GENERAL PSYCHIATRY RESIDENCY TRAINING PROGRAM

POLICIES AND PROCEDURES MANUAL

Department of Psychiatry and Behavioral Sciences
University of Texas Medical Branch
Galveston, Texas

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TABLE OF CONTENTS

OVERALL PHILOSOPHY ................................................................. 3
RESIDENCY TRAINING DIRECTOR AND THE RESIDENCY TRAINING COMMITTEE ........................................... 3
OTHER COMMITTEES ........................................................................... 4
A. Clinical Competency Committee ....................................................... 4
B. Program Evaluation Committee ......................................................... 5
CHIEF RESIDENT AND ASSISTANT CHIEF RESIDENT ................................................................. 5
RESIDENT ADVISOR ........................................................................... 5
INTERVIEWING AND ACCEPTANCE PROCESS ............................................. 6
PROGRAM OBJECTIVES, PROGRAM GOALS AND CORE COMPETENCIES .................................................. 7
A. Program Goals ............................................................................. 7
B. Program Objectives ..................................................................... 7
C. Objectives by PG-Year ................................................................ 8
D. Core Competencies .................................................................... 9
RESPONSIBILITIES OF RESIDENTS .......................................................... 11
A. Case Load .................................................................................. 12
B. Residents’ Call Guidelines ............................................................. 12
C. Transition of Care ...................................................................... 12
D. Seminars, Supervision and other Academic Activities ................... 12
E. Protocol for Primary Care Rotation Assignments for PGY-1 Residents .................................................. 13
SUPERVISION, DUTY HOURS, & ALERTNESS MANAGEMENT & FATIGUE MITIGATION .... 13
DOCUMENTATION ........................................................................... 14
RESIDENT OFFICES ......................................................................... 14
TEACHING RESPONSIBILITIES OF RESIDENTS ........................................ 14
LINES OF AUTHORITY .................................................................... 14
EVALUATION .................................................................................. 15
CREDIT FOR RESIDENCY TRAINING ...................................................... 15
CONTINUATION OF RESIDENT IN PROGRAM ......................................... 16
ELECTIVES ..................................................................................... 16
ADDITIONAL EMPLOYMENT ............................................................... 16
MOONLIGHTING ............................................................................ 17
OVERSIGHT .................................................................................. 17
TRAVEL AND BOOK ALLOWANCE ....................................................... 17
SPECIAL HARDSHIPS AND PRESSING FINANCIAL NEEDS .................... 17
LEAVE CATEGORIES FOR HOUSESTAFF ............................................... 18
VACATION ..................................................................................... 18
ILLNESS ....................................................................................... 18
ADMINISTRATIVE LEAVE ................................................................. 19
CORRECTIVE ACTIONS AND ASSURANCE OF DUE PROCESS ...................... 19
PERSONNEL AND EVALUATION FILES ............................................... 20
EXCEPTIONS .................................................................................. 20
ADDITIONS AND AMENDMENTS .......................................................... 21
ACTIONS OR PROCEDURES NOT SPECIFIED IN THE GENERAL RESIDENCY TRAINING PROGRAM POLICIES & PROCEDURES ................................................. 21
EMERGENCY SITUATIONS .................................................................. 21
ACGME HOUSE STAFF DUTY HOURS & THE WORKING ENVIRONMENT .................................................. 21
ACGME HOUSE STAFF DUTY HOURS & THE WORKING ENVIRONMENT .................................................. 26
SPECIALTY SPECIFIC FOR PSYCHIATRY
I. OVERALL PHILOSOPHY

A. The UTMB General Psychiatry Residency Training Program (the “Program”) is an accredited four-year Program designed to train physicians in the medical specialty of psychiatry so they can function in a variety of professional settings.

B. The Program’s policies and procedures may be modified at any time by the Department of Psychiatry & Behavioral Sciences’ Residency Training Committee (the “Committee”), but all policies and procedures must be consistent with standards and criteria established by the following sources:

1. Essentials of the Accreditation Council for Graduate Medical Education
2. UTMB Policy and Procedures, especially as they apply to housestaff

C. The Program comprises four major components:

1. Inpatient and outpatient clinical experience in psychiatric care of adults, adolescents, children and families. Subspecialty clinical areas include geriatrics, emergency psychiatry, addiction psychiatry, consultation and liaison psychiatry, community and forensic psychiatry, administrative psychiatry and research.

2. Supervision by faculty in diagnostic evaluation, psychiatric consultation, somatic treatments and in a variety of individual, group and family psychotherapies.

3. Didactic seminars and other academic activities.

4. Elective opportunities for more intensive concentration on any particular area(s) including research.

II. RESIDENCY TRAINING DIRECTOR AND THE RESIDENCY TRAINING COMMITTEE

A. The Chairman of the Department of Psychiatry & Behavioral Sciences (the “Department”) will appoint or reappoint annually a full-time senior faculty member to serve as Training Director of the Residency Training Program (the “Training Director”). The Training Director must be board certified in psychiatry or possess equivalent qualifications and must devote no less than 50% time to the administration, operation, and teaching responsibilities related to the Program. The Training Director will be responsible for the oversight and organization of the training Program. The Training Director or the Training Director’s delegate will chair all meetings of the Residency Training Committee.

B. The Residency Training Committee will perform all functions of an education policy committee as described in ACGME requirements. The Committee will participate actively in:

1) planning, developing, implementing, and evaluating all significant features of the residency program, including the selection of residents (unless the Committee delegates this function to a special committee)
2) determining curriculum goals and objectives; and
3) evaluating both the teaching staff and the residents
4) providing advice to the Residency Training Director as needed

C. The Committee will comprise up to 12 faculty members and residents. Faculty members may be full-time or part-time and need not hold the M.D. degree. The first five positions will be automatically filled by the persons holding the indicated titles:

Director of Residency Training Program—Chairperson
Associate Director of Residency Training (if that position is filled)—Chair, in absence of Chairperson
Director of Child Training—Chair, if both of the above are absent
Director of Undergraduate Education
Chief Resident of General Psychiatry

One (1) Faculty member from the General faculty elected by faculty
One (1) Faculty member from General Adult Clinical services elected by faculty
One (1) Faculty member from the General faculty elected by residents
One (1) Faculty member selected by the Training Director

Faculty will be appointed to the Residency Training Committee by the Chairman of Psychiatry who will receive nominations from the Training Director.

One (1) PGY-1 resident, elected by the residents
One (1) PGY-2 resident, elected by the residents
One (1) PGY-3 resident, elected by the residents

D. Terms of service to the Residency Training Committee will be for the academic year (July-June) for faculty. The PGY-1 representative will be elected by the residents before the end of July for the incoming resident class. The resident representatives may serve less than a year term as suggested by that resident year and voted on by the RTC.

E. The Committee will meet monthly, and will follow Robert’s Rules of Order. Meetings are open except when a motion has been passed for the Committee to go into closed session to discuss personnel matters. Only committee members have voting privileges. With the exception of the General Psychiatry Chief Resident, resident representatives will absent themselves from discussion and voting on current resident evaluations, any corrective actions, issues related to resident advancement or continuation in the Program, selection of the Chief Resident and the Assistant Chief, or any other personal or personnel (e.g., extended vacation time) matters pertaining to individual residents which are brought before the Committee.

F. Decisions affecting the residency program require that 2/3 of members be present. Each member has one vote. A simple majority will carry motions. Decisions regarding personnel actions related to residents require the presence of at least 5 committee members (faculty or chief resident). A simple majority will carry motions in this forum.

G. Minutes of each committee meeting, open and closed sessions alike, will be kept and distributed to all committee members (minutes from closed sessions will be marked “CONFIDENTIAL”). In addition, minutes from open sessions will be available to any interested department staff upon request to the Training Director’s office. The Residency Training Director will forward recommendations from the Residency Training Committee to the department Chairman or the Chairman’s delegate.

H. The Training Director may appoint committees composed of Residency Training Committee members to address specific issues in residency training. These committees may draft policies and/or make recommendations about specific issues which the Training Director can implement.

III. OTHER COMMITTEES

A. Clinical Competency Committee (CCC)

The Clinical Competency Committee (CCC) is appointed by the Program Director and includes all faculty members of the Residency Training Program Committee. The duties of the Clinical Competency Committee includes:

1. Review all training evaluations of resident performance
2. Preparation of the semiannual report of all residents’ Milestones progress
3. Recommendations on resident progress including promotion, remediation and dismissal

The Committee will meet monthly, and will follow Robert’s Rules of Order. Meetings are open except when a motion has been passed for the Committee to go into closed session to discuss personnel matters. Only committee members have voting privileges.
B. Program Evaluation Committee (PEC)

The program, through a Program Evaluation Committee (PEC), shall conduct an annual evaluation of the program, documenting formal, systematic evaluation of the curriculum and rendering a written Annual Program Evaluation (APE).

The program director will appoint the current members of the Training Committee and any other necessary faculty and residents to serve as members of the PEC. The PEC is responsible for the planning, developing, implementing and evaluating of the educational activities of the program. It is also reviews and makes recommendations for revision of competency-based curriculum goals and objectives. It must address any areas of non-compliance with ACGME standards and review the program annually using evaluations of faculty, residents and others. Areas to be addressed in the APE include: resident performance, faculty development, graduate performance, program quality and progress on the previous year’s APE. The APE must also include any initiatives to improve performance on the areas listed.

IV. GENERAL PSYCHIATRY CHIEF RESIDENT & ASSISTANT CHIEF RESIDENT

A. General Psychiatry Chief Resident

Policy:
The department Chairman shall appoint annually a Chief Resident from the PGY-4 year or higher and one or more Assistant Chief Residents from the PGY-3 year.

Procedure:
The General Psychiatry Chief Resident and Assistant Chief Resident positions will be open to application by all PGY-4 and PGY-3 residents respectively. Residents will apply by submitting a letter of intent. The Training Director and the Associate Training Director will interview applicants and shall propose names of candidates for Chief Resident and Assistant Chief Resident(s) from the general Program, excluding those in the full-time child Program, to the Residency Training Committee. The Committee can suggest modifications to the list or approve the nomination of the Training Director to the department Chairman. The Chairman, after receiving the recommendation, has the final decision on appointments. The General Psychiatry Chief Resident will be appointed for a duration of one year. The position of General Psychiatry Chief Resident includes an increased stipend to compensate for the additional duties that this position requires. S/he composes all coverage schedules. Call schedules are composed by Assistant Chief Residents; Chief Resident is ultimately responsible for the call schedule. S/he has the option of bringing matters of a disciplinary nature involving residents to the attention of the Training Director. In the event s/he cannot fulfill the duties of General Psychiatry Chief Resident, the department Chairman will appoint a replacement for the remainder of the one-year period.

B. General Psychiatry Assistant Chief Resident

Policy: An Assistant Chief Resident, nominated by the Residency Training Director and appointed by the department Chairman, for a minimum six-month period. The Assistant Chief Resident fills in for the General Psychiatry Chief Resident when s/he is temporarily absent. Other duties include coordinating the journal club meetings and resident lunches, as well as other tasks assigned by the Chief Resident. The Assistant Chief Resident will be compensated for his/her extra duties.

V. RESIDENT ADVISOR

Policy:
There shall be a Resident Advisor designated by the Training Director after discussion with each resident.

Procedure:
A Resident Advisor will be designated by the Training Director in the beginning of the PGY-1 year (or the year of entry) for the duration of training. A Resident Advisor may be changed at the discretion of the Training Director.
Requests for such change may be initiated by the resident, the advisor, the Residency Training Committee, or the Training Director. The Resident Advisor will act as the resident’s clinical and professional mentor.

In addition, the advisor will be responsible for seeing the resident is having a clinical and academic experience with adequate supervision and appropriate working hours and is receiving appropriate feedback and evaluations. Copies of the resident advisee’s evaluations, personnel actions, PRITE scores, etc. will be sent to the advisor to be discussed with him or her, signed and returned to the office of Residency Training. The mentor relationship is intended to play a central role in nurturing the resident’s progress and academic development. For example, an advisor may answer questions about general career issues, or about more personal concerns, or issues within the department. An advisor might also serve as mentor for the resident interested in a research or subspecialty, advising him or her about the process of selecting an area of interest and developing readings, electives, supervisors, and other educational opportunities.

A Resident Advisor must be a board-eligible or -certified psychiatrist in the Department. Resident Advisors are expected to meet with their residents at regular intervals: monthly meetings are appropriate for new residents; meetings of greater or less frequency may be indicated at various stages of the resident’s progression. The Resident Advisor may be present when the Residency Training Director is conducting a resident’s annual evaluation.

The advisor will not be required to submit regular evaluations on advisees, but the resident should be aware that the relationship is not confidential, and the advisor may be asked to participate in oral or written assessments of any problems that arise.

VI. INTERVIEWING AND ACCEPTANCE PROCESS

Policy:
There shall be a standard interviewing and review process for applicants to the Program.

Procedure:
A. Applications are accepted through the ERAS system. After an application is approved for interview by the Director or the Associate Director, the prospective applicant is contacted for interview.

B. Applicants will not be accepted into the Program without personal interviews. (In the case of needing to fill post-match this interview may be a phone interview if necessary) The plan for a Recruitment Day, which will allow up to 5 applicants/day to be interviewed. Faculty and residents involved in the interview process will receive a copy of the applicant’s materials at least 24 hours before the interview day.

- Most applicants will be scheduled for a series of 4 or 5 interviews lasting 30 minutes each.
  Applicants will be taken to lunch and given a campus tour by the residents.

C. For those applicants unable to interview on one of the Resident Recruitment Team Days, a separate interview day will be scheduled.

D. All applicants who are interviewed will receive written description of the current structure of the residency program. Applicants will also be given written information regarding financial compensation and UTMB policies covering professional liability, vacations, sick leave, maternity/paternity leave, as well as other special leaves.

E. The applicant’s complete credentials along with interviewers’ evaluations will be presented to the Committee as soon as possible after the applicant’s visit. The Committee will decide whether or not the applicant is to recommended for ranking. A letter will then be sent only to potentially qualifying applicants to indicate either:

1. Favorable response and encouragement, or
2. Need for further information or additional interviews.

F. International medical students must be ECFMG certified and have a visa; they must further demonstrate sufficient competency in the English language and familiarity with the American culture to work with psychiatric patients.
G. Committee final recommendations are understood to be a result of an overall evaluative process based on the applicant’s past experience, letters of reference, and interviewers’ judgments. No single or overall numerical score will be used as an inclusion or exclusion criterion. Neither will one criterion or group of criteria be considered sufficient for automatic acceptance or rejection. Criteria other than those listed may be used in evaluating an applicant.

After an applicant matches our Program, s/he will be sent a contract for signing.

J. PGY-1 applicants:

If the PGY-1 positions are not filled via the match or if extra positions become available, the Training Director may continue recruiting. Members of the Committee may be included in this process.

K. Applicants other than for the PGY-1 year:

PGY-2 applicants will be considered only after a broad-based clinical year of accredited training in the United States or Canada in programs in internal medicine, family practice, pediatrics or psychiatry, or after one year of an accredited residency in a clinical specialty requiring comprehensive and continuous patient care. The same procedures will be used for all PGY-2, 3 and 4 applicants except that the Committee can decide on acceptance since no match is involved, and the letter to the applicant may reflect this. The Training Director must review the applicant’s previous clinical rotations to ensure that s/he is eligible for entering at the year applied for (refer to Special Requirements). For a transferring applicant, the Training Director must obtain documentation from the previous training directors about the clinical training experiences, past performance and professional integrity of the applicant.

VI I. PROGRAM OBJECTIVES, PROGRAM GOALS AND CORE COMPETENCIES

A. Program Goals

1) To train residents in General Psychiatry to evaluate patients in a biopsychosocial model of various ages, socioeconomic status, and diagnoses; to plan and carry out treatment in the appropriate setting and with the appropriate treatment modality.

2) To train residents to be competent clinicians who understand the importance of academic and scientific endeavors to the field of psychiatry who become life-long learners in an effort to continue to provide quality care throughout their practice lifetime.

B. Program Objectives

1) The residents will learn the important principles of neuroscience at it relates to psychiatry as evidence by participation in didactic seminars and performance on the in-service exam.

2) The residents will learn the pharmacologic treatments for patients with mental illness and exhibit their knowledge in the in service exam and through examination by their clinical supervisor.

3) The residents will learn psychopathology and be able to recognize the diagnoses as related to the current manual and exhibit their knowledge in the in service exam as well as through clinical supervision.

4) The residents will learn the principles of the various modalities of psychotherapy as evidence by assessments by their individual and didactic supervisors.

5) The residents will be able to demonstrate their ability to interview patients and come up with an appropriate diagnostic formulation and treatment plan as assessed informally during daily clinical supervision and formally at the end of the 2nd and 4th years of training.
6) The residents will be able to demonstrate their psychotherapy skills as assessed by their individual supervisor through observation and supervision.

7) The residents will be able to operate as a member of an interdisciplinary team as evidenced by their interactions with other disciplines assessed by their clinical supervisors and co-workers and students (through anonymous assessments).

8) They will be able to contribute to the teaching of medical students and other members of the treatment team, assessed by their student evaluations and evaluations of presentations at case conferences.

C. Objectives by PG-Year

PGY-1

1) Residents will learn how to assess acute patients and treat them in an inpatient setting as part of an multidisciplinary team, as well as provide liaison and transition to an outpatient setting and the community.

2) Residents will begin training in emergency assessments of patients with supervision by senior residents and faculty.

3) Residents will have an experience in primary care which improves their general medical knowledge and ability to treatment general medical disorders.

4) Residents will learn to collaborate with and teach medical students in inpatient and emergency clinical settings.

5) Residents will become familiar with forensic issues related to psychiatric patients by supervised participation in commitment proceedings.

6) Residents will participate in team conferences addressing issues of quality of care—including treatment planning, case management, and resource utilization.

Residents in the PGY-1 year must successfully complete their inpatient and primary care rotations as assessed by supervising attendings and pass all assessments in their didactics to be promoted to the PGY-2 year.

PGY-2

1) Residents will continue to enhance their assessments skills and knowledge base, with additional emphasis on child, adolescent and geriatric patients.

2) Residents will expand their consultation and liaison skills, providing service to other non-psychiatry services and the Emergency Room with direct supervision by faculty.

3) Residents will become aware of treatment options for substance abusing patients and be able to participate in a multidisciplinary team approach to treatment of this patient population.

4) Residents will improve their knowledge base in neurologic disorders, with particular emphasis on those disorders most relevant to psychiatric disorders.

5) Residents will be active participants at the various clinical sites in conferences related to quality care and improvement related to those settings.

6) Residents will learn to collaborate and teach medical students in diverse clinical settings.

Residents must successfully complete their rotations in the PGY-2 year as assessed by supervising attendings, pass all assessments in their didactics and pass a clinical interview and assessment exercise to be promoted to PGY-3. Residents who have not exhibited a 25% tile score will have to pass a departmental written exam in order to promote to the next year.
PGY-3

1) Residents will be able to perform diagnostic evaluations on patients referred to the outpatient service with faculty supervision.

2) Residents will be able to perform group, family, and individual psychotherapies in a variety of models supervised by faculty.

3) Residents will be able to treat patients with a variety of psychotropic medications with on site faculty supervision.

4) Residents will be able to make appropriate referrals to community agencies, other health professionals, and coordinate patient care with primary care physicians.

5) Residents exhibit increasing independence in decision making and clinical responsibilities.

6) The Chief resident for the outpatient year will serve on the departmental Quality Care and Improvement Committee representing the PGY3 year regarding relevant outpatient issues.

Residents will successfully complete the PGY-3 rotations as assessed by the supervising faculty, pass all assessments in their didactics. Residents who have not exhibited a 25% tile score will have to pass a departmental written exam in order to promote to the next year and may be required to use some of their elective time in the PGY-4 year in order to improve their performance.

PGY-4

1) Residents will be able to take on a more administrative and supervising role with medical students and junior residents.

2) The residents will become familiar with the practice of forensic psychiatry by observation and participation in competency evaluations.

3) Residents will be able show that they are able to function more independently in regard to patient treatment.

Residents must complete the PGY-4 rotations as assessed by supervising faculty and pass a clinical interviewing assessment in order to graduate from the program.

D. Core Competencies in Psychiatry

Policy:
At the completion of residency training, a resident must be proficient in the following six core competency areas.

Procedure:
The Faculty of the Department of Psychiatry is dedicated to providing the education and leadership necessary to aid the psychiatry resident in achieving and possibly surpassing these competency goals.

1. Patient Care: Residents are expected to provide patient care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health.
   - Gather accurate, essential information from all sources, including interviews, physical examinations, mental status examinations, medical records, and diagnostic/therapeutic procedures.
   - Make informed recommendations about preventive, diagnostic and therapeutic options and interventions that are based on clinical judgment, scientific evidence, and patient preference.
   - Develop, negotiate and implement effective patient management plans and integration of patient care.
Perform competently the diagnostic and therapeutic procedures considered essential to the practice of psychiatry.
Inform patient and family of concerns, issues, and rights. Work with ancillary services to help with these issues.

2. Medical Knowledge: Residents are expected to demonstrate knowledge of established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- Apply an open-minded and analytical approach to acquiring new knowledge.
- Access and critically evaluate current medical information and scientific evidence.
- Develop clinically applicable knowledge of the basic and clinical sciences that underlie the practice of psychiatry
- Apply this knowledge to clinical problem-solving, clinical decision-making, and critical thinking in patient care.

3. Practice-Based Learning and Improvement: Residents are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
- Identify areas for improvement and implement strategies to enhance knowledge, skills, attitudes, and processes of care.
- Analyze and evaluate practice experiences and implement strategies to continually improve the quality of patient practice.
- Develop and maintain a willingness to learn from errors and use errors to improve the system or processes of care.
- Use information technology or other available methodologies to access and manage information, support patient care decisions and enhance both patient and physician education.

4. Communication and Interpersonal Skills: Residents are expected to demonstrate interpersonal communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
- Provide effective and professional consultation to other physicians and health care professionals and sustain therapeutic and ethically sound professional relationships with patients, their families, and colleagues.
- Use effective listening, nonverbal, questioning, and narrative skills to communicate with patients and families.
- Interact with consultants in a respectful, appropriate manner.
- Maintain comprehensive, timely, and legible medical records.
- Work effectively as a member of the treatment team.

5. Professionalism: Residents are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.
- Demonstrate respect, compassion, integrity, and altruism in relationships with patients, families, and colleagues.
- Demonstrate sensitivity and responsiveness to the gender, age, culture, religion, sexual preference, socioeconomic status, beliefs, behaviors, and disabilities of patients and professional colleagues.
- Adhere to principles of confidentiality, scientific/academic integrity, and informed consent.
- Recognize and identify deficiencies in peer performance.
- Remain professional in appearance and behavior in the performance of all duties.

Systems-Based Practice: Residents are expected to demonstrate both understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.
- Understand, access, and utilize the resources, providers and systems necessary to provide optimal care.
- Understand the limitations and opportunities inherent in various practice types and delivery systems, and develop strategies to optimize care for the individual patient.
Apply evidence-based, cost-conscious strategies to prevention, diagnosis, and disease management.

Collaborate with other members of the health care team to assist patients in dealing effectively with complex systems and to improve systematic processes of care.

7. Residents are expected to develop a personal program of learning to foster continued professional growth with guidance from the teaching staff and to participate fully in the educational and scholarly activities of their program and, as required, assume responsibility for teaching and supervising other residents and students.

C. Psychotherapy Competencies – Residents must achieve competency in at least the following forms of treatment:

1. Brief Therapy
2. Cognitive-Behavioral Therapy
3. Combined Psychotherapy and Psychopharmacology
4. Psychodynamic therapy
5. Supportive therapy

VIII. RESPONSIBILITIES OF RESIDENTS

Policy:
Residents shall have definite clinical and academic duties as a part of the training Program.

Participation in scheduled supervision by faculty and in seminars and other educational activities of the Department constitute the highest priority use of a resident’s time, subject only to clinical emergencies.

Procedure:
In this Program usual hours are generally interpreted to be 8:00 a.m. to 5:00 p.m. for day-long assignments, 8:00 a.m. to 12:00 noon for morning assignments, and 1:00 p.m. to 5:00 p.m. for afternoon assignments. Specialized clinical situations may require modification of these hours and the resident will be expected to accommodate those clinical needs. Appropriate patient care may, however, extend beyond these specified hours and the resident is expected to act in a professional manner under these circumstances. If a resident feels that his/her hours are repeatedly too long, this should be brought to the attention of the Chief Resident who shall determine where the problem, if any, lies and attempt to solve the problem. Any unresolvable differences will be referred to the Training Director and then, if necessary, to the Committee for solution. Residents shall be responsible for all in-patients assigned to them with the understanding that the on-call resident provides temporary coverage during nights and weekends. Coverage during leave or vacation must clearly be delineated.

The Chief Resident (or Assistant Chiefs) shall construct an on-call schedule for each month. Any special requests will be entertained prior to formulation of the schedule by the Chief Resident. The call schedule will reflect the names of the on-call resident, the back-up resident, the faculty back-up, and the Child Psychiatry back-up. If a resident is unable to take call for any reason, procedures outlined in Section XX should be followed.

Unless authorized by the department Chairman, all residents must have a home telephone number and on file with the residency program, the psychiatry department and the UTMB hospital switchboard. In other matters, the resident should be guided by patterns of practice and courtesy that would prevail were s/he practicing medicine elsewhere.

When the resident is on another service, the policy and procedures regarding availability and call shall be the same as any resident on that service.
Residents should arrange their schedules to permit full and regular participation in scheduled seminars, regular faculty supervision, and other educational activities of the Department. Patient appointments, clinical duties, rounds and research activities should be scheduled so that they do not conflict with supervision and seminars. Schedule conflicts should first be brought to the attention of the resident’s immediate faculty supervisor. If satisfaction cannot be achieved, then such schedule conflicts should be appealed to the Chief Resident and then to the Training Director.

A. Case Load

The number of patients for which a resident has primary responsibility at any one time must be sufficiently small to permit the resident to conduct a detailed study of each patient and provide each patient with appropriate treatment, and sufficiently large enough to provide a variety of clinical experiences. This load must be compatible with the requirement to participate in the academic activities of the Program. Residents assigned to inpatient clinical services will carry a maximum of 8 cases on that inpatient service.

B. Resident Call Guidelines

At no time shall a resident’s clinical service load—especially frequency of night, weekend and holiday calls—interfere with the Program’s educational goals.

Procedure concerning residents on call when ill:

1. Residents are to find their own replacement when possible
2. Contact back-up resident on call concerning illness and have them assist with finding another resident to take call
3. The Chief Resident has ultimate responsibility for finding replacement
4. If no other replacement can be found, then the back-up resident must take first call
5. Payback by the resident who was ill is expected and should be arranged between the residents

C. Transition of Care

At any time there is a transition of care the resident will be responsible for making sure that the on call resident is aware of important clinical issue related to their patient.

For inpatient this will be documented in the daily note, and any specific concerns will be directly communicated to the clinical team on call.

For consultation/liaison, issues of concern will be documented in the consult and communicated to the primary team.

For outpatient, any issues of concern should be noted in the outpatient chart and communicated directly to the clinical team on call.

For all other services there is a primary person responsible for transition of care other than the resident, but the resident should participate at the appropriate level to assure patient safety.

D. Seminars, Supervision and other Academic Activities

Except for clinical emergencies, residents are expected to regularly attend all seminars, supervisory sessions, and the Department’s Academic Program promptly as scheduled. Attendance will be taken at these scheduled didactics and will be one of the criteria for evaluation of resident performance.

Each entering resident is also required to complete one academic paper by the end of the third year.

Detailed information about the current curriculum, clinical assignments, and the academic paper are to be given to all new residents.
E. Protocol for Primary Care Rotation Assignments for PGY-1 Residents

Policy:
PGY-1 residents will follow protocol for requesting assignments and changes to assignments of primary care rotations.

Procedure:
By April 30, incoming PGY-1 residents will submit their preferences concerning the timing of their primary care rotations and their preferences (pediatrics, internal medicine, family medicine). Residents that match through the combined general psych/child psych track may select up to 4 months but must take at least two months of pediatrics; residents matching through the general track may select up to two months of pediatrics.

In May, the program will form a template for the coming year and contact the other three programs to arrange for specific rotation assignments, which will include the precise rotations and the identities of the faculty physicians in charge of each rotation. Every effort will be made to comply with the residents’ preferences, but this may not always be possible.

During June, the program will provide a specific month-by-month schedule to each PGY-1 resident for the coming year.

Thereafter, a PGY-1 resident could make changes in this rotation schedule only with the written approval of the Psychiatry Chief Resident and the Program Director.

IX. SUPERVISION, DUTY HOURS, AND ALERTNESS MANAGEMENT & FATIGUE MITIGATION

Supervision:
PGY1’s will have direct supervision until they are evaluated by a supervising faculty to move to the next level of supervision as defined by the ACGME. Addendum C is a copy of the assessment form.

Duty Hours:
UTMB and all residency programs it sponsors are committed to abiding by Duty Hour Standards set by ACGME and responsible for:

a. Promoting patient safety and Resident/Fellow well-being and to providing a supportive educational environment;

b. Ensuring that the learning objectives of the programs are not compromised by excessive reliance on Residents/Fellows to fulfill service obligations;

a. Ensuring that Residents/Fellows’ education and clinical training have priority in the allotment of Resident/Fellow’s time and energy;

b. Ensuring that duty hour assignments recognize that faculty and Residents/Fellows collectively have responsibility for the safety and welfare of patients;

c. Providing guidelines for Alertness Management and Fatigue Mitigation to all residents/fellows at the annual house staff orientation and located also on the GME web site.

The ACGME Policy on Resident/Fellow Supervision and Duty Hours is attached as Addendum A for reference. Specific policies for Psychiatry are attached as Addendum B.
Alertness Management and Fatigue Mitigation:

1. All incoming residents are educated regarding Fatigue as part of the orientation.
2. The House Staff Sleep Rooms are available at all times for residents/fellows too fatigued to drive home after in-house call. If they choose to use the sleep rooms after completion of duty, it will not count towards their duty hours.
3. During a departmental faculty meeting annually there will be a presentation to faculty regarding the recognition of fatigue and sleep deprivation in residents as well as alertness management and fatigue mitigation processes.

X . DOCUMENTATION

Policy:
Residents are responsible for the documentation of service to patients under their care.

Procedure:
Residents are required to follow the documentation guidelines for the clinical services that they rotate on.

All outstanding medical records documentation must be completed prior to any vacation leave. Certificates of completion of residency training will not be issued until all outstanding documentation requirements are completed.

XI. RESIDENT OFFICES

Policy:
Residents shall have offices consistent with their educational needs.

Procedure:
In compliance with the Special Requirements, there shall be no more than three PGY-1 or PGY-2 residents sharing the same psychiatry offices, and no more than two residents per office for PGY 3 and PGY-4 residents. When possible, individual offices will be made available as training advances.

XII. TEACHING RESPONSIBILITIES OF RESIDENTS

Policy:
Residents in psychiatry should be active participants in the teaching of medical students and in the teaching of more junior residents and other health professionals.

Procedure:
Residents’ primary teaching responsibility is for the medical students on their service. Specific meeting times should be arranged on a formal basis between the resident and their students. Advanced residents may be assigned an instructional role with more junior colleagues at the request of the Service Chief.

XIII. LINES OF AUTHORITY

Policy:
There shall be clear lines of authority within the General Psychiatry Residency Training Program. Residents shall have access to all policies and procedures of the Program and to any official descriptions of the organizational structure of the Program.

Procedure:
General psychiatry residents shall have access to and be accountable to the following department individuals in this order:

A. Senior resident on the service to which the resident is assigned
B. Service Chief
Depending on the issue involved, the order of B, C, and D. While on a Child Psychiatry rotation, the Child Psychiatry Training Director should be approached prior to the General Psychiatry Training Director.

XIV. EVALUATION

Policy:
Residents shall be periodically evaluated in educational activities, including clinical rotations, seminars, faculty supervision and electives. The Program will formally examine at least annually the cognitive knowledge of each PGY-1, PGY-2, PGY-3 and PGY-4 resident, and conduct an organized examination of clinical skills annually during the four years of training. These assessments will be the basis of a significant portion of the discussions held in the meeting between the Residency Director or Associate Director and the resident, which will occur twice yearly.

Semi-annual meetings between each resident and the Training Director or Associate Director will be conducted. The Training Director will notify the resident at least two weeks in advance of such meetings. The purpose of these meetings is to make the residents aware of the assessment of their progress toward attainment of professional competence.

Procedure:
Formal written evaluations of the resident by the supervisor and of the learning experience by the resident will take place at the end of the rotation or designated time periods if the rotations are longer than 2 months. The faculty and residents will be sent notices through New Innovations when they have evaluations to complete. Any educational experience that lasts three months or less shall be subject to the above procedure except that formal written evaluations will be completed and submitted to the Training Director no later than the last day of the end of the educational experience.

Results from individual evaluations of residents’ cognitive skills and examination of clinical skills will become part of the resident’s permanent file. The Training Director will meet in February to compile a synopsis of each resident’s performance. This will be presented to the Committee who will vote on resident reappointment in February no later than the 3rd Tuesday of February. Residents will be notified of the Committee’s decision within one week. Evaluation materials that are received by the Training Director must be made available to the resident and discussed with him/her before they become part of that resident’s file. The resident will be invited to respond, and any written response will also be entered into the file.

There shall be evaluations by residents of all faculty members participating in the Program. Evaluations will be completed by residents by the last day of rotations and seminars and will be submitted to the office of Residency Training. Evaluations of individual faculty supervisors will be collected yearly and are due by the last day of June. Credit will be given when evaluations are turned in and evaluations will be collated anonymously.

The Residency Training Office will notify the department Chairman’s office if there is a delay in the evaluation process by the faculty or residents.

XV. CREDIT FOR RESIDENCY TRAINING

Policy:
There shall be procedures regarding credit given for residency training.

Procedure:
Credit for each month shall be given independently if performance is satisfactory as judged by the Committee. “Satisfactory performance” is taken to mean satisfactory evaluations from all activities during
that period of time. If a resident leaves the Program before a rotation is completed, credit might be denied for all or part of that rotation.

Credit will be given only after all chart work and academic requirements are completed.

After all sick leave and accrued vacation time has been used, credit will not be given for periods when the resident is absent from the Program and such time must be made up at the end of the year or the last year of residency.

A resident-initiated request for anything less than full-time credit must be in writing and contain a justification along with an explicit description of the proposed part-time schedule. Part-time credit will be given only when the request has been approved by the Committee prior to any schedule change.

XVI. CONTINUATION OF RESIDENT IN PROGRAM

Policy:
The Committee, as described in Section II, shall make recommendations each year on a scheduled basis as to whether each resident is to be continued in the Program. Before the Committee comes to any final conclusion about the resident, the resident shall always have the opportunity to request a meeting with the Committee.

Procedure:
The Committee shall meet to determine whether each resident will be offered a new contract and will continue in the Program. This decision will be made no later than the 3rd Tuesday in February prior to contract renewal which occurs by March 1. If a resident is in danger of not being reappointed because of poor performance, administrative action described under the procedures for corrective actions in this manual (Chapter XXII) should be taken. All aspects of the resident’s clinical and academic assignments should be considered before promoting a resident. This information will be presented to the Residency Training Committee. A majority vote of the Committee will determine whether or not a resident will be continued. The Training Director, upon the Resident’s graduation, will affirm in the training record that there is no documented evidence of unethical or unprofessional behavior, or of serious question of clinical competence. Where there is such evidence, it will be comprehensively recorded, along with the responses of the trainee.

XVII. ELECTIVES

Policy:
PGY-4 residents shall have time available for elective activities.

Procedure:
Elective proposals, including supervisory arrangements and a justification of the relevance of the elective to psychiatric training, shall be presented by the resident in writing (with signatures of approval of involved people, including noted supervisor and Resident Advisor) to the Residency Training Director for approval. Off-campus Electives must meet conditions outlined in UTMB Hospitals – General Information for Housestaff, Section 1 P.

PGY-4 residents will have up to six months of elective time.

All clinical and research electives should be adequately supervised and all UTMB policies regarding research must be followed.

XVIII. ADDITIONAL EMPLOYMENT

Policy:
There can be no pay offered for residents’ services other than the approved University stipend during the regular working hours of 8:00 a.m. to 5:00 p.m., Monday through Friday, or at any time the resident is on first or second call. Any additional UTMB or non-UTMB employment must have written approval from the Training Director.

Procedure:
Written prior approval must be obtained from the Training Director’s office for any additional employment outside regular working hours. A form for this request is available in the Residency Training office and will
include a full description of the proposed nature, hours, employer, and location of the activity, source of malpractice insurance; this information must be updated when appropriate.

**XIX. MOONLIGHTING**

**Policy:**
Because residency education is a full-time endeavor, the program director ensures that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. Psychiatry residents may engage in moonlighting only with the explicit, written permission of the Program Director.

**Procedure:**
The program director complies with the sponsoring institutions written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III.D.1.k.

Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor’s primary clinical site(s), i.e., internal moonlighting, is counted toward the 80-hour weekly limit on duty hours.

Those engaging in moonlighting activities must provide a copy of evidence of independent licensure by the State of Texas. The Training Director, with approval from the Committee, may at any time require a decrease or termination of the activity if it is believed that the additional employment interferes with a resident’s performance.

**XX. OVERSIGHT**

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

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

**XXI. TRAVEL AND BOOK ALLOWANCE**

**Policy:**
The department will support whenever possible the professional development of residents by facilitating attendance at professional meetings and the purchase of professional literature.

**Procedure:**
The department will provide an annual allowance of at least $1,000 for PGY-1 residents and $500 per resident, for PGY-2’s, PGY-3’s and PGY-4’s for travel and/or books depending upon the availability of funds. This allowance cannot be carried over to the next year if not used.

**XXII. SPECIAL HARDSHIPS AND PRESSING FINANCIAL NEEDS**

**Policy:**
There shall be a mechanism for appeal by residents to the Committee when conditions of special hardships and/or pressing financial needs occur.

**Procedure:**
If a resident finds himself or herself in a condition of special hardship and/or pressing financial need, the resident may contact the Training Director in writing, delineating the circumstances. The resident should also speak directly to the Training Director or the Committee. The Director will consider the problem in closed personnel session and offer suggestions and/or recommendations. If the circumstances in question impair the resident’s ability to participate in the training Program or interfere with the care of patients, the
Committee may require some resolution of the difficulties before the resident continues in these activities. This would, however, be regarded as a corrective action.

XXIII. LEAVE CATEGORIES FOR HOUSE STAFF

POLICY:
To define leave categories for house staff.

PROCEDURE:
This section will clearly define leave categories

1. Categories simply listed as a regular work day (with covering travel request as appropriate)
   i. Educational leave for medical meeting without a resident presentation – maximum of five (5) days per year.
   ii. Additional educational leave for medical meetings at which resident presents – maximum of five (5) additional days per year
   iii. USMLE Exam – maximum of three (3) days during program for first-time takers only
   iv. Preparation Course of USMLE Exam – additional five (5) days for first-time takers (may be granted at the discretion of training director)
   v. Specialty certification or recertification exam – maximum of three (3) days each for oral and written components for first-time takers only.
   vi. Job Interviews – maximum of six (6) days total during residency
   vii. Department recruitment trips at Program Director’s request – maximum of five (5) days per year

XXIV. VACATION

Policy:
The Department shall encourage vacation for its residents in accordance with UTMB regulations
Vacation accruals and carry overs are dictated by the University Policy

Procedure:
1. Requests for short vacation periods should be submitted and all approval signatures obtained at least one month prior to the leave occurring. (Forms for vacation & sick leave are kept in the room where the mailboxes are – if you take the last one, please notify the Residency Training office).

2. Vacation requests for continuous periods greater than two weeks must be submitted at least three months in advance and approved by the Residency Training Committee. If extenuating circumstances prevent the required advance notice, the Director may approve the request in writing.

3. No vacation may exceed two continuous weeks during each of the first two years without the Director’s written approval. In general, only one resident from any post graduate year class will be on vacation at any time.

4. Vacation should not be requested while assigned to primary care or neurology rotations.

5. In general, only one resident from any post graduate year class will be on vacation at any time. Vacation may not exceed 10 working days in the 6-month periods, July-December and January-June, without approval from the Training Director. Vacations for the month of June should be requested in April for consideration by the Training Director.

XXV. ILLNESS

Policy:
When unable to work because of illness, residents shall use accrued sick leave and vacation time.

Procedure:
1. When unable to work because of illness, residents are required to notify the residency training office at 747-9786. The Residency Training Office will notify your rotation supervisor. Please note: You may call in to your rotation or supervisor, but you must still notify the Residency Training Office.
2. Sick leave may be taken for personal illness or for illness in the immediate family (spouse & children, father or mother). If you call in sick, a leave form will be placed in your box for signature. When you return, please sign and turn in to Residency Training office.

3. Sick leave may be used for doctor’s appointments. (These forms must be completed in advance). Please fill out the request form, obtain appropriate signatures, and turn in to Residency Training office.

4. If a resident whose name appears on a call schedule already issued should become ill, s/he will be required to obtain coverage for that call. If the resident is unable to do so, arrangements will be made on the resident’s behalf and the resident will be required to pay back call taken in his/her place.

5. In the event of illness, the resident shall notify the appropriate Service Chief and the Residency Training Director. Unless the resident is physically unable to do so, s/he shall arrange coverage for the first seven days. After the first week, coverage shall be arranged by the General Psychiatry Chief Resident. Sick leave may be taken for personal illness or for illness in the immediate family (spouse and children). On the day of return from sick leave, the resident must complete a House Staff Leave Request.

There is no separate policy or benefit for maternity leave or paternity leave. The policy for sick and maternity/paternity leave is delineated in the “General Information for Housestaff, Section IIK”, and based on conditions and terms of the Family Medical Leave Act.

Every effort will be made by the Director in arranging the resident’s schedule and Program so that pregnancy leave does not interrupt major inpatient rotations or required rotations on other services such as primary care and neurology.

XXVI. ADMINISTRATIVE LEAVE

Policy:
A resident may request or be placed on administrative leave under warranted circumstances.

Procedure:
On written request to the Director, all residents may be granted up to five days of leave with pay annually for professional development. Any unused days cannot be carried over to the next year. Any resident attending an educational conference must have an official travel request form executed by the Department’s administrative office.

Residents desiring a leave of absence should apply in writing to the Training Director indicating the reason and the length of time for the request. The Training Director may grant or deny leave. Residents may appeal a denial of leave to the Committee. Leave may be granted with or without pay, for a period up to one week; extensions longer than one week must also have the approval of the Committee. If the period of approved leave is more than one week, the Training Director will determine whether the additional leave will be charged to vacation time or will be taken without pay, and whether the resident’s training must be extended for a similar period. The UTMB House Staff office will be informed of leaves of absence and conditions relative thereto as per UTMB Hospitals-General Information for Housestaff, Section II. No administrative leave pay will be granted to a resident on probation.

Reentry to the Program at the conclusion of a leave of absence longer than one week shall require prior approval by the Committee. The Committee may require a resident who has been on leave of absence to be interviewed by all or some Committee members before a decision is made regarding the reentry of that resident into the Program. The Training Director may require additional independent evaluations of the resident by individuals who are not members of the Department.

XXVII. CORRECTIVE ACTIONS AND ASSURANCE OF DUE PROCESS

Policy:
In matters requiring administrative action involving residents, the Department and UTMB shall provide for clear notice, specific statements of deficiencies, opportunity for clarification, and fairness to the resident concerned.

Procedure:
Any faculty member identifying a problem in a resident’s performance should meet with the resident and state expectations for remediation. If the problems are repetitive or sufficiently serious, a faculty member will send a letter to the Training Director, with a copy to the resident, describing the specific problem(s)
and a summary of all previous meetings with the resident. Clear indication should be given as to the present and possible future impact of the deficiencies on patient care or professional competency. If the issue involves behavior that could endanger patient welfare or seriously damage the institution’s professional reputation, the Training Director must also inform the Chairman. In exceptional circumstances, the Training Director with only the department Chairman’s approval may place a resident on mandatory leave of absence for a period not to exceed one week. Suspension of a resident for any longer period requires prior approval by the Committee. If a resident is urgently relieved of duties, the Associated Dean for Graduate Medical Education will be notified; then within 10 days the resident must be given a written statement from the Training Director or their designee containing a description of deficiencies and a plan for remediation. This will be deemed a corrective action which will need to be approved by a majority vote of eligible Committee members and the Associate Dean for Graduate Medical Education will be notified.

On receipt of a letter of deficiency, the Training Director will schedule a meeting with the resident, the Resident Advisor, and any faculty members involved. The Training Director then has the option of presenting the problem to the Committee at the next regularly scheduled meeting or calling a special meeting. Committee members and the resident involved must be given at least two days notice of a specially called meeting. The resident has the option of attending this meeting or may be required to attend by the Training Director. The resident as well as the Training Director may request the presence of any additional faculty member, resident or staff member to help clarify the facts. At the completion of this process, the resident and all non-Committee members will leave and the Committee may then decide on a recommended course of action. All faculty members involved in the situation in question will abstain from the deliberations, unless asked to participate by the Training Director.

The Residency Training Committee, as described in Section II, Items E and F, can recommend by majority vote one of two actions: 1) Exoneration, if there is insufficient evidence of any deficiencies in performance; 2) Probation for a clearly specified period, during which time the resident must provide clear evidence of having remedied the specific deficiencies. The Training Director will notify the Institutional Office of Graduate Medical Education of the probationary status of a resident as well as any faculty who will be working in a clinical setting with the resident. The decision to inform other personnel who have a need to know will be at the discretion of the Training Director or their designee. At the end of the stipulated probationary period, the Committee will review the resident’s progress: if the deficiencies have not been satisfactorily cleared, the resident faces renewal of the probation or outright dismissal.

The Residency Training Committee, with at least three-fourths of the members, eligible to vote on disciplinary issues, present can at any time recommend by a two-thirds vote dismissal of the resident.

All Committee recommendations are to be forwarded by the Training Director to the department Chairman. Procedures regarding probation and corrective actions as outlined in the UTMB Hospitals-General Information for Housestaff, Section III – Due Process and Grievances will be followed. Residents may challenge probationary status and/or termination decisions by the procedures outlined in the UTMB General Information for House Staff, Section III F and H.

XXVIII. PERSONNEL AND EVALUATION FILES

Policy:
A personnel file and an evaluation file will be kept on each resident.

Procedure:
A personnel file and an evaluation file will be kept on each resident in a locked cabinet in the Residency Training Office. Residents must be notified of all materials entered in their files. Residents may submit comments to be included in their files at any time. Within the limits of state and federal laws all documents in these files are permanent and may not be expunged. Files will be available for review only by the resident, Resident Advisor, faculty members of the Committee, the Vice-Chair and Chair of psychiatry, and the Vice President of Hospital Affairs. All files must be examined in the Residency Training Office or the Chairman’s Office. Access to personnel files by any other individuals must be via procedures with regard to personnel records established by the University of Texas Medical Branch.
XXIX. EXCEPTIONS

Policy:
Residents may request exemptions from these policies and procedures under unusual or exceptional circumstances.

Procedures:
Residents requesting an exception to any of these policies shall submit the request in writing to the Training Director. The Training Director may approve or deny the request with or without the advice of the Committee. Should the resident disagree with the decision, he/she may appeal to the Committee and then to the Chairman, whose decision shall be final and binding.

XXX. ADDITIONS AND AMENDMENTS

Policy:
These Policies and Procedures may be amended or added to.

Procedure:
These Policies and Procedures may be amended only by a vote of members of the Committee and with the consent of the department Chairman and the Training Director or Associate Training Director. All residents and faculty must be notified in writing of any proposed amendments at least 14 days prior to the final vote. Any modifications will become effective no earlier than one month after final approval.

XXXI. Actions or Procedures not specified in the General Psychiatry Residency Training Program Policies and Procedures

Any actions or procedures not defined in this policy and procedure manual are left to the discretion of the Training Director with the approval of the department Chair.

XXXII. Emergency Situations

Whenever, the UTMB Emergency Preparedness Plan is invoked, it supersedes all Policies and Procedures in place under usual work conditions.

Addendum A

ACGME House staff Duty Hours and the Working Environment

VI. Resident Duty Hours in the Learning and Working Environment
VI.A. Professionalism, Personal Responsibility, and Patient Safety
VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.
VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.
VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.
VI.A.4. The learning objectives of the program must:
VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,
VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.
VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and
acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;
VI.A.5.b) provision of patient- and family-centered care;
VI.A.5.c) assurance of their fitness for duty;
VI.A.5.d) management of their time before, during, and after clinical assignments;
VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;
VI.A.5.f) attention to lifelong learning;
VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,
VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

VI.A.6. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.
VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the healthcare team of attending physicians and residents currently responsible for each patient’s care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.

VI.D. Supervision of Residents

VI.D.1. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care.

VI.D.1.a) This information should be available to residents, faculty members, and patients.
VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient’s care.
The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

Supervision may be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

Levels of Supervision

To ensure oversight of resident supervision and graded authority and responsibility, the program must use the following classification of supervision:

- Direct Supervision – the supervising physician is physically present with the resident and patient.
- Indirect Supervision:
  - With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
  - With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

- The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.
- Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.
- Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

- Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.
- In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee will describe the achieved competencies under which PGY-1 residents progress to be supervised indirectly, with direct supervision available.]
VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

[Optimal clinical workload will be further specified by each Review Committee.]

VI.F. Teamwork

Residents must care for patients in an environment that maximizes effective communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty.

[Each Review Committee will define the elements that must be present in each specialty.]

VI.G. Resident Duty Hours

VI.G.1. Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

VI.G.1.a) Duty Hour Exceptions

A Review Committee may grant exceptions for up to 10% or a maximum of 88 hours to individual programs based on a sound educational rationale.

VI.G.1.a).(1) In preparing a request for an exception, the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.

VI.G.1.a).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution’s GMEC and DIO.

VI.G.2. Moonlighting

VI.G.2.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.

VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

VI.G.4. Maximum Duty Period Length
VI.G.4.a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.

VI.G.4.b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.

VI.G.4.b).(1) 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 must be no longer than an additional four hours.

VI.G.4.b).(2) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

VI.G.4.b).(3) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

VI.G.4.b).(3).(a) Under those circumstances, the resident must:

VI.G.4.b).(3).(a).(i) appropriately hand over the care of all other patients to the team responsible for their continuing care; and,

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.

VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

VI.G.5.

VI.G.5.a) Minimum Time Off between Scheduled Duty Periods

PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

VI.G.5.b) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

VI.G.5.c) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

VI.G.5.c).(1) 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 [as defined by the Review Committee] 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.
VI.G.5.c).(1).(a) 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.

VI.G.6. Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

[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 Review Committee.]

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

VI.G.8. At-Home Call

VI.G.8.a) 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 weeks.

VI.G.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

VI.G.8.b) 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”.

Addendum B-

ACGME House staff Duty Hours and the Working Environment
Specialty Specific for Psychiatry

VI.D.1. Only licensed independent practitioners as consistent with state regulations and medical staff bylaws may have primary responsibility for a patient.

VI.D.5.a).(1) PGY-1 residents may progress to being supervised indirectly with direct supervision available only after demonstrating competence in:
   a) the ability and willingness to ask for help when indicated;
   b) gathering an appropriate history;
   c) the ability to perform an emergent psychiatric assessment; and,
   d) presenting patient findings and data accurately to a supervisor who has not seen the patient.

VI.D.1.b) Both the junior resident and supervising resident should inform patients of their respective roles in that patient’s care; and,

VI.D.4.c) Assignment is based on the needs of each patient and the skills (demonstrated competency in medical expertise and supervisory capability) of the individual supervising resident. This includes the supervision of PGY-1 residents by PGY-2 residents. An attending physician must always be available to provide back-up supervision, which may be by phone. Other non-physician, licensed, independent practitioners designated by the program director may supervise residents. An attending physician must be available to provide back-up supervision as appropriate and as needed.
VI.F. Contributors to effective interprofessional teams include consulting physicians, psychologists, psychiatric nurses, social workers, and other professional and paraprofessional mental health personnel involved in the evaluation and treatment of patients.

VI.G.5.b) PGY-2 residents are considered to be at the intermediate level.

VI.G.5.c) Residents at the PGY-3 level or beyond are considered to be in the final years of education.

VI.G.5.c).(1) There are no circumstances under which residents in the final years of education may stay on duty with fewer than eight hours off.

VI.G.6. Residents should not be scheduled for more than four consecutive weeks of night float during the required one-year, full-time outpatient psychiatry experience. Residents should not be scheduled for more than a total of eight weeks of night float during the one-year of consecutive outpatient experience.
Date:

Resident:

Faculty providing evaluation:

Yes  
No

Resident exhibits the ability and willingness to ask for help when indicated

Comments:

Resident is able to gather an appropriate history

Comments:

Resident is able to perform an emergent psychiatric assessment

Comments:

Resident is able to present patient findings and data accurately to a supervisor who has not seen the patient.

Comments:

Signature of Faculty _________________________

Signature of Resident_________________________