed by a physician who shares responsibility for the patient for whom the orders were written or entered. Orders written by a medical student will not be honored if they are not co-signed.
- D. ***House officers who coerce or otherwise encourage medical students to write or enter orders in violation of this policy or who coerce or encourage students to forge (actual or electronic) signatures on orders are subject to disciplinary action up to and including dismissal at the discretion of the PEC and Program Director.***
- E. Attendings and house officers at levels higher than PGY1 may write orders if necessary for responsible patient care and if the PGY1 is not available. In all cases, however, the PGY1 should be notified of the order.
- F. Voice orders for inpatients may be given in accordance with the policies of the institution. Voice orders must be signed within 24 hours.
- G. All orders written or entered in the outpatient setting by an unlicensed physician must be co-signed by an attending or a supervising house officer.
- H. Do not resuscitate orders must be written according to hospital protocols.

## **XX. Conference Attendance**

### **A. Department of Medicine Residency Program Key Conference Attendance Policy**

The Program requires house officers to attend 100% of all key conferences. Minimum satisfactory conference attendance is 60%. Conference attendance is defined as being present for the majority of any conference. Exceptions during which attendance is not required are vacation blocks; off-site rotations such as Community Based Teaching rotations or ED rotations; and night float rotations. Failure to attend 60% of conferences during any rolling 3-month period may result in any and all sanctions including proposal for and placement on a status of "Probation." The chief residents may waive attendance for a specific resident at any given conference if the house officer provides a reasonable and convincing excuse for his or her absence.

Any house officer who recruits another house officer to falsely document his or her attendance or who engages in false documentation will be immediately proposed for probation. Conference attendance and participation are considered vital to the overall educational experience of the Program.

Conference attendance records will be considered in the overall evaluation of the house officer, in dictating the terms and conditions of remediation or probation, and in evaluating the house officer for moonlighting privileges.

Punctuality is a component of professionalism and demonstrates respect for faculty, peers, patients, and the educational process. House officers who are consistently late for rounds or conference may be subject to disciplinary action. House officers

late without justification for morning report or rounds more than once in any month may be subject to disciplinary action up to and including probation.

## **XXI. Externships, Travel, International Rotations, Reimbursement for Travel**

- A. A small number of residents each year request permission to do rotations at facilities not associated with the Program. We are anxious to approve these requests providing they serve an appropriate educational priority. These rotations may provide meaningful training experiences. However, the program has obvious obligations to our hospitals, namely to cover the medical services adequately, and to each house officer, namely to make sure that each month of education is a meaningful one. For these reasons and to avoid some logistical roadblocks, there are a number of prerequisites for externships:
1. The house officer is responsible for all aspects of the arrangement. He or she should find a location, contact that institution or site and set up the rotation. The house officer must provide the name of a physician who will be responsible for proctoring you during the rotational experience and who will be responsible for evaluating performance at the end of your rotation.
  2. The rotation must add something to the education that the Residency Oversight Committee recognizes as unique, an experience not otherwise available during the regular residency training. Working on a Native American Reservation or a unique research opportunity might be such experiences.
  3. A request for an externship must be submitted no later than April 1<sup>st</sup> prior to the beginning of the academic year in which you wish to travel. For example, by April 1 of the second year if the house officer wishes to do the rotation in the third year.
  4. The house officer must spend a full block at this rotation.
  5. The Program may not be able to honor all requests. Requests will be considered on the merit of the rotation and record of the house officer.
  6. If the house officer is on a local externship and living at his or her usual residence, that house officer must attend his or her usual continuity clinic.

## **B. Externships, Travel, International Rotations, Reimbursement for Travel**

### **1. US & International Externships**

- i. Categorical Interns will not be allowed to do externships.
- ii. Preliminary program interns will be allowed one externship within the US but only under extraordinary circumstances and only with the approval of the Preliminary Program Director. Senior residents are eligible for one international rotation or externship. Senior Resident requests for additional externships will be considered on a case-by-case basis and must be presented to the Program Director. These

requests must have a substantial educational rationale.

- iii. All residents interested in a US or International Externship must obtain prior permission by completing all the appropriate application forms and agreements at least 3 months prior to their externship. These can be obtained from the Residency Program Coordinator. All residents who travel out of state or out of the US must also register their travel through the University of California. Instructions for doing so will be provided at the time the externship is approved

## **2. Reimbursement for Travel Expense**

The Department of Medicine will reimburse senior residents for travel if their travel meets either of the sets of criteria noted in this policy. The maximum reimbursement is set by the Department on a yearly basis and applies cumulatively over three years for any and all activities related to travel that meets either of these sets of criteria. Once that limit is reached for any activity, the department cannot provide additional resources. These resources cannot be transferred between residents or reserved to residents who are not directly participating in the rotation or presentation.

## **3. Travel to present research.**

Up to the current maximum amount, the DOM will reimburse residents for travel to present their own original research. This may include any type of invited presentation, including case reports. Expenses can include reimbursement for transportation, meals, materials for the presentation, and registration fees. Residents must submit receipts to the Residency Program after attending and returning from the event. Receipts must be itemized with details about meals or materials purchased. Meal reimbursement will be only for the resident making the presentation, not for others traveling with that resident. Upon their return, residents will be required to present their research to a meeting of the residency as arranged by the chief resident.

## **XXII. Research Electives**

- A. The UCI Internal Medicine Residency Program wishes to promote its house officer's intellectual pursuit and research endeavors. House officers are encouraged to participate in the design and completion of research projects. However, research conducted for credit must meet the criteria of the Program.

This policy sets forth those criteria.

- B. Approved research electives will provide elective credit towards residency graduation requirements. The house officer will receive a maximum of 4 blocks over 3 years of credit towards graduation. To arrange electives, house officers should contact faculty directly or refer to the manual of research opportunities or the Program's website under research. House officers must receive Program Director approval prior to beginning the elective. Credit will not be given if prior approval is

not obtained.

- C. House officers will receive this policy and the research application packet at the time they receive the scheduling materials for the second and third years of the program. They must identify their intention to do research, the topic of their research and their faculty mentor at the time they submit their schedule requests. They must submit a completed packet 4 weeks prior to beginning their research. In the event that a complete packet is not submitted, the house officer will be assigned to other duties.
- D. House officers are responsible to identify a project, recruit a faculty advisor, and submit the appropriate documentation. Participation in the elective requires a minimum of 40 hours per week performing responsibilities of the elective during the elective period.
- E. Review of the literature without original research work or case reports/series are not acceptable for elective credit. In some cases, systematic reviews with critical analysis and an intention to publish the work may be considered appropriate.
- F. The application must contain a paragraph addressing each of the following:
  - 1. Introduction and explanation of the background for the research.
  - 2. Degree of participation by the house officer in the design of the study, and a notation as to whether this is a new or ongoing project.
  - 3. Background, experience, and degree of participation of the faculty sponsor.
  - 4. Research hypothesis.
  - 5. Specific methods.
  - 6. Daily schedule of activity during the elective period.
  - 7. Specific statement indicating what the house officer expects to produce from the study.
- G. The application packet must include a signed statement (as follows) from the faculty sponsor :

***I have reviewed the research elective request. I agree with the information provided, in particular with respect to the nature and degree of the participation of the house officer in this study. I understand that literature reviews and case reports are not appropriate as the sole activity of this elective research experience. Participation must go beyond simple data collection to serious intellectual pursuit. I believe that this elective will provide the house officer with meaningful research experience.***
- H. To receive credit for the rotation, at the conclusion of the elective period, the house officer must submit a 1 to 2 page document describing the house officers actual participation and productivity as well as the outcome of the work. This statement must be submitted to the PEC for final credit approval. In addition, the house officer, must present his or her work to a meeting or seminar of the Residency Program.

### **XXIII. Leave and Family Leave**

- A. Vacation Leave

1. Leave with compensation shall be scheduled by mutual agreement with the Chief Resident, Departmental Chairperson, or Program Director
2. Resident will receive 4 weeks of vacation per year.
3. To the extent possible, vacations will be granted in accordance with housestaff requests. When applying for vacation time, house officers shall specify at least three sets of dates in order of preference. The Department will endeavor not to assign unrequested vacation dates.
4. Changes in posted vacation schedules must be requested by members of the housestaff, in writing, not less than eight weeks prior to the desired change. Such changes are subject to the staffing requirements of the Department and the approval of the Program Director and the Chief Resident.
5. Changes in the vacation schedule may be initiated when required by Department activities. The Program Director will endeavor to give advance notice of any change.
6. Vacation must be taken within the year of appointment with discretionary allowance for carry over by each Department.
7. In the event a house officer leaves before the end of the year, vacation time shall be pro-rated at one week per quarter. Time owed can be taken as terminal pay or vacation. Time that has been taken will not be required to be paid back.

#### B. Sick Leave

1. As professionals, house officers are expected not to abuse privileges. They are expected to take advantage of sick leave only for true medical illness, which would reasonably prevent them from performing their duties, impair their health, or endanger their patients. Sick leave utilized by one house officer affects others. Excessive sick leave affects other house officers excessively. It also adversely impacts program morale and patient care.
2. **Each house officer will have 8 days of paid sick leave per year.**
  - i. Each house officer shall immediately notify the Chief Resident and appropriate individuals, including fellow residents, attendings, and clinic managers of any illness requiring leave. House officers must ensure that their responsibilities are covered.
  - ii. The Chief Resident will notify the Residency Coordinator for purposes of record keeping.
  - iii. House officers may be required to provide physician records to document illness lasting three consecutive days or an unusual absence pattern.
  - iv. Sick leave for legitimate illness will not be grounds for penalty or reproof. However, abuse of the sick leave policy will be considered

highly unprofessional.

- v. Sick leave will be made up in some manner to compensate the program and other house officers for educational time lost and for coverage. Make up time may also be required to meet educational objectives.
- vi. Not more than five days of accrued sick leave may be used when a house officer is required to be in attendance or provide care because of illness in the family or if a house officer's attendance is required due to the death of a relative.

#### C. Bereavement

1. A house officer shall be permitted to use not more than 5 days of sick leave when that house officer's absence is required due to the death of a parent/grandparent, spouse, child/grandchild, or sibling. In addition, a house officer shall be permitted to use not more than 5 days of sick leave in any calendar year for bereavement or funeral attendance due to the death of any other person. The house officer shall provide prior notice to the Program Director as to the need for and likely length of any such absence.
2. NOTE: If a house officer has been issued advance vacation or sick leave (borrowed from the upcoming year) and separates from the Program prior to the beginning of the new year, all advanced time shall be reimbursed to the University.

#### D. Jury Duty

1. Leave of absence for jury duty shall be granted with no loss in pay or benefits. The house officer must notify the Program of a call to jury duty within 7 days of being notified by the court of the requirement. Jury duty of more than 2 weeks duration may lead to delay of graduation

#### E. Maternity/Paternity Leave

1. The University does not provide paid maternity or paternity leave. The Program will endeavor to arrange the house officer's vacation to occur at a time convenient to the birth of the house officer's child. A mother may take long term disability after the initial 30-day waiting period for pregnancy related health concerns. House officers may take unpaid leave in accordance with the terms of the Family Medical Leave Act, as stated below. In order to be eligible for Family Medical Leave related to the birth of a child, the house officer must have been employed by the Program for at least 12 months. Residents may use in addition the 8 sick days available to them during any academic year. The house officer who becomes pregnant is responsible to notify the Program Coordinator and Program Director. At the time that resident notifies the Program Coordinator of her pregnancy, the Coordinator will arrange for the house officer to meet with

- i. The chief resident responsible for schedules to review her schedule
- ii. The Human Resources representative for house officers to review options for time off, health care options (including registering the newborn for insurance), disability options, and salary options.
- iii. The Health and Wellness Faculty Advisor
- iv. A peer counselor

**The program strongly encourages residents to take a minimum of 6 to 8 weeks time off using cumulative vacation or leave before returning to work after the delivery.**

While we acknowledge their right to return to work when they and their personal physicians feel they are fit for duty, we believe strongly that new mothers should take a minimum of 6 weeks time off for the benefit of their own health and the wellbeing of their newborn. The program will endeavor to ensure that residents graduate on time or are able to begin fellowship programs on time. This may not be possible in all cases, given ACGME and ABIM requirements for completion of residency training in Internal Medicine. We will also arrange schedules for light duty upon their initial return.

#### F. Military Duty

1. House officers shall be excused from their training Program to meet military training obligations when such absences are approved by the Dean, School of Medicine.

#### G. Family Leave

1. General Conditions - A resident may request from the Program Director an unpaid family leave to care for his/her recently born or adopted child; for the serious illness of his/her child, parent, or spouse; or for his/her own serious illness that renders the resident unable to perform the functions of the position. Such leave must include the use of vacation, sick leave, or educational leave at the onset of the leave. The duration of the family leave must conform with Departmental and American Board of Internal Medicine requirements together with applicable state and federal law, including AB 1460, Federal Family and Medical Leave Act of 1993.
2. Duration - A resident must have completed the initial year of appointment to be eligible for a family leave of up to 12 workweeks in a 12-month period. A female resident is entitled to up to four (4) months of unpaid leave for pregnancy-related disability.
3. Benefit Status - During the portion of leave of absence designated as family leave (including pregnancy-related disability), benefits will be paid for the first 12 weeks of family leave. A husband and wife who are both employed may request family leave of a combined total of 12 weeks during a 12-month period for the birth or care of their child; for placement of their child for



adoption or foster care or to care for the child after placement; or to care for a parent with a serious health condition.

4. Qualifying Time for Board Requirements - If it is determined that training experience necessary to satisfy American Board requirements is lacking and the resident must gain such experience, the pay status of the time spent in making up training will be determined prior to commencement of the make-up activity. In general, the Program will pay in total for 36 months.
5. Notice and Certification - The resident may be required to provide advance leave notice of 30 days when the leave is "foreseeable" or 150 days advance notice in the case of pregnancy related leave. Medical certification may be required, and is to be issued by the health care provider of the individual requiring care. The certification must include the date on which the serious health condition commenced; the probable duration of the condition; an estimate of the amount of time needed to care for the individual; and a statement warranting the participation of a family member to provide care during the period of treatment or supervision. In addition to these requirements, for his/her own serious health condition, a statement that the resident is unable to perform the function of his/her position is required.

#### **XXIV. Working Conditions**

The following constitute the working conditions and rules for house staff in the Department of Medicine.

##### **A. Restrictions of Scheduled Work Hours**

1. Maximum Scheduled in-house work week of 80 hours per week averaged over a 4 week period. All other work hours policies are the same.
2. In-house on-call will be no more than every fourth night averaged over a one-month period.

##### **B. Time Off**

1. Minimum time off will include two 24-hour periods within a two-week period.

##### **C. Ancillary support services must include:**

1. 24 hour phlebotomy and IV services
2. 24 hour access to medical records
3. 24 hour access to radiology, laboratory, and other diagnostic services
4. 24 hour transport and escort services
5. 24 hour ward secretarial services

## XXV. Procedural Skills Certification

### A. Procedures

Safety is the highest priority when performing any procedure on a patient. The ABIM recognizes that there is variability in the types and numbers of procedures performed by internists in practice. Internists who perform any procedure must obtain the appropriate training to safely and competently perform that procedure. It is also expected that the internist be thoroughly evaluated and credentialed as competent in performing a procedure before he or she can perform a procedure unsupervised.

For Certification in internal medicine, the ABIM has identified a limited set of procedures for which it expects all candidates to be competent with regard to their knowledge and understanding. This includes (1) demonstration of competence in medical knowledge relevant to procedures through the candidate's ability to explain indications, contraindications, patient preparation methods, sterile techniques, pain management, proper techniques for handling specimens and fluids obtained, and test results (2) ability to recognize and manage complications and (3) ability to clearly explain to a patient all facets of the procedure necessary to obtain informed consent.

For a subset of procedures, ABIM requires all candidates to demonstrate competence and safe performance by means of evaluations performed during residency training. The set of procedures and associated competencies required for each are listed below.

#### **Competency is required in the following procedures and by the following parameters:**

Indications;	
Contraindications;	
Recognition &	
Management of	
Complications; Pain	
Management; Sterile	
Techniques	
Specimen	
Handling	
Interpretation	
of Results	
Requirements	
& Knowledge	
to Obtain	
Informed	
Consent	
Abdominal paracentesis	X X X X O
Advanced cardiac life support	X N/A N/A N/A X
Arterial line placement	X N/A X X O
Arthrocentesis	X X X X O
Central venous line placement	X X N/A X O
Drawing venous blood	X X X N/A X
Drawing arterial blood	X X X X X
Electrocardiogram	X N/A X N/A O
Incision and drainage of an abscess	X X X X O
Lumbar puncture	X X X X O
Nasogastric intubation	X X X X O
Pap smear and endocervical culture	X X X X X

Placing a peripheral venous line X N/A N/A N/A X  
Pulmonary artery catheter placement X N/A X X N/A  
Thoracentesis X X X X O

UCI internal medicine residents must be certified in all areas marked by an “X” in the preceding table. The program will provide opportunities to become certified to “Perform Safely and Competently” in the areas marked with an “O”. However, it is the responsibility of the resident to ensure that the appropriate documentation is provided to certify competence. The documentation will be tracked by the residents’ mentors at the semi-annual review. Residents cannot obtain sufficient experience to be certified to safely perform pulmonary artery catheter placement.

## B. Process

1. The Program requires certification in those procedures listed above. Skill and knowledge must be evaluated in 4 areas and for a minimum number of recommended observations:
  - i. Knowledge of the indications and potential risks
  - ii. Ability to explain risks to patients in understandable terms
  - iii. Ability to interpret the information obtained correctly
  - iv. Ability to technically perform the procedure and deal with expected complications.
2. Successful completion of a minimum number does not guarantee certification. The minimum number is only a guideline and must be taken in the context of overall skills and the denominator of attempts.
3. The house officer may not independently perform a procedure until certified to do so.
4. It is the responsibility of the house officer to obtain assistance and evaluation.
5. It is the responsibility of the house officer to obtain documentation of successful completion of the required procedures by the beginning of the second year of residency to the Chief Resident. Without documentation, certification will not be given, and residents cannot perform procedures independently without certification.
6. A qualified evaluator is one who is certified or credentialed in a specific procedure.
7. House Officers must bring their procedure documentation to each semiannual review.

## XXVI. Consultation Response Time on the Inpatient Services

- A. The UCI Clinical Enterprise Committee has approved the following recommendation from the Specialty Practice Management Committee as a point of information to the Medical Staff Bylaws Rules and Regulations:
  - 1. "Response to consultation requests shall be within twenty-four (24) hours by the Department receiving the request."
  
- B. The Senior Resident, Fellow, or Attending shall make the request for the consultation. The requestor shall document their name, pager number, and the time that the request was ordered.
  - 1. If the request is made before 12:00 pm, then the initial consultation shall occur by 6 pm that day. If the request is made after 12:00 pm, then the initial consultation shall occur by 12:00 pm the following day.
  - 2. If the consultation does not occur in the above time frame, the staff nurse has the authority to contact the Attending physician.
  - 3. The requesting physician or nurse must document the name, pager number, and time that the consultant was notified.
  
- C. The consultation will be provided by the Senior Level Resident, Fellow, or Attending only.
  - 1. The consultant will document the time of the consultation.
  - 2. The Senior Level Resident or Fellow will present to the Attending within 12 hours of the initial consultation.
  - 3. The Attending will examine the patient and make appropriate documentation on the chart within 24 hours of the initial request for consultation.

## **XXVII. Computer Systems : Use and Abuse**

- A. In recognition of the evolving, central, and powerful role of computers in medical care, the Internal Medicine Residency Program, School of Medicine, University of California, Irvine hereby states its policy on use and abuse of computers and data contained in computer systems. The purposes of this policy are to protect the integrity of patient information or records, and to ensure the quality of patient care.
  
- B. Any incident or series of incidents of abuse of a computer system or computer based information or communication system will be considered by the Program Evaluation Committee.

C. Abuse is:

1. Any act on any hospital computer system for which the individual(s) involved do not have express authorization.
2. Any act which is not in accord with the purpose of the program or information system.
3. Any act which might be construed as game playing or prank.
4. Any unprofessional act including, but not limited to obscene, racist, sexist, homophobic, or unprofessional messages. These include messages which are open or encrypted.
5. Any act which violates patient confidentiality or which might compromise patient care.
6. Any intentional act which interferes with the function of any system.
7. Any unauthorized act which alters data or messages in any manner.
8. Any unauthorized use of electronic mail or bulletin boards.
9. Any intentional access to data or programs for which the individual is not authorized or which might be considered a breach of confidentiality or which would provide the house officer with access to patient information that the house officer has no legitimate medical or patient care or authorized research need to access.
10. Any action which would improperly enter orders or cause orders to be entered by unauthorized individuals (See XIV Notes, Documentation and Completion of Medical Records).
11. Transport of protected health information on un-encrypted devices.

D. If it is found by the ROC that the incident in question is an abuse of this policy, the following actions can be recommended by the ROC to the Chair.

1. Abuse which is deemed a serious violation of this policy by virtue of the fact that it has significantly compromised patient care or confidentiality is punishable in the first instance by any or all available remedies including dismissal from the Program.
2. Abuse of a less serious nature may lead to probation in the first instance. A second violation is punishable by any or all available remedies including dismissal from the Program.
3. The nature of the punishment will be determined by the PEC.

**XXVIII. Photocopying of Copyrighted Materials**

- A. Copyrighted materials such as textbooks and study guides are the financial and intellectual property of those who own the copyright. The Program does not condone

- or endorse photocopying or reproducing copyrighted materials, even for educational purposes. The Program considers a violation of this policy to be a serious breach of professionalism.
- B. House Officers are not to use the Program's photocopying machines to reproduce materials, except in such limited instances where the institution has purchased and licensed the materials for limited reproduction.
  - C. The only materials which may be photocopied are:
    - 1. MKSAP questions utilized in Board Review Sessions. Only the chief residents may copy these materials for utilization at the review sessions. The Program purchases these materials for each house officer.
    - 2. Journal articles obtained from the library from journals which the library has licensed for use.
    - 3. Other exceptions may be made, but only with the permission of the Program Directors.
  - D. Violations of this policy will be referred to the PEC. Significant violations of this policy may lead to probation.

## **XXIX. Gifts, Gratuities and Conflict of Interest**

- A. Acceptance of Gifts and Gratuities by University Employees
  - 1. It is the policy of the University of California that its officers and employees shall comply with the provisions of State and Federal law governing the acceptance of gifts and gratuities. In addition to compliance with the requirements of law, University officers and employees must avoid the appearance of favoritism in all of their dealings on behalf of the University. All University officers and employees are expected to act with integrity and good judgment and to recognize that the acceptance of personal gifts from those doing business or seeking to do business with the University, even when lawful, may give rise to legitimate concerns about favoritism depending on the circumstances. If a University officer or employee has any question regarding the propriety of a gift, disclosure of the gift or proposed gift should be made to a supervisor or other appropriate University official for a determination of the proper course of action.
- B. UC 1997 Conflict of Interest Code
  - 1. The California Political Reform Act of 1974 requires certain state and local government officials to publicly disclose their private economic interests on an official Statement of Economic Interests form and that all government (University) employees disqualify themselves from participating in decisions in which they have a personal financial interest. A conflict of interest code lists the position titles of those employees or officials (designated position) in an organization who are required to provide personal financial information, assigns disclosure categories to these positions, and indicates the types of economic interest which must be reported, such as investments, interests in

real estate, or sources of income or gifts (see Designated Officials at UCI with Indicated Required Disclosure Categories. The University's Conflict of Interest Code is revised annually and submitted to the Fair Political Practices Commission for approval. The Commission is the state body that administers, interprets and enforces the California Political Reform Act. The University's approved Code has the force of law and any violation of the Code by a designated employee is deemed a violation of the Political Reform Act.

### **XXX. Sexual Harassment Policies**

- A. On March 10, 1986, the Office of the President issued the University of California Policy on Sexual Harassment and Complaint Resolution Procedures. Relevant sections of that policy are presented below:
- B. The University of California is committed to creating and maintaining a community in which students, faculty and administrative and academic staff can work together in an atmosphere free of all forms of harassment, exploitation, or intimidation, including sexual. Specifically, every member of the University community should be aware that the University is strongly opposed to sexual harassment and that such behavior is prohibited both by law and by University policy. It is the intention of the University to take whatever action may be needed to prevent, correct, and if necessary, discipline behavior which violates this policy.
- C. Unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature constitute sexual harassment when:
  1. Submission to such conduct is made either explicitly or implicitly a term or condition of instruction, employment, or participation in other University activity;
  2. Submission to or rejection of such conduct by an individual is used as a basis for evaluation in making academic or personnel decisions affecting an individual; or
  3. Such conduct has the purpose or effect of unreasonably interfering with an individual's performance or creating an intimidating, hostile, or offensive University environment.
- D. In determining whether the alleged conduct constitutes sexual harassment, consideration shall be given to the record of the incident as a whole and to the totality of the circumstances, including the context in which the alleged incidents occurred.
- E. The following University policies are applicable to sexual harassment complaints:
  1. The Faculty Code of Conduct, as adopted through resolution of the Academic Senate, outlines ethical and professional standards which University faculty are expected to observe. It also identifies various forms of unacceptable behavior, which are applicable in cases of sexual harassment and outlines sanctions and disciplinary procedures. Because the forms of unacceptable behavior listed in the Faculty Code of Conduct are interpreted to apply to

sexual harassment, a violation of the University policy on sexual harassment constitutes a violation of the Faculty Code of Conduct.

2. Applicable academic personnel policies and procedures are contained in the following sections of the Academic Personnel Manual - Conduct and Discipline; Affirmative Action and Non-discrimination; and Appeals.
3. Policies applying to other academic appointees include existing provisions of academic personnel policy or memoranda of understanding which prohibit conduct which violates law and University policy with respect to sexual harassment.
4. Policies Applying to Campus Activities, Organizations, and Students. Part A sets forth the types of student misconduct that are subject to discipline and the types of disciplinary actions that may be imposed for violation of the University policies or campus regulations. A violation of the University policy on sexual harassment is interpreted as a violation of those policies. Part B sets forth the University of California Policy on Sexual Harassment and Complaint Resolutions Procedures.
5. Applicable policies and procedures contained in the UCI Student Code of Conduct.
6. Existing provisions of Staff Personnel Policy or memoranda of understanding prohibit conduct, which violates law and University policy, including University policy on sexual harassment, and provide for disciplinary action for inappropriate conduct.
7. The applicable Personnel Policies for the Executive Management Program, the Management and Professional Program, and Administrative and Professional Staff.

### **XXXI. Occupational Injuries**

- A. ***Infection Control Guidelines pertaining to needlestick injuries at UCI and affiliated hospitals are appendixes to this document.***
- B. In order to expedite care of house officers at **UCIMC** who have a needlestick injury or other blood/body fluid exposure, the procedure has been modified as follows:
  1. After an exposure, immediately clean wound site. Flush the area with water (gently expressing blood if it is a percutaneous injury).
  2. Notify your department's House Staff Coordinator and sign an Industrial Injury Referral Form.
  3. Page the Infectious Diseases Fellow on call at your rotation site.
  4. Housestaff requiring further medical treatment should go to Employee Health immediately.



5. On weekends, holidays, or evenings, go to the Emergency Medicine Department. Bring an Industrial Injury Referral Form. Follow up with Employee Health as soon as they re-open.
6. If more complete exposure management protocols are needed, the Infection Control Manual can be found in all patient care units.

## **XXXII. ACGME**

- A. The Accreditation Counsel for Graduate Medical Education (ACGME) is the unified accrediting body for graduate medical education training programs. Through its Residency Review Committee for Internal Medicine (RRC-IM), the ACGME sets policies and establishes standards for training in Internal Medicine. The Program will regularly review the policies of the RRC-IM and the General Requirements of the ACGME in order to assure compliance with established policy. The Program will participate in the regular accreditation site reviews of the RRC-IM. The Program Director will retain oversight responsibility for training in General Internal Medicine and for the subspecialty training programs of Internal Medicine sponsored by the UCI COM
- B. House officers can contact the ACGME directly to express significant concerns about the Program or about their treatment by the Program.
- C. ED General Admissions Priorities & Policies

This policy expedites admissions from the ED, allowing reduced waiting time for new patients.

1. After ED evaluation, the Emergency Medicine faculty will decide whether the patient needs admission. The Emergency Medicine faculty will consult with the appropriate service, if necessary, to help in the admission decision.
2. The Emergency Medicine faculty will then:
  - i. Assign the patient for admission to an inpatient service and attending.
  - ii. Determine the level of care for the patient (ICU, floor, PCU).
3. The Emergency Medicine faculty or resident will then notify the senior resident or fellow of the admitting service of the admission. This will not be a call to get consent from the admitting service. The call will notify you of the admission.
4. If the inpatient bed is ready, the patient will go upstairs from the ED, even before you see the patient.
5. The emergency medicine resident or faculty will write "interim orders" including admitting service, attending and house officer, IV, activity and diet.

6. If the inpatient bed is not ready, you may begin your workup in the ED, but the patient will be sent upstairs as soon as the bed is ready.
7. If the patient needs further testing (such as CT or ultrasound) after the decision to admit, this will be done from the inpatient bed. If timing for radiology fits with the patient's move upstairs, the study may be done on the way.
8. Some procedures will need to be done upstairs, including non-emergent laceration repair (there is an inpatient suture cart), paracentesis, thoracentesis, lumbar puncture, and incision and drainage. Supplies for these procedures must be obtained from central supply or the floor or unit, not the ED.
9. If you disagree with the decision to admit to your service, you must discuss this with your attending. As a resident or fellow, it is not appropriate for you to delay or dispute the admission decision. Any discussions regarding the appropriateness of admission will be attending to attending only.
10. If the patient turns out to have a diagnosis that is better managed on another service, plan the transfer of service with your attending.

### **XXXIII. Distribution of Departmental Policies and the Acknowledgement of their Receipt**

- A. Residents selected into the Program through the MATCH or hired into more senior positions must be apprised of the Program's Policies and Procedures. A copy of the Policy and Procedure Manual must be provided to each incoming House Officer and each House Officer must then sign an Acknowledgment of Receipt by the time that they begin their employment in the Program. Signature on the Receipt is a requirement for employment.

### **XXXIV. Independent Study**

- A. Independent Study rotations will be assigned on special case-by-case basis. Residents interested in doing an independent study elective will require to submit a proposal with a meaningful study plan and a specific goal. Purely study months (that is, just to catch up on reading) will not be allowed. Independent study will be for special projects with definable goals and outcomes.

### **XXXV. Away Electives and Independent Study Electives**

- A. Preliminary Interns will be allowed one away rotation but only under extraordinary circumstances and only with Dr. Kaplan's approval. In regards to independent study, these rotations will be assigned on a special case-by-case basis. Residents interested in doing an independent study elective will be required to submit a proposal with a meaningful study matter. Purely study months (that is, just to catch up on reading) will not be allowed. Independent Study will be for special projects with definable goals and outcomes.

**XXXVI. Revision to Requirements for Non-traditional Electives including Radiology and Pathology Electives & Externships**

- A. In order to obtain authorization for a non-traditional elective or externship the house officer must create a document similar to the application for a research elective. That document must have the following components.
1. Identify a single faculty mentor who will be responsible for your rotation and evaluation in either pathology or radiology.
  2. Specify a rationale for the rotation.