

2015-2016 PEDIATRIC HOUSE STAFF POLICY AND PROCEDURE MANUAL

This booklet is designed to provide the Pediatric House Officer at the University of Rochester Medical Center/Golisano Children's Hospital at Strong/Strong Memorial Hospital/Rochester General Hospital with a resume of duties, procedures, and requirements. **Please read and become familiar with this material and the Resident Manual from the Graduate Medical Education Office prior to and during the year; do not hesitate to ask us for clarification or expansion.**

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PLEASE PAY PARTICULAR ATTENTION TO THE AREAS HIGHLIGHTED IN YELLOW.

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INTRODUCTION

Welcome to the University of Rochester/Golisano Children's Hospital at Strong/Strong Memorial Hospital/Rochester General Hospital Pediatric Program. While your training may be quite rigorous, we have a flexible program that is responsive to your needs. At the same time, we have an expectation of excellence in all areas of your education and experience. Your education will rely heavily on learning acquired through the provision of patient care under appropriately graded supervision, in addition to a structured didactic core curriculum and individual scholarly activity. You will need to continue your commitment to learning by **reading**, assessing, and appropriately utilizing the medical literature, endeavors necessary throughout your career.

You should be aware that the Accreditation Council for Graduate Medical Education and the Pediatric Residency Review Committee are constantly defining new requirements for residency education. Accordingly, changes in the program have and will continue to occur. On the one hand, please be patient during transitional periods. On the other hand, **if you have constructive suggestions**, this is your training program so **please discuss your ideas with us**.

Work hard, work together, and **READ**.

EDUCATIONAL MISSION STATEMENT

*Pediatric Residency Training Program
University of Rochester Medical Center
Golisano Children's Hospital at Strong/Rochester General Hospital*

The **GOALS** of the Pediatric Residency Training Program at the University of Rochester Medical Center/Golisano Children's Hospital at Strong include:

1. To provide competency-based comprehensive training in all aspects of pediatrics such that residents completing the program will be prepared to practice independently and be competent to handle any pediatric problem in an efficient and thorough manner.
2. Pediatric residents are expected to model the ICARE behaviors: Introduce themselves; Communicate with warmth; Answer questions clearly; Respond to feelings; and, Exceed expectations.
3. To provide an atmosphere of scientific inquiry that will foster intellectual curiosity, promote habits of life-long learning and intellectual achievement, and promote the development of pediatrician/scientists.
4. To promote advocacy, communication, professionalism, and teaching skills so the graduates of our program can become leaders in the pediatric community.
5. To mandate the highest standards of ethical behavior and professionalism.
6. To remain flexible to the needs of the individual resident and to the entire resident group.

E-MAIL

The vast majority of schedules, important notices, the weekly teaching schedule, and evaluations are now sent to you electronically. It is imperative that you check your e-mail on a regular **AND PREFERABLY DAILY** basis so that you are kept up-to-date about your residency training at all times.

You will also, at times, receive notices in your mailbox. It is also essential that you check your mailboxes on a regular basis.

MEDHUB

MedHub is our electronic evaluation and administrative data collection system. In this system, you will be expected to log your completed procedures, log work hours, complete evaluations, and upload portfolio documents. Here is the link:

By in large, all communication from the GME office will be posted in MedHub. All rotation goals and objectives will be located in MedHub. Most program announcements will be posted in MedHub. **As such, you should be logging into MedHub daily.**

MOONLIGHTING

A statement of departmental policy concerning moonlighting by house staff members and fellows is provided below. This was formulated after discussions with past chief residents, the department's division chiefs, and the University of Rochester Strong Memorial Hospital Medical Center administrators in the interests of: 1) maximizing the personal educational experiences of house officers and fellows and of the medical students they teach; 2) maintaining levels of excellence in the delivery of pediatric patient care at The Golisano Children's Hospital at Strong and Rochester General Hospital; 3) protecting house officers, fellows, the two hospitals, and the University from malpractice litigation; and 4) remaining in compliance with the N.Y. State 405 work hour regulations.

PL-1s:

Moonlighting is not allowed.

PL-2s and PL-3s:

Moonlighting is strongly discouraged.

If, despite this, a resident decides to moonlight, the following conditions must be met:

- A. **Moonlighting must be PRE-APPROVED by the Director of the Pediatric Resident Training Program in writing (forms available in the Department's office – see Piera Inglese) of the resident's moonlighting plans, including sites and schedules.** Any moonlighting without consent of this individual is unapproved. Unapproved moonlighting and some approved moonlighting will not be covered by the University's medical malpractice insurance. (Please see malpractice coverage.)
- B. Moonlighting will not result in > 80 hours of total work/week. (Moonlighting counts towards work hours).
- C. All NY State 405 regulations must be followed (see page 14).
- D. Moonlighting will not be allowed during NICU, PICU, or ED rotations.
- E. A weekly moonlighting schedule shall not exceed one night or weekend day.
- F. Moonlighting the evening or night prior to a scheduled night on duty at SMH or RGH will not be allowed.
- G. Residents cannot expect to leave the floors, clinics or electives early or arrive late because of a moonlighting commitment. This means that at least 1 resident from each ward or team should be available until 6 P.M. or later, if needed, to finish the day's work.
- H. Residents may not miss elective time as a result of moonlighting.

- I. Moonlighting schedules **MUST** be provided prior to moonlighting shifts to the program director continually and in advance or moonlighting privileges will be revoked.
- J. Please review the moonlighting policy in the Graduate Medical Education Resident Manual, especially regarding malpractice coverage.
- K. A valid NY State medical license is required for moonlighting. You cannot use your residency DEA suffix for moonlighting (you need to apply for your own DEA).
- L. **Moonlighting overnight prior to a required day rotation is a violation of the work hour regulations.**

Fellows:

Moonlighting is strongly discouraged.

If, despite this, a fellow decides to moonlight, his or her fellowship program director and the chairman of the department must be informed, in writing, of the fellow's moonlighting plans, including sites and schedules. Unapproved moonlighting and some approved moonlighting will not be covered by the University's medical malpractice insurance.

* Moonlighting includes all medical practice that occurs outside residency or fellowship program curricula, whether or not payment is received or services rendered. Anyone moonlighting or working as a volunteer physician in a community facility must have a temporary or permanent New York State License.

MALPRACTICE INSURANCE

Malpractice insurance coverage is provided for pediatric house staff for activities within the scope of the Graduate Medical Educational Program. Specifically, Strong Memorial Hospital provides coverage for educational activities at Strong, Rochester General Hospital, and in the community. These coverages do not apply to any activities outside of your assigned duties in the program, and in particular do not apply to any moonlighting or other extracurricular professional activities. If you engage in approved outside professional activities, you must arrange for professional liability coverage with the outside employer. **Electives taken elsewhere as well as locum tenens are covered by Strong Memorial Hospital malpractice insurance provided the experience has been pre-approved by the Program Director as an educational experience. Coverage is not available during vacations, disability leaves, suspension, leaves of absence, or any inactive status. It is essential to check malpractice coverage whenever you moonlight.**

Questions about malpractice insurance should be directed to the Office of Counsel to the medical center (758-7602). Any potential malpractice claims should also be reported to the Office of Counsel (ask for the on-call risk management staff person).

RESPONSE TO LAWYERS AND INSURANCE COMPANIES

House Staff responses to lawyers and insurance companies made independently of those made by the attending physicians on the case are not appropriate and are not permitted. Therefore, any requests from lawyers or insurance companies received by a House Officer should either be directed to the attending physician or reviewed and signed off by the attending physician and the Office of Counsel prior to submission to the requestor. Likewise, any patient-related contacts with law enforcement personnel should be discussed with the SMH Legal Affairs Office Personnel (ext. 758-7611), and with the attending physician. Any questions regarding this policy or procedure should be directed to the Office of Counsel (ext. 758-7613).

RESIDENT SUPERVISION

- A. Every patient who is admitted to the pediatric service has his/her own attending physician of record who supervises the residents in the work-up and management of that patient.

- a. Residents and attendings inform patients of their role in the patient's care.
 - b. Supervising faculty delegate the appropriate level of patient care authority and responsibility to residents.
- B. The resident is responsible for knowing the limits of his/her scope of authority. In the Ambulatory Clinic, preceptors supervise one to four residents in every clinic including subspecialty experiences. The attendings review every patient with the residents and sign the residents' note.
 - C. In the Neonatal Intensive Care Unit and Pediatric Intensive Care Unit, there are attending faculty members who are responsible for every patient. The faculty members supervise the residents in their care of the patients.
 - D. In the Pediatric Emergency Department, one to two members of the Emergency Medicine faculty are on duty at all times to supervise the residents seeing patients.
 - E. While the residents are on subspecialty services, they are supervised by the subspecialty attending faculty.
 - F. When residents are assigned to night team or baby float duty, they are supervised by the admitting physician of record, intensive care unit, or emergency room attending faculty.
 - G. All interns have direct supervision available or immediately available.
 - H. Upper level residents, R-2s, R-3s, or R-4s supervise pediatric interns as they go through their daily activities. They also supervise them in all procedures until such time as the program directors credential the intern to carry out a given procedure without direct supervision. The privilege of progressive responsibility in patient care delegated to each resident is assigned by the program director and faculty.
 - I. All pediatric residents supervise the activities of medical students in conjunction with the assigned attending faculty member.
 - J. An in-house attending is always available in the Emergency Department and in the PICU to assist with emergencies.
 - K. Patient care-related problems will always be discussed with the pediatric attending of record. Unresolved problems, interspecialty differences, and administrative difficulties should be addressed with the chief residents as well as the attending physician of record followed by the inpatient director, the chief of service, the associate chair for clinical affairs or the inpatient director, Lauren Bruckner, M.D., and finally the chair of pediatrics.
 - L. One of the pediatric program directors is always available to discuss and resolve resident-related issues.

PATIENT AND FAMILY COMMUNICATION

Effective communication is a requisite skill for success in any endeavor. During residency training, appropriate interaction and communication with patients, their families, and the professional staff is a necessary competency for certification by the American Board of Pediatrics. In addition, four very important expectations concerning communication are noted below:

1. Pages should be answered immediately and certainly within 3 to 5 minutes. If you are unable to answer the page yourself, ask a colleague or one of the staff members to answer for you.

2. Communicate with the attending physician of your patient on a regular basis and immediately with the development of a major change in your patient's status. Try to put yourself in the shoes of the attending to understand the importance of keeping the attending fully informed.
3. Patient confidentiality should be maintained at all times. Patient care discussions should NOT occur in hallways, the cafeteria, or other public locations.
4. There is an inherent reluctance to bring problems about your residency training to the program directors, apparently because of a fear of being labeled as a complainer. This is an unfounded concern. The program directors are in their positions to assist you in all aspects of your training. Please share with us any concerns or suggestions that arise about your training. Two other groups to which concerns or suggestions may be addressed are the chief residents and members of your House Staff Committee.

CODE OF CONDUCT

Policy

It is a stated Value of Strong Memorial Hospital that we treat each other with personal and professional respect while focusing on our institution's Mission Statement. Strong Memorial Hospital is committed to maintaining a collaborative environment of integrity, fairness, and compassion in all interpersonal contacts. To that end, we strive to provide a workplace that is free from harassment and/or discrimination. This includes behavior that could be perceived as inappropriate, harassing, or that does not meet the highest standards of professionalism.

Description

The purpose of the *Code of Conduct Policy* is to clarify the expectations of all staff when interacting with other persons. This policy is intended to promote appropriate conduct and to address conduct that does not meet this institution's behavioral standards. In dealing with incidents of inappropriate conduct, the protection of all staff, patients, and other persons at the Hospital and its orderly operation are primary concerns. In addition, the well being of the staff person whose conduct is in question is also of concern. This policy defines a process for addressing disruptive behavior at Strong Memorial Hospital. All individuals working at Strong Memorial Hospital must treat others with respect, courtesy, and dignity, must protect all persons within these facilities from behavior that does not meet this expectation, and must report immediately conduct that is disruptive or otherwise inappropriate.

1) General Expectations of all Staff:

Each person working within Strong Memorial Hospital must endeavor to maintain the highest quality of conduct, refraining from behaviors that may be reasonably considered offensive to others or disruptive to the workplace or patient care. All Strong Memorial Hospital staff are subject to the expectations and consequences of this policy.

Integral to interactions in the workplace is active communication. Communicating actively means that through language and discourse, people either accept or contest each other's statements until they have reached an understanding of an issue. Disagreements among individuals are expected to be handled with courtesy, respect, and dignity for one another.

2) Definition of Disruptive and Inappropriate Behavior:

Disruptive behavior is an aberrant style of interaction with staff, patients, family members, or others that could interfere directly or indirectly with patient care, daily operations and/or staff satisfaction. The definition includes, but is not limited to, threatening, demeaning or abusive language, loud or obscene comments, inappropriate or unprofessional physical contact or gestures, or offensive comments or action based on gender, race, ethnicity, religion, disability, or sexual orientation.

- 3) Addressing Disruptive and Inappropriate Behavior:
 - a. Physicians, nurses, and other Hospital and University employees who are involved in or who observe disruptive behavior in the Hospital are expected to report the incident immediately.
 - b. Incidents should be documented and reported according to existing Strong Memorial Hospital and University of Rochester Personnel Policies/Procedures or Medical Staff Bylaws as appropriate to the reporting individual through the on-line QUANTROS system anonymously.
- 4) Consequences of Failure to Comply with Policy:
 - a. Investigation of reports of disruptive behavior shall be in accordance with existing Strong Memorial Hospital and University of Rochester Personnel Policies/Procedures and/or Medical Staff Bylaws.
 - b. Should any disciplinary measure be applied after investigation, such measures and any appeal mechanisms shall be as described in existing Strong Memorial Hospital and University of Rochester Personnel Policies/Procedures and/or Medical Staff Bylaws.

PROFESSIONALISM

The Components of Professionalism listed below are from a consensus statement on professionalism from the Association of Pediatric Program Directors.

Components of Professionalism

1. Honesty/integrity is the consistent regard for the highest standards of behavior and the refusal to violate one's personal and professional codes. Honesty and integrity imply being fair, being truthful, keeping one's word, meeting commitments, and being forthright in interactions with patients, peers, and in all professional work, whether through documentation, personal communication, presentations, research, or other aspects of interaction. They require awareness of situations that may result in conflict of interest or that result in personal gain at the expense of the best interest of the patient.
2. Reliability/responsibility means being responsible for and accountable to others, and this must occur at a number of levels. First there must be accountability to one's patients, not only to children but also to their families. There must also be accountability to society to ensure that the public's needs are addressed. One must also be accountable to the profession to ensure that the ethical precepts of practice are upheld. **Inherent in responsibility is reliability in completing assigned duties or fulfilling commitments.** There must also be a willingness to accept responsibility for errors.
3. Respect for others is the essence of humanism, and humanism is central to professionalism. This respect extends to all spheres of contact, including but not limited to patients, families, other physicians, and professional colleagues, including nurses, residents, fellows, and medical students. One must treat all persons with respect and regard for their individual worth and dignity. One must be fair and nondiscriminatory and be aware of emotional, personal, family, and cultural influences on patient well-being and patients' rights and choices of medical care. It is also a professional obligation to respect appropriate patient confidentiality.
4. Compassion/empathy is a crucial component of the practice of pediatrics. One must listen attentively and respond humanely to the concerns of patients and family members. Appropriate empathy for and relief of pain, discomfort, and anxiety should be part of the daily practice of medicine.

5. Self-improvement is the pursuit of and commitment to providing the highest quality of health care through life-long learning and education. One must seek to learn from errors and aspire to excellence through self-evaluation and acceptance of the critiques of others.
6. Self-awareness/knowledge of limits includes recognition of the need for guidance and supervision when faced with new or complex responsibilities. One must also be insightful regarding the impact of one's behavior on others and cognizant of appropriate professional boundaries.
7. Communication/collaboration is critical to providing the best care for patients. One must work cooperatively and communicate effectively with patients and their families and with all health care providers involved.
8. Altruism/advocacy refers to unselfish regard for and devotion to the welfare of others and is a key element of professionalism. Self-interest or the interests of other parties should not interfere with the care of one's patients and their families.

POLICY ON PROFESSIONAL MISCONDUCT

For purposes of this policy, professional misconduct is defined as any behavior that is defined as professional misconduct under New York Public Health and Education Laws. **Residents are held to the same standards of conduct as other physicians and dentists, whether or not they are licensed in New York State.** Professional misconduct includes but is not limited to the following:

- Obtaining a license fraudulently
- Practicing fraudulently, beyond authorized scope, with gross incompetence, with gross negligence on a particular occasion or negligence or incompetence on more than one occasion
- Practicing while impaired by alcohol, drugs, physical disability, or mental disability
- Being convicted of a crime under New York State law, Federal Law, or the law of another jurisdiction which would constitute a crime in New York State
- Accepting or performing professional responsibilities which the practitioner knows he/she is not competent to perform
- Delegating professional responsibilities to a person when the practitioner knows or has reason to know that such person is not qualified to perform them
- Refusing to provide professional services because of a person's race, creed, color, or ethnic origin
- Abandoning or neglecting a patient in need of immediate professional care
- Performing professional services which have not been authorized by the patient or his/her representative
- Willfully harassing, abusing, or intimidating a patient, either physically or verbally
- Altering or falsifying medical records in such a way that needed information for patient care is omitted or falsified

While anyone may report possible professional misconduct by physicians or dentists to the appropriate New York State Office, Public Health Law requires that physicians report suspected cases of misconduct. Reporting to the hospital's peer review mechanism or reporting directly to the OPMC will satisfy this obligation.

A resident who is concerned about professional misconduct on the part of another health care provider, or anyone with concerns about professional misconduct on the part of a resident, is encouraged to report the concerns to the Department Chair or the Chief Medical Officer of SMH (Raymond Mayewski, M.D.). The Office of Counsel of the Medical Center will work with the department chair or Chief Medical Officer to investigate the concern.

If it is determined that misconduct has occurred on the part of a medical resident as described above, the SADGME will report such misconduct to the OPMC. In addition, the SADGME will report to the OPMC or the OPD, as appropriate, if any of the following occur:

1. The suspension, restriction, termination or curtailment of the training employment, association or professional privileges related in any way to:

- Alleged mental or physical impairment
- Incompetence
- Malpractice
- Misconduct
- Impairment of patient welfare

2. The denial of certification of completion of training for reasons related to those listed in 1.

3. The voluntary or involuntary resignation or withdrawal of association, or of privileges, to avoid the imposition of disciplinary measures.

4. The receipt of information that indicates a resident has been convicted of a crime.

If termination of a resident has been made on the basis of professional misconduct, the required probationary period of three months will be waived and termination shall be immediate.

POLICY ON EMPLOYEE BEHAVIOR BOUNDARIES WHILE WORKING WITH MINORS

All employees will have a background check prior to their first day of employment. Adult employees may not:

1. Engage in direct and personal electronic communication with minors (including but not limited to email and social media), unless another adult is included in the communication.
2. Have personal and private (one-on-one) contact with minors outside of the program.
3. Drive minors in the employee's personal vehicle unless specifically authorized in writing by parent/guardian and program administrator
4. Enter a private bathroom facility or similar area where privacy is expected without another adult present.
5. Physically assault, abuse, or inappropriately touch children.
6. Use language, make suggestions, or offer advice that is sexually inappropriate offensive or abusive.
7. Behave in a manner that is sexually provocative.
8. Act in ways intended to shame, humiliate, belittle or degrade children or otherwise perpetrate any form of emotional or physical abuse.
9. Employees shall not:
 - a. Provide alcohol or illegal drugs to any minor
 - b. Provide prescription drugs or any medication to a minor unless specifically authorized in writing by the parent/legal guardian.
 - c. Make sexual materials in any form available to minors or assist them in obtaining these materials.

Any credible allegation or reasonable concern that an adult employee may have engaged in conduct constituting sexual abuse/molestation, physical or emotional abuse of the minor will result in cessation of the employee's involvement in the Programs and Services for Minors and any other University functions requiring direct contact with minors (pending investigation).

If you suspect sexual abuse/molestation, physical, or emotional abuse, you MUST report it as soon as possible. You can report it to:

- Your immediate supervisor
- Your program administrator, chiefs, or directors
- University Security
- Human Resources
- Office of Counsel

All allegations must undergo a thorough and credible investigation led by a skilled and neutral investigator. The Medical Center's Human Resources Department must also be notified promptly using Department notification process/chain of command.

NEW PARENT POLICY

PHILOSOPHY

It is understood that residency coincides, for many people, with a time when they may be starting a family. As a department, it is our policy to support residents who are new parents. This will be accomplished through the granting of leave as needed to promote good physical and emotional health within the limits of the programs ability to continue its service and educational obligations. This is to be done by arranging coverage by other residents for new mothers and fathers with the expectation that they will make up for time missed both for their education and to keep from unfairly burdening other residents. As a group, residents need to be flexible to accommodate each others needs, recognizing the importance of working as a team and knowing that the system will balance out in the long run.

Under the Family and Medical Leave Act (PL 103-3), residents (new mothers and/or fathers) are eligible for a maximum of 12 weeks of leave around the birth or adoption of a child. [Currently 6 weeks of leave after a vaginal delivery and 8 weeks after a C-section delivery will be paid (for the mother only) by University disability insurance.] If the resident chooses to take less time, we recommend a minimum of 6 weeks. All missed time can be made up by extending residency and/or using vacation time (up to two years worth) in order to complete the required 33 months of active residency.

COMPLICATIONS

Should medical complications arise, sick mothers will be given leave as needed. Fathers will be given time off as with other illnesses with extra time arranged as needed and payback (either directly to an individual or to the program) expected. Alterations of the schedule (e.g. changing NICU rotations etc.) will be made with the help of the chief resident with plans for compensation as indicated.

DEPARTMENT OF PEDIATRICS POLICY CONCERNING RESIDENT ABSENCE RESULTING FROM ILLNESS OR OTHER REASONS AND APPROPRIATE USE OF THE PULL CALL RESIDENT

PULL CALL POLICY

Appropriate Use of Pull Call:

The purpose of this policy is to outline a fair process for dealing with unexpected absences. This policy recognizes our professional responsibility to (1) cover for one another at times of illness and true emergencies, and (2) to request coverage only under those urgent circumstances for which the request is justified. The following circumstances justify requesting coverage through the pull call system:

- 1) Personal illness of a nature that either
 - a) prevents effective duty as a physician, or
 - b) risks communication of disease to patients or other health care workers.
- 2) Unanticipated personal or family crises (such as the death or serious illness of a parent, sibling, spouse, or child).

All other circumstances **do not** routinely fall under the jurisdiction of the pull call system; for example, anticipated family/personal events (e.g., marriage, reunions, house closings, job or fellowship interviews) and unanticipated family/personal events of a non-crisis nature. In such circumstances, a resident has an obligation to fulfill his/her assignment. A resident may arrange alternate coverage by a colleague on elective and repay this at a later date. **However, such arrangement needs prior approval from the Chief Residents.**

Residents will be pulled to provide coverage for unexpected absences for the following critical services:

- Inpatient floors
- Intensive Care Rotations
- Emergency Department rotations (certain shifts)
- Outpatient/Ambulatory rotations (some days)
- Overnight rotations

In unusual circumstances, residents may be pulled to cover other services. These decisions will be made at the discretion of the Chief Residents and/or Program Director.

I. OPERATIONAL DEFINITIONS:

A. The Pull Call resident is a PGY2, PGY3, or PGY4 on Elective and a PGY1 on Newborn Nursery Rotation or Elective who is scheduled in advance to be available to cover for residents unable to fulfill patient care responsibilities on a given day.

B. It is the duty of each resident to know when he/she is scheduled for pull call, and to remain available at all times during these periods. **Inability to contact a resident during a scheduled pull call rotation will be considered an unexcused absence.**

C. Residents scheduled for pull call may trade this responsibility with other residents with the appropriate level of training. **This may only be done with prior notification of and approval by the Chief Residents.**

D. As with all residents, each Pull Call resident will receive a 24 hour period per week free of both pager call and all clinical responsibilities. Every effort will be made to rearrange schedules, to minimize the clinical burden to others and to minimize use of the Pull Call resident.

E. The American Board of Pediatrics has stated that all residents must have completed a minimum of 33 months of active residency. With one month of vacation per year, there is obviously little room for flexibility. If more than 5 days per year are missed for any reason, the resident will be required to make-up the appropriate amount of time by using vacation time or extending residency. If the Program Director determines that pull call was used inappropriately, he/she can require make-up of individual days.

II. SPECIFIC SITUATIONS:

A. Death or illness in immediate family/significant others:

1. Pull Call may be used to cover in the event of an acute need. For prolonged absence (3 days or more) the Chief Residents and the resident involved will work to arrange for further

coverage and the resident is required to meet with the Program Director. Days missed will count toward the 5 days/year maximum. If 5 or more days of a required rotation is missed, that rotation will need to be made up. For the pulled resident, that will be arranged within their schedule; for the resident needing to leave, he/she will make up the missed time at the end of residency.

B. Fellowship/Job Interviews:

1. It is the individual responsibility of all residents scheduling interviews for fellowship, jobs, etc. to arrange their own coverage during their absence and to anticipate and address the need for coverage prior to scheduling an interview. The Chief Residents will be glad to assist residents in this process. Note: It is often useful to provide multiple options for interviews to the Chiefs if you are asking for assistance. You are strongly advised to use personal days for interviews (see details in the "Leave of Absence" policy).

C. National conferences/Presentations:

1. It is the individual responsibility of all residents presenting a talk/poster/paper at a regional or national medical conference to arrange their own coverage during their absence and to anticipate and address the need for coverage prior to making travel arrangements. The Chief Residents will be glad to assist residents in this process.

D. Patient Funerals:

1. From time to time we are faced with the death of one of our pediatric patients. All residents are welcome to attend funeral/memorial services at their own discretion; however, Pull Call **will not** be used for coverage in this situation. Residents have the option to try to arrange their own coverage, but must obtain approval for any schedule changes from the Chief Residents.

E. Prolonged or Frequent Absences:

1. If a resident's *illness* results in absence for 3 or more *consecutive* days, this individual will contact the Program Director by phone on the 3rd day to explain their absence and ensure proper medical care is sought. He/she will meet with a Chief Resident and Program Director as soon as possible to discuss the impact on educational experience and residency requirements, as well as the need for additional support.

2. If a resident's *illness* results in absence for 5 or more *consecutive* days, this individual will follow guidelines above AND is required to provide a note from his or her medical care provider to ensure proper medical care is sought and to ensure that this individual does not return to work before it is medically advisable.

3. If a resident requires Pull Call coverage for 5 or more days in an academic year for any reason, he/she will meet with a Chief Resident and Program Director as soon as possible (ideally within 1 week after the 5th absence) for a discussion as detailed above.

4. Occasionally residents will experience illness or other emergencies for which it can be anticipated that they will be out for extended periods of time (i.e. major surgery)¹. At these times, the Chief Residents may be able to find suitable trades with residents not on pull call. For example, a resident scheduled for an inpatient rotation, who must be out for several weeks for surgery might trade with a resident who is on an elective at that time. The ill resident will then

¹ As described in the Leave of Absence policy, residents who are out for extended periods of time will have to make up their missed training time at a later date and either extend residency or in some circumstances may be able to use vacation time.

“pay back” the covering resident by taking an inpatient rotation in lieu of an elective later that year. The purpose of these trades is to avoid using pull call residents from their electives for extended periods of time. It must be emphasized that these trades will only occur when feasible and convenient for all concerned, including faculty and patients.

5. All time from any rotation will need to be made up if it exceeds 5 days.

F. Confidentiality:

1. All Pull Call situations are considered confidential and details will not be released to those being pulled.

III. RESPONSIBILITIES OF RESIDENT REQUESTING COVERAGE

A. If a resident feels he or she is unable to work, the resident will call and speak to the on-call Chief Resident as soon as the need arises. *Note that email and text messages are not appropriate means of communication in this instance.* This should be done in all absences regardless of the anticipated need for coverage. Excused absences are limited to those circumstances described above as justifying use of the pull call system.

B. The resident will explain to the Chief Resident the reason for absence and expected duration of absence. The program reserves the right to request appropriate documentation of the event justifying the absence, which may include a statement from the resident’s personal physician (or other care provider) regarding the presence and severity of the illness.

C. Each resident is allowed up to five (5) days of excused absences each academic year. Absences beyond this five-day limit must be made up by the resident.

D. Unexcused absences are defined as any other absence, including ordinarily excused absences for which proper notification (as above) was not made. **All unexcused absences will be made up.** A pattern of repeated unexcused absences will be brought to the attention of the Program Director, who may choose to take disciplinary action or refer the resident to the Clinical Competency Committee.

IV. RESPONSIBILITIES OF PULL CALL RESIDENT

A. A resident on Pull Call will turn his or her pager on at 8PM on the evening before their Pull Call Coverage begins. The resident is *not* on Pager Call and has *no* Pull Call responsibilities at this time. This is only to allow for early notification in the rare instance when it is known in advance that Pull Call will be needed for the following day.

1. If a resident is travelling or has an obligation which will make them unavailable by pager on the evening before their Pull Call coverage begins, he or she is encouraged to call the on-call Chief Resident to make him or her aware. This will avoid unnecessary or bothersome attempts to contact the resident. In this case, the resident needs to be available by pager at 6AM on the day they are scheduled.

2. If a resident is not reachable by pager on the evening before their Pull Call coverage begins this will not be considered a violation of professional conduct. However, if that resident is still not reachable in time to arrive at the hospital to cover for a 7AM shift on the first day of their Pull Call coverage block, the matter will be referred to the Program Director and is considered a lapse in professionalism.

B. Residents on Pull Call must be available on pager 24 hours a day (starting and ending at 6AM). The resident will return the page within 10 minutes, and arrive at the designated site within 1 hour of the page.

C. The Pull Call resident will be responsible for covering all activities and responsibilities of the resident they are covering for. This includes post-call rounding when applicable.

D. If a resident on Pull-Call is ill, has a personal or family emergency, or other matter that will keep the resident from fulfilling Pull Call responsibilities, he or she will contact the on-call Chief Resident immediately, so that appropriate back-up Pull Call coverage can be arranged.

E. If a resident is found to be unavailable for Pull Call, the Chief Residents will refer the matter to the Program Director as an unexcused absence and a violation of the professional code of conduct.

F. This is a non-payback system. A Pull Call resident who has been called in to cover may not request another resident to "pay back" that shift.

1. An exception is when coverage is required for an extended period of time and the covering resident has missed extensive elective or newborn nursery time covering one resident.

2. Another exception is when a non-Pull Call resident voluntarily covers in the case when a Pull- Call resident is unreachable or is found to be unavailable for Pull Call coverage without prior discussion with the Chief Resident. The Pull Call resident will be responsible for "pay back".

V. RESPONSIBILITIES OF CHIEF RESIDENT

A. When notified of an absence, the on-call Chief Resident will determine necessity of Pull Call activation. Every effort will be made to rearrange schedules to minimize the clinical burden to others and to minimize use of the Pull Call resident.

B. If Pull Call coverage is required, the Chief Resident will evaluate the Pull Call schedule and pull one of the two or more residents on Pull Call by taking the following into consideration:

1. Responsibilities of the shift for which coverage is required and experience of Pull Call residents

2. Year of resident requesting coverage; all efforts will be made to provide coverage using a resident of the same year of training

3. Continuity Clinic schedule

4. Previous day and following day activities/responsibilities

5. "First Pull Call" and "Second Pull Call" designations when more than one resident from a given year is on Pull Call

6. Note: To maintain continuity of patient care, coverage of a single resident's absence will be covered by a single Pull Call resident, whenever possible.

7. If all residents on Pull Call have been pulled, the Chief Resident will request that an individual who has used Pull Call most frequently provide coverage as appropriate, with the hope that this would help minimize the impact of frequent absences on this resident's

educational experience. Alternatively, the Chief Resident may ask a resident on elective if they would voluntarily provide coverage. Should there be no residents available for Pull Call, the Chief Resident on-call will fulfill the shift obligation.

C. The on-call Chief Resident will then page the selected Pull Call resident. If there is no response within 10 minutes, they will send another page, and attempt to contact the resident by phone. The Chief Resident will inform the Pull Call resident of the situation and coverage needed.

D. The Chief Residents keep a running log of who has required Pull Call coverage and will notify the program director when a resident requires Pull Call coverage for 3 consecutive days due to illness, 5 consecutive days due to illness, and 5 or more days during one academic year so that appropriate actions may be taken as described above.

RESIDENT BACK-UP POLICY

1. In the event that the supervising residents feel that either the number or acuity of patients becomes overwhelming or unsafe for patient care, the Chief Resident on call should be paged, and will facilitate additional help (Chief Resident or pull call).
2. In times of crisis (natural disaster, multi-vehicle accident, etc.) should the Chief Resident feel that either the number or acuity of patients cared for by the Pediatric team compromises patient safety, the Chief Resident should page the Chief of Service for additional resources.

RESIDENT FATIGUE

It is recognized that residency training, while intellectually stimulating, is a physically demanding process. You will be working long hours, including overnight call and night rotations. This disruption in your regular sleep-cycle may lead to fatigue.

Fatigue leads to increasing lapses of attention, declining memory, instability in alertness and vigilance and cognitive slowing. You may begin tasks well, but performance deteriorates when speed is required. Verbal processing and complex problem solving may be impaired. In addition, sleep deprivation may alter an individual's mood and lead to irritability, hostility, and indifference to interpersonal relationships.

Problems with fatigue at work may include:

1. Poor decision making and procedural skills in patient care activities
2. Poor driving skills
3. Poor overall health status

If you are experiencing fatigue as a result of your residency work hours:

1. If it is in the midst of active patient care activities, and you believe you are not able to provide optimal care to your patients, contact your supervising physician immediately. Most often this will be your senior resident or chief resident.
2. If you are becoming chronically fatigued so that your patient care activities are compromised, contact your supervising physician as above.
3. If you find that your schedule as laid out would put you in violation of the New York State Department of Health or the ACGME work hour regulations, contact your chief resident or the program director immediately. Changes in your schedule will have to be made.
4. Do not leave venues where you are actively caring for patients without first checking with your supervising physician.
5. If you feel too fatigued or otherwise unfit to travel home after your assigned shift may access

a call room to sleep or recover prior to traveling home or may take a taxi home and be reimbursed by the GME office.

THE NEW YORK STATE WORK HOUR REGULATIONS AND THE ACGME WORK HOUR REQUIREMENTS WERE DESIGNED TO MINIMIZE RESIDENT FATIGUE AND THE POTENTIAL FOR ADVERSE OUTCOMES. AT ALL TIMES, YOU MUST BE IN COMPLIANCE WITH THE WORK HOUR REGULATIONS AS STATED IN THE SECTION ON NEW YORK STATE CODE 405 REGULATIONS.

RESIDENT STRESS

Residency training is recognized as a stressful experience, in part related to long hours of work as well as the complexity and severity of the illnesses of the patients under your care. Other sources of stress include interpersonal relationships outside of the residency training program, children, illnesses, and a large burden of debt.

Chronic stress may lead to physical and emotional disturbances, poor interpersonal relationships, substance abuse, ill health, and suicide at rates greater than those in the general population.

The signs and symptoms of stress in residents may be subtle or overt, and may include physical problems, family problems, social problems, and work related problems. When confronted by a peer or by a faculty member, the resident with signs of stress, including anxiety and/or depression, may exhibit an initial response of denial. However, with persistence, most affected individuals will admit to experiencing stress and its associated signs and symptoms. If you are experiencing a level of stress or chronic stress that is interfering with your ability to care for patients and/or your life outside of the residency program, it is mandatory that you discuss your current situation with the Chief Residents and the Program Director to ensure patient safety and your overall well-being. Self-reporting is kept confidential, but, if patient safety or your health is a major concern to the Chief Residents and the Program Director, a schedule change and/or leave may be recommended. In general, recommended counseling is done through the Employee Assistance Program (EAP). The program may be contacted by calling 275-4987. Other counseling options include: CPEP – 496 White Spruce 475-0432 and Behavioral Health Partners (located in the Saunders Research Building, Suite 1302, 276-6900). All such counseling is completely confidential, but you may need to speak to the Pediatric Residency Training Program Director before resuming duties, if a schedule change was required.

The program has developed a number of methods to reduce stress during residency training. These include:

1. Adherence to the New York State Department of Health 405 Work Hour Regulations.
2. Four weeks of vacation each year.
3. A pull-call and back-up system for coverage in the event of illnesses, family emergencies, and other unanticipated events.
4. A liberal maternity leave policy, and a paternal leave policy.
5. Resident retreats.
6. Alternating stressful rotations with less-stressful rotations.
7. The night-team system.
8. Department sponsored social events.
9. Communication with the Program Director.

If a resident is recognized as experiencing a high level of stress which may affect his or her clinical duties and which may undermine his or her overall well-being, and this situation is not self-reported, in the interest of patient safety and the health of the affected resident, a member of the professional staff may report his or her concerns to the Chief Residents or the Program Director. In this instance, the resident will be asked to meet with the Program Director in a timely fashion to discuss perceived problems. The same pertains to the impaired resident.

POLICY ON RESIDENT WELLNESS AND IMPAIRMENT

The University of Rochester recognizes that drug addiction, mental disability and alcoholism are illnesses.

The University will take all reasonable steps to protect the confidentiality of the employee who seeks voluntary treatment or is referred for treatment by his/her supervisor subject to applicable legal constraints and the provisions of this policy.

Impairment is defined as “the inability to practice medicine with reasonable skill and safety due to physical or mental illness, loss of motor skills or abuse of drugs including alcohol” (American Medical Association). It is professional misconduct to practice medicine while impaired. New York State Education Law § 6530 includes within the definition of professional misconduct the following:

- (1) Practicing the profession while impaired by alcohol, drugs, physical disability, or mental disability;
- (2) Being a habitual abuser of alcohol, or being dependent on or a habitual user of narcotics, barbiturates, amphetamines, hallucinogens, or other drugs having similar effects;
- (3) Having a psychiatric condition which impairs the licensee’s ability to practice.

The Committee for Physician Health of the Medical Society of the State of New York (CPH) will provide confidential evaluation, treatment planning, and monitoring for physicians who voluntarily enroll. CPH NEVER reports participating physicians to the Office of Professional Medical Conduct (OPMC) of the New York State Department of Health **unless** the physician:

- (1) is believed to be an imminent danger to the public,
- (2) refuses to cooperate with CPH,
- (3) refuses to submit to treatment, or
- (4) impairment is not substantially alleviated through treatment.

VOLUNTARY SELF REFERRAL FOR MENTAL HEALTH OR DRUG/ALCOHOL EVALUATION IN THE ABSENCE OF PERFORMANCE ISSUES

A resident who is concerned that he/she or a colleague may have a problem may confidentially contact CPH directly (phone 518.436.4723; fax 518.436.7973; web www.cphny.org; email Terry@cphny.org) or may discuss the issue with a faculty member, the program director, the Department Chair or the Senior Associate Dean for GME (SADGME).

If a resident brings a concern about his/her own potential illness to the attention of any of these individuals, the individual so notified must notify at least one of the others, and at least two of these individuals must meet with the resident to determine an appropriate course of action. The meeting with the resident must occur as soon as possible but within two business days. For residents who require further voluntary evaluation and possibly treatment, the program director and/or Chair should notify the SADGME who will arrange for referral to CPH. A resident who has enrolled in a CPH approved treatment program may be permitted to return to work with agreement of CPH and in accordance with the “Return to Work Section” of this policy.

REFERRAL FOR DRUG/ALCOHOL EVALUATION BY OTHERS IN THE CONTEXT OF PERFORMANCE RELATED CONCERNS

When a resident is experiencing performance related problems or engaging in suspicious behavior, and illness is suspected, the program shall have the right to require the resident to undergo further evaluation.

Suspicious behavior is defined as any instance in which another resident, faculty member, other hospital employee, patient or patient's family, or other person witnesses inappropriate behavior by a resident during the exercise of his/her professional duties. These incidents may include, but are not limited to, perceived problems with judgment, behavior, speech, emotional outbursts, depression, alcohol odor or other evidence of substance abuse.

Suspicious behavior may be reported to the resident's attending physician, residency program director, or Department Chair. Reports to the resident's attending physician should be brought to the attention of the residency program director or Department Chair. Upon receiving such a report, the residency program director and Department Chair should conduct an interview with the resident within 2 business days. If both the program director and Department Chair agree that the report has no foundation and that there are no performance concerns with respect to the resident, no further action will be taken.

If the program director and Department Chair believe the report has foundation, they shall further evaluate the situation. At this point, the resident shall be provided the opportunity of enrolling in the Committee for Physician Health. If the resident refuses, the program director and Chair may require the resident to undergo further testing (psychiatric evaluation and/or drug or alcohol testing). If a decision to require testing is made, the program director or Department Chair should contact the SADGME to arrange for this testing. Results of the tests will be reported directly to the Department Chair.

The program director may allow the resident a personal leave (University Leave of Absence) or if necessary the program director may suspend the resident from clinical duties while the situation is investigated if it is felt that further training will put patients, the resident, or other hospital staff at risk. If a decision to suspend the resident during the investigation and evaluation period is made, this should be communicated in writing to the resident with a copy to the SADGME. A suspension or restriction of clinical privileges must be reported to the New York State Health Department. The Office of Counsel to the Medical Center (OCMC) must be contacted in such circumstances so it may make the appropriate report. If, after evaluation, it is believed that the resident needs further evaluation to eliminate the concern, the matter will be referred to the SADGME. The resident will be offered the opportunity to voluntarily enroll with CPH, which will arrange for an intake evaluation. The SADGME will assist the resident in enrolling in CPH.

If, after evaluation, both the program director and Department Chair determine that the resident does not require treatment or rehabilitation, they shall address the resident's performance problems in accordance with departmental evaluation standards and related institutional policies (Evaluation Policy and Disciplinary Procedures and Appeals Policy).

RETURN TO WORK

If treatment or rehabilitation is recommended by CPH, and the resident enrolls in a CPH-approved treatment program, the resident will be required to waive his/her right to confidentiality to the extent that:

- the SADGME will be notified as to whether the proposed treatment plan limits the resident's ability

to work, and if so, will be provided with a description of the limitations,

- the SADGME will be notified periodically whether the resident is participating in the treatment plan and whether treatment has been successful; and
- any other information needed by the SADGME to assess the resident's continued fitness to work.

Whether a resident will be allowed to return to work or complete his/her residency will be evaluated on a case-by-case basis, taking into consideration the recommendations of the treatment program, the limitations, if any, on the resident's ability to practice and expected duration of the limitations, whether reasonable accommodations can be made by the residency program, the circumstances that give rise to the initial report of potential impairment (i.e. whether any serious incidents or violations of law occurred), and whether patient and staff safety can be maintained.

REFUSAL TO COOPERATE

If a resident who self-reports potential impairment or is determined by his program director and Department Chair to require further evaluation refuses to enroll or remain enrolled with CPH, the SADGME will be obligated to report the resident to the OPMC. In addition, the SADGME may terminate the resident's clinical privileges and may terminate the resident from the residency program. The resident shall have the right to appeal the decision to terminate him/her from the program pursuant to the appeal procedures set forth in the Resident Disciplinary Procedures and Appeals Policy.

LEAVE-OF-ABSENCE POLICY

I. OPERATIONAL DEFINITIONS

A. Leaves of absence from the University require **at least one year** of service and a minimum of 1250 hours of work before a resident is eligible for this leave.

B. Prior to beginning your leave, you will need to speak with the Chief Residents, the Program Director, and the Program Coordinator. **The number of weeks of leave taken will be added on to the end training date and will determine the new completion date. This will be discussed with the Program Director prior to taking leave and confirmed upon return.**

C. All requests for leaves of absence (including maternity leave) or deviations from the traditional pediatric residency curriculum require prior approval from the Residency Program Director. Any resident requesting a specific schedule configuration or any form of leave is also required to submit the proposal to the rising pediatric Chief Residents before the deadline that is established each spring in order to have the request considered for incorporation into the following year's schedule. Submitting such a request after the deadline will generally not result in revision of the year-long schedule.

II. PERSONAL DAYS

A. Every resident is allowed up to 2 personal days per year, which may be used for personal obligations such as job/fellowship interviews and appointments.

B. In general, these should be scheduled 3 months in advance during non-pull electives with notification of the chief resident, the rotation attending, and the rotation supervisor. Since a resident may not know about an interview that far advance, these should be submitted as soon as possible to the Chief Residents, but at least 2 weeks in advance during non-pull electives. The chief residents will keep a tally of personal days.

III. NEW PARENT POLICY

A. It is understood that residency coincides, for many people, with a time when they may be starting a family. As a department, it is our policy to support residents who are new parents. This will be accomplished through the granting of leave as needed to promote good physical and emotional health within the limits of the program's ability to continue its service and educational obligations.

B. Coverage by other residents will be arranged for new mothers and fathers with the expectation that they will make up for time missed both for their education and to keep from unfairly burdening other residents. As a group, residents need to be flexible to accommodate each other's needs, recognizing the importance of working as a team and knowing that the system will balance out in the long run.

C. Under the Family and Medical Leave Act (FMLA; PL 103-3), residents (new mothers and fathers) are eligible for a maximum of 12 weeks of leave around the birth or adoption of a child. [Currently 6 weeks of leave after a vaginal delivery and 8 weeks after a C-section delivery will be paid (for the mother only) by University disability insurance.] If the resident chooses to take less time, we recommend a minimum of 6 weeks.

D. Should medical complications arise, sick mothers will be given leave as needed per the University disability policy. Fathers will be given unpaid time off per the FMLA policy.

E. Alterations of the schedule (e.g. changing NICU rotation) will be made with the help of the chief resident. All missed time will be made up by extending residency and/or using vacation time in order to complete the required 33 months of active residency.

IV. JOB AND FELLOWSHIP INTERVIEWS

A. **Interviews should be scheduled during vacation or elective time whenever possible.** Interviews may not be scheduled during acute care assignments (ICU, floors, or ED at SMH or RGH). Interview days should be scheduled on non-clinic days whenever possible. When non-vacation time is used, residents may take a maximum of five (5) days for job or categorical fellowship interviews. Interview days in excess of that listed above will be subtracted from vacation time.

B. All requests for permission for time off to interview must be submitted **in writing** to the program **at least two weeks prior to departure** and include the type of interview, location, and dates of time away.

C. Interview days taken which are not approved in the manner described in this policy will be treated as "unapproved absences". As described in the Pull Call policy, house officers will be required to make up unapproved absences, and disciplinary action may be taken

D. It is the **resident's responsibility to arrange for alternative on-call coverage**, if needed. Please note that residents scheduled for pull call cannot provide alternative coverage. If no coverage can be found and documented attempts to find coverage can be provided, the Chief Residents may assist in arrangements for alternative coverage.

E. The resident is also responsible for notifying and obtaining approval from his/her subspecialty preceptors, as appropriate, for time away.

V. OUT-OF-TOWN POSTERS, PRESENTATIONS, ABSTRACTS

A. Residents are encouraged to present posters, abstracts, and presentations at one national conference during residency. Prior to s

B. The Department of Pediatrics will reimburse travel, lodging, and food expenses for one out-of-town conference during the three years of pediatric residency, provided the resident is presenting at the conference. Conference attendance fees are also covered.

1. Expense reimbursement is for the resident ONLY. Expenses for non-pediatric residents are not covered (ie. family members).

2. Travel Expenses: Must be equivalent to the cost of one round-trip airplane ticket as determined by the pediatric residency office. Any travel expenses beyond this dollar amount will not be covered.

3. Lodging Expenses: Must be approved by the pediatric residency office prior to reservations being made. Residents are expected to share a room with others who may be attending the conference.

4. Food Expenses: The resident will be reimbursed for 3 meals per day while out of town. Snacks are not included. Alcoholic beverages are not included.

5. Detailed receipts should be provided to the residency office after the conference is over. Any receipts that are not detailed will not be reimbursed.

C. Here is the link to the University of Rochester's policies for reimbursement:

1. <http://www.rochester.edu/adminfinance/finance/policies/index.html>

VI. OTHER LEAVES OF ABSENCE

A. In addition to maternity leave or illness, absences from the program are permissible for a variety of reasons after discussion with the Program Director. However, there is a contractual obligation to pay back the time taken from your residency training. As previously noted, the American Board of Pediatrics requires 33 months of active residency time.

B. Unless the leave is certified as disability (e.g. 6 weeks of maternity leave), you will not be paid during your absence. Rather, hospital policy dictates that you will be paid during your payback period. Because the accounting procedures require a finite amount of time and depending upon the urgency of your request, you may see a smaller or absent paycheck the following month.

If there are any questions concerning this policy, do not hesitate to contact the program coordinator or the chief resident.

JOB AND FELLOWSHIP INTERVIEWING REQUEST FORM

Resident name (please print): _____

My interview request(s) will be as follows:

1. Time away: _____ through _____
Location: _____
Type of Interview: _____
2. Time away: _____ through _____
Location: _____
Type of Interview: _____
3. Time away: _____ through _____
Location: _____
Type of Interview: _____

Date Submitted: _____

Continuity Clinic Preceptor (if conflicts):

Chief Resident:

Approved: ____ yes; ____ no

Approved: ____ yes ____ no

Signature: _____ Date: _____

Signature: _____ Date: _____

Program Director:

Approved: ____ yes; ____ no

Signature: _____ Date: _____

Reminder to residents: It is your responsibility to:

1. Arrange for alternative on-call coverage, if needed.
2. Notify and obtain approval from your subspecialty preceptors. _____

Copies of completed forms should be sent to resident, chief resident, continuity clinic preceptor (if appropriate), and program file.

PARENTAL LEAVE REQUEST FORM

Name of resident: _____

Anticipated date when leave is to begin: _____

Requested duration of leave: _____

Chief Resident (signed): _____

Anticipated new residency completion date: _____

Approved: ___ Yes² ___ No

Program Director (signed): _____

SUPPLEMENTAL FORM FOR REQUEST FOR LEAVE OF ABSENCE

I am requesting a Leave of Absence from the University of Rochester. This will be an un-paid leave however my benefits will continue.

I understand that the appropriate amount of pay will be deducted from my paycheck. Because the timing of this request may not correspond to a payroll deadline, I authorize the appropriate amount of pay to be deducted from a pay period that may not correspond to my actual time away.

I understand that all time taken in excess of 4 weeks/year (vacation) must be made up according to the guidelines of the American Board of Internal Medicine and the American Board of Pediatrics.

Resident Signature

Date

Program Director Signature

Date

Cc: File
Payroll Office
GME office

² Approved requests should be forwarded to the resident’s continuity clinic site and program files.

PROCESS FOR REQUESTING SCHEDULE CHANGES

The following process should be followed if, after a schedule has been completed (the year long schedule or night call schedules), you wish to try to change your assignments.

1. Look at the schedule to see which of your peers might be able to switch with you and contact them to see if they are willing to do so.
 2. Once you find someone who is agreeable to changing with you, contact the chief residents with the appropriate information either by email or in writing.
 3. The chief residents will review the requests, and, based on implications for your schedule and other schedules (e.g. Continuity Clinic, Rotation sequences, other night call requirements) will approve or disapprove the request. The request then will be directed to all parties involved and schedules changed.
1. All schedule changes must result in compliance with the 405 work hour regulations.

The change of schedule request should be submitted at least 10 days before the date of the anticipated change. The further in advance you submit your request, the greater the likelihood is that a successful solution to your scheduling conflicts can be achieved. (For changes in the yearlong schedule, see the LEAVE POLICY on page 9.)

VACATION POLICY

Every Pediatric resident receives 4 weeks of vacation every academic year. Contact your chief resident(s) to request specific dates for vacation; otherwise, vacation weeks will be assigned randomly, in 2-week intervals. **Senior graduating residents cannot take vacation in the last month of residency training.**

SUSPENSION OF RESIDENT STAFF FOR DELINQUENT MEDICAL RECORDS

If a medical record remains incomplete 21 days following discharge, a letter of pending suspension signed by the Chairman of the Medical Records Committee will be mailed to the resident's home address. This letter follows two prior notifications of medical record deficiencies sent from the Medical Records Department. It is the resident physician's responsibility to routinely check his/her mailbox and email for these notifications.

Upon receipt of the letter of pending suspension it is the Clinical Department's responsibility to insure that the resident physician promptly receives the letter, as the Clinical Department is in the best position to know a resident's schedule. The physician has four days from the date of letter to complete his deficiencies. If medical records remain incomplete, a notice of suspension is delivered to the resident by the Office of the Associate Chair for Clinical Affairs. As malpractice insurance coverage as well as clinical privileges to participate in the residency training program are suspended, it is the Clinical Department's responsibility to insure that a physician is not working during the period of suspension. **TIME MISSED BECAUSE OF SUSPENSION MUST BE MADE UP FROM VACATION TIME. A SUSPENSION WILL ALSO BECOME PART OF YOUR PERMANENT RECORD AND MAY HINDER VERIFICATION PROCESSES.**

NEW YORK STATE CODE 405 REGULATIONS

1. No house officer shall work more than 12 consecutive hours in the Emergency Department and must have ten hours free of duty before and after such an assignment. All patient care activities in the Emergency Department must be supervised by a board-certified or board-eligible physician.

2. No intern shall work more than 16 consecutive hours in direct patient care service and no senior resident (PL-2, PL-3, or PL-4) shall work more than 24 consecutive hours in direct patient care service. Three additional hours for transfer of patient information is allowed. If you arrive at 6:30 AM to begin patient care rounds, you must leave the hospital by 9:30 AM the following day to be in compliance.

NOTE: THIS IS YOUR RESPONSIBILITY TO BE IN COMPLIANCE.

3. No house officer will work more than an 80 hours per week.
4. Every house officer must receive at least one 24-hour period each week during which they have no patient care responsibilities, including beeper call.
5. Residents must have 10 hours off after moonlighting before returning to training program work.

If you are on an elective experience with beeper or home call and you come in to the hospital for a consultation of greater than 1 ½ hours duration between the hours of 12:00 AM and 7:00 AM, please check with your attending physician to allow you to come in later the next morning so that you obtain an adequate amount of rest. If any questions arise as to this policy, please speak with the program director.

It is recognized that there is an inherent desire not to leave extra work for your colleagues. However, New York State Law mandates compliance with the 405 work hour regulations. Sign-out of incomplete work must be done efficiently and comprehensively in order to maintain the highest quality of patient care and to make sure that you are in compliance. All such transfers of incomplete work will balance out over time. Succinct, comprehensive sign-out is a learned competency.

Compliance with these statutes will be internally reviewed by the GME office and externally reviewed by New York State periodically. Non-compliance will result in substantial penalties.

POLICY ON MONITORING NUMBER OF HOURS WORKED

The Pediatric Residency Training Program at the University of Rochester is committed to providing a high quality education for the housestaff while abiding with New York State Health Code Regulations that limit the total number of hours per week that individual residents may work.

In order to monitor our compliance with these regulations, the Office of Graduate Medical Education requires you to log your work hours in MedHub once a week. Please make sure you report your work hour data carefully and honestly. Do not inflate your hours. Your work hours will be reviewed regularly for compliance. If compliance is not present, the rotation(s) will be reviewed for modification of resident working hours so that the regulations will be met in the future.

HIV POLICY

All pediatric house officers are expected to participate in the care of any pediatric emergency department, clinic, or hospitalized patient. This includes, but is not limited to, patients with HIV infections. During the hospital wide resident orientation there will be a mandatory session pertaining to the Occupational Safety and Health Administration (OSHA) guidelines regarding Occupational Exposure to Blood Borne Pathogens. In the event of any exposure of blood, serum, vaginal fluid, CSF, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, or saliva in a dental procedure, please contact Infection Control immediately. Residents may also refer to either the Infection Control Manual on Management of Blood Exposure at SMH or the UR Exposure Control Plan, section V, regarding post-exposure evaluation and follow-up. Infection Control personnel in either institution in which the exposure occurs (SMH or RGH) will guide the resident through appropriate channels for counseling, decisions for treatment, follow-up, and incident reporting. University Health Services and Infectious Disease faculty are on call 24 hours per day for any issues regarding counseling and exposure.

- Both confidential HIV testing and anonymous testing are available to residents.

PEDIATRIC ELECTIVES

The RRC requires a minimum of 7 months of elective rotations excluding adolescent medicine, behavior and development, and intensive care experiences. Each resident must complete a minimum of four different core 1-month block rotations taken from the following list of pediatric subspecialties:

- Allergy, Immunology, Rheumatology
- Cardiology
- Endocrine/Metabolism
- Gastroenterology
- Genetics
- Hematology/Oncology
- Infectious Diseases
- Nephrology
- Neurology
- Pulmonology

Additional subspecialty experiences may be selected from the following list:

- Child Psychiatry
- Dermatology
- Ophthalmology
- Orthopedics & Sports Medicine
- Pediatric Otolaryngology
- Pediatric Radiology
- Casting and Suturing
- Pediatric Surgery

If a house officer wishes an elective that is not offered, "**individualized**" electives can be arranged, with the assistance and approval of the director of the residency program. These may occur at the U of R/SMH or at other academic centers, or other traditional or nontraditional practice settings in this country or abroad.

It is imperative that the approval process for such an individualized elective be completed before the resident begins the experience. For all "individualized" electives the program director must have written documentation that the resident has been accepted for the elective and an appropriate supervisor has agreed to take responsibility for the resident's experience. The resident needs to define his/her goals and objectives for this experience as well as the location, dates, and name and address of the accepting supervising physician. **It is mandatory that you meet with the Program Director BEFORE you start to arrange such an elective.** In order for the resident to obtain credit for an individualized elective, an evaluation form must be completed by the mentor and returned to the Program Director. Unless extremely unusual circumstances prevail, away electives are not permitted during the final block of residency training.

No residency credit can be given for an individualized elective if these requirements are not fulfilled before commencing the elective, including submission of 2-3 goals and objectives for your elective experience.

Each resident is entitled to one "away" elective rotation during either his or her 2nd or 3rd year. Any night call missed during this block must be made up during other elective time.

RESIDENT TRACKS/PATHWAYS

During the second and third years of training, residents in good standing may elect to enter a track with a half-day of protected time per week.

We offer 5 specialized resident tracks: Research Track, Primary Care Track, Global Health Track, the Refugee Track and the Community Advocacy Track. You will meet with the Program Director and Track Directors during your intern year to go over the details of each track and the process necessary to register for a track, if you are interested.

We also offer individualized pathways for career development in:

- Primary Care
- Procedure-based subspecialties
- Other subspecialties
- Career exploration

Your pathway will be determined by your interests and through discussions with the Program Director and/or Associate Program Directors.

Any resident participating in a track, must meet ALL track requirements as set forth by track leadership. If all requirements are not met, the resident will be required to make-up all protected track time.

RESIDENT SELECTION POLICY

1. All appointments to the Resident Staff of the University of Rochester Medical Center, including post-residency fellows, must hold the M.D. or D.O. degree, and they must be graduates of schools approved by the LCME or the AOA or, in cases of international schools, approved for listing by the World Health Organization or equivalent accrediting bodies and possess a valid ECFMG certificate.
2. All residents applying to the University of Rochester Pediatric Residency Training Program must have completed at least two active clinical rotations (not observerships) in ACGME approved programs or programs approved by the accrediting bodies in Canada or, in rare circumstances, in England.
3. All first year residency positions (PL-1) are offered through the National Residency Matching Program. If our program does not fill through the match, residents are appointed to unfilled positions from the pool of unmatched students as long as they meet institutional standards.
4. Only J-1 visas are generally accepted for pediatric residency positions at the University of Rochester.
5. All applicants invited for an interview meets with the pediatric residency training program director and have a formal interview with at least two faculty members. All applicants who have been granted an interview are subsequently ranked using a numerical score by the pediatric residency training program director, our two associate pediatric residency training program directors, the medicine/pediatric program director, the chair, and members of the pediatric residency selection committee.

RESIDENT APPOINTMENT AND REAPPOINTMENT POLICY

1. All appointment agreement letters (contracts) are for one year and each resident must be reappointed for each subsequent year of training, contingent upon satisfactory completion of the current post-graduate year.
2. Recommendations for appointment and reappointment of residents are initiated by the pediatric department and pediatric residency training program and are sent to the Office for Graduate Medical Education.

3. A resident whose performance has failed to meet the level of competence for reappointment in a subsequent year shall be notified by his/her department and program in writing. Specific guidelines for decisions on termination or non-reappointment are found in the Disciplinary Procedures and Appeals Policy.

Residents are expected to notify their department at least four months in advance if they do not intend to return the following year.

CRITERIA FOR RESIDENT PROMOTION

Resident performance assessment is based on the ACGME Pediatric Milestones, which define specific behaviors, attributes, or outcomes in the six general competency domains to be demonstrated by residents during residency. Twice a year, the Clinical Competence Committee (CCC) meets to discuss each resident's performance and to make a recommendation to the Program Director on the future status of the resident (promotion, remediation, probation, or termination).

I. From PL-1 to PL-2

- A. The resident must have demonstrated satisfactory performance (on evaluation by the majority of attending physicians and supervisory residents) in the following areas:
 1. Inpatient floors
 2. Neonatal Intensive Care Unit
 3. Outpatient and emergency room acute care
 4. Continuity clinic
 5. Normal newborn nursery
 6. Pediatric Links to the Community
- B. Satisfactory performance/attainment of required milestones on the above rotations in each of the below areas:
 1. Clinical judgment and acumen (patient care)
 2. Factual knowledge (medical knowledge, practice-based learning and improvement)
 3. Ability to efficiently organize data and prioritize patients (patient care)
 4. Communication skills including charting (interpersonal skills and communication)
 5. Professional attitudes and behavior (professionalism)
 6. Acquisition of technical skills in required procedures (patient care)
 7. Teamwork, health care delivery (systems-based practice)
 8. Evidence of a commitment to on-going learning (PBL & I)
- C. Satisfactory completion of all items on the year end checklist which will be distributed to you during the latter part of your PG1 year.
- D. Completion of all peer, faculty, and rotation evaluations.

II. From PL-2 to PL-3

- A. Satisfactory performance for PL-2s will include the same measures as in 1A and 1B
- B. In addition, satisfactory performance (by similar evaluation mechanisms) must be demonstrated in:
 1. Ability to supervise interns and medical students. Supervision includes:

- a) Assuring good patient care
 - b) Allowing interns to take an appropriate amount of responsibility for patients
2. Ability to assist interns and medical students in their learning by a variety of methods (observing history and physical examination skills, chart review, individual patient discussion, serving as a role model for methods to increase factual knowledge, etc.).
- C. Completion of the year end checklist.
 - D. Completion of all peer, faculty, and rotation evaluations
- III. Graduation from program
- A. All expectations as listed for promotion from PL-2 to PL-3.
 - B. Demonstration of increased independent learning. An important area for this will include subspecialty rotations where residents often act as primary consultants (see evaluation form for specialty rotations).
 - C. Completion of all incomplete medical records and the year end checklist.
 - D. Completion of all peer, faculty, and rotation evaluations
 - E. **Verification of competence in the six general competencies: patient care, medical knowledge, interpersonal skills and communication, professionalism, practice-based learning and improvement, and systems-based practice, by the program director.**

DISCIPLINARY PROCEDURES AND APPEALS POLICY

These procedures are applicable to all residents and are intended to protect the rights of residents, patients, the training program, and to ensure fair treatment for all parties. **The primary responsibility for defining the standards of academic performance and personal professional development rests with individual departments and program directors.** In each program, there must be clearly stated bases for evaluation and advancement. At least semi-annually, each resident's performance must be evaluated against these standards, and a written summary assessment prepared. This summary will document in some manner that it has been reviewed with the resident, and a copy shall be made available to the training program. The written assessment will then become part of the resident's record in both the program and Office for Graduate Medical Education.

DISCIPLINARY MECHANISMS

1. **Immediate Termination:** Immediate termination can occur if a resident puts patients, other health care professionals, employees or third parties at risk, or compromises the integrity of the program. The bases for immediate termination include but are not limited to suspension or revocation of the resident's license or permit; incompetence; misconduct; any conduct that has the potential to jeopardize patient safety or the quality of patient care, is disruptive of hospital operations, is a serious violation of URMC policy, is a serious violation of law or regulation, or is conduct constituting criminal activity. If the resident is terminated, his/her appointment shall end immediately and no probationary period is required. Residents who are terminated will receive one month's salary and benefits in lieu of notice. Credit for training may be given in the event of any satisfactory performance prior to termination, per the guidelines of the individual board.

Reporting obligations related to conduct constituting professional misconduct is covered separately in the policy on Professional Misconduct in the GME office policy manual.

2. **Termination After Probation:** When a resident's performance is not commensurate with his/her appointed level of training, notification of the deficiencies must be made, in writing, to the resident by the program director with copies to the Associate Dean for Graduate Medical Education (ADGME). A plan to correct deficiencies, which includes the manner and time frame in which the deficiencies will be corrected, and the consequences of not correcting the deficiencies within the time frame, should be a part of this notice. There should, however, be a probation period of at least three months, which may be extended to a maximum of six months, before a decision is made to terminate a resident. A letter to the resident, which specifies the period of probation, must indicate the possible outcomes (full reinstatement to the program, continued probation, termination). In the case of termination, the end of the appointment is immediate and one additional month of salary is paid to the resident in lieu of notice. The resident is to be notified in writing of this action with a copy of the letter to the ADGME.

The resident does not continue to work after the notice of termination. Credit for training may be given for periods of satisfactory performance, per the guidelines of the individual board. If deficiencies in professional competence that may endanger patients arise during the probationary period, the resident may be terminated or suspended immediately (as described above) after consultation with the ADGME.

3. **Non-Renewal of Contract After Probation:** In the event of non-renewal of a resident's contract, at least four months notice prior to contract expiration should be provided to the resident. There should be a probation period of at least three months prior to a decision not to renew a contract. If the end of the resident's probation period is within four months of the end of the contract year, the fact that the resident is on probation will serve as notice that the contract may not be renewed if the probation is not remediated successfully. The notice of non-renewal of contract will be made in writing to the resident with a copy to the ADGME. If the primary reason for the non-renewal occurs within the four months prior to the end of the contract, the program must provide the resident with as much written notice of the intent not to renew as the circumstances will reasonably allow. The resident will continue to work at his/her appointed level of training through the end of the contract period. Full credit for the year may be given to the resident at the discretion of the Program Director and guidelines of the individual board. In cases of non-renewal of contract, the trainee will be terminated at the end of the contract period. If deficiencies in professional competence that may endanger patients arise during the probationary period, the resident may be terminated or suspended immediately after consultation with the ADGME.
4. **Delayed Promotion of a Resident:** If a resident has not met the program standards sufficiently in his or her current training level, the program may make a decision not to promote a resident to the next level of training. These rules will also apply to a resident whose performance has been acceptable but who has not completed the required number of weeks of training during the contract period. An official period of probation may or may not be indicated

The resident should be notified of this decision as soon as circumstances reasonably allow, and in most cases 4 months, prior to the end of the contract year. Exceptions to this timeframe would include performance issues that primarily arise within the final 4 months of the academic year. If a resident is on probation, and the end of the resident's probation period is within 4 months of the end of the contract year, the fact that the resident is on probation will serve as notice that the resident may not be promoted if the probation is not remediated successfully.

The notice of non-promotion should outline the remediation steps to be accomplished prior to the resident's advancement to the next level. The resident will be paid at his or her present level until they are advanced to the next level. If the resident does not successfully complete the remediation plan, the process listed above for termination will apply.

5. **Independent Evaluations:** In order to determine an appropriate plan to address a resident performance problem, a program director, in consultation with the ADGME, may require an

independent evaluation of a resident when the program director has a reasonable basis to believe that a resident's performance is affected by an impairment including, but not limited to a medical, mental health or substance abuse problem. The purpose of the evaluation is to determine the resident's ability to perform his or her clinical duties and responsibilities. See also the Resident Impairment Policy (GME policy manual).

6. **Suspension:** A resident may be suspended from clinical activities by his/her program director, department chair or the chief medical officer of Strong Health. This action may be taken in any situation in which continuation of clinical activities by the resident may compromise URMIC operations, the program, or the safety of patients, employees, the resident, or third parties. Bases for suspension include but are not limited to potential threat to the safety of patients or others, quality of care concerns, a suspension or loss of the resident's licensure, potential impairment of the resident, debarment from Medicare or other federal program, potential misconduct by the resident, or potential incompetence. A resident may also be suspended pending an investigation of an allegation of any of the above concerns. At the discretion of the Program Director, the resident may also be offered a voluntary leave of absence pending investigation. Such voluntary leave shall be for no longer than one week, at which time the resident will be automatically suspended unless the investigation has been completed and a decision favorable to the resident has been made. Unless otherwise directed by the program chair, a resident suspended from clinical services may participate in other program activities. Suspension may be with or without pay at the discretion of the program director. The resident must be notified in writing, with a copy to the ADGME, of the reasons for the suspension. The notice of suspension must be reviewed with the resident, who must sign and date indicating the material has been reviewed with him/her.

The resident may appeal the suspension to the Dean of the School of Medicine and Dentistry. The resident must appeal the decision within 5 working days of the suspension by written appeal to the Dean. The Dean shall make the final decision with respect to the appropriateness of the suspension.

Within 10 working days of a decision to suspend the clinical privileges of a resident, the program director must determine if the resident may return to clinical activities and/or whether further action is warranted including but not limited to counseling, warning letter, probation, fitness for duty evaluation, medical leave of absence, or termination. Written notification of the program director's decision should be given to the resident with a copy to the ADGME. If further investigation is needed before a determination can be made, the program director shall so notify the resident, but must complete the investigation within an additional 10 working days from the date of the suspension. The resident must cooperate fully with the investigation.

Suspensions Related to Medical Records Documentation: See policy on delinquent medical records

Suspensions Related to Impairment: See policy on impairment (GME manual).

APPEALS

When a resident receives notice of termination, non-renewal or non-promotion by the Program director, he/she shall have the right to appeal such action. Performance evaluations or the placement on probation cannot be appealed.

To initiate the appeal process, the resident shall notify the Associate Dean for Graduate Medical Education. This notice shall be in writing, and must be delivered to the Associate Dean for Graduate Medical Education within ten (10) working days of the resident's notification by the Program Director. Such notification must include the reasons for the requested formal appeal. **Failure to notify the Associate Dean for Graduate Medical Education within the prescribed time frame will terminate the appeal process at this point.** The expected duration of this appeal process is approximately 3-4 months from the time the resident receives written notice of the adverse action from his/her department. If the resident

is an Exchange Visitor on a J1 visa and he/she has received a notice of dismissal from the program, every effort will be made to expedite the process so that the resident may appear in person before the ad hoc committee.

Within ten working days of receipt of the request for appeal, the Associate Dean for Graduate Medical Education will appoint an ad hoc committee, and will notify the resident and the members of the ad hoc committee in writing of the committee's appointment with a copy to the program director and chair.

The chair of said ad hoc committee will be a member of the Graduate Medical Education Committee, and one additional faculty member and one resident will comprise the committee. Eligible faculty for the ad hoc committee are defined as full-time physician faculty members of clinical departments in the School of Medicine with the rank of Assistant Professor or higher, and may not be members of the department which sponsors the resident's program. The resident member of this committee must be from a department other than that which sponsors the aggrieved resident's program.

The Office for Graduate Medical Education will provide administrative support to the ad hoc committee and will notify the aggrieved resident, the members of the ad hoc committee, the program director, department chair and the Associate Dean for Graduate Medical Education of the time and place of the meeting. The meeting shall occur within 30 days of the committee's appointment.

Prior to the meeting, the department should submit the resident's departmental file and any other materials on which it bases its decision to the Office for Graduate Medical Education, for distribution to the committee. To preserve the confidentiality of anonymous evaluations, the appeal mechanism does not entitle the aggrieved resident to review his/her complete departmental file. Upon written request, the resident will be provided with a photocopy of summary evaluations, and photocopies of any correspondence to the resident from the program, before the committee meeting is held.

The process of the meeting will not be rigidly prescribed, except that, the resident shall be given the opportunity to appear before the committee and will be allowed to be accompanied by an advocate who is not an attorney. The resident should be prepared to present evidence for rescinding the action.

The program director should appear and be prepared to present evidence for upholding the action. The meeting shall be confidential and open only to the committee members and a note taker.

If either the program director or resident would desire individuals with factual information regarding the decision of the department, above and beyond information in the file, to appear before the committee, the interested party may make the appropriate arrangements. The meeting may only be rescheduled under extraordinary circumstances at the discretion of the chair of the ad hoc committee. At the discretion of the chair, the program director and resident may question their own witnesses. If the committee decides that additional information is required, the chair may request written materials and additional meetings, which may occur beyond the 30-day time period referenced above.

The ad hoc committee's scope of review shall be to determine:

- whether there was adequate documentation on which to base the disciplinary decision, and
- whether the appropriate procedures (e.g. notice of deficiencies, plan of remediation) were followed.

In cases where the ad hoc committee determines that the department either failed to follow procedures or lacks adequate documentation for its decision, the committee will recommend to GME the appropriate resolution considering all the circumstances.

The ad hoc committee's decision shall be communicated to the Associate Dean for Graduate Medical Education within thirty (30) days of the hearing. The preparation of the committee's final report shall be the responsibility of the Chair of the ad hoc committee. If in the interest of a thorough review of the resident's appeal, additional information is required which cannot be obtained in sufficient time to meet

this thirty (30) day time period, that time period may be extended by the Chair and the resident will be so notified by the Chair.

The ADGME will then present the ad hoc committee's report to the GMEC at its next regularly scheduled meeting. The GMEC will consider the ad hoc committee's report and recommendations. Voting members of the GMEC will make a decision as to whether to confirm, modify or reverse the Ad Hoc Committee's decision. GMEC will make its decision based on a closed ballot vote, with the resident's program director excused. The majority of the voting members must be present to call a vote.

The Associate Dean for Graduate Medical Education shall make notification to the resident of the GMEC's decision in writing with a copy to the Program director and Chair. If the resident or program director wishes to appeal the decision of the GMEC, he/she may do so in writing to the Dean of the School of Medicine and Dentistry within ten working days of the date of the written notice of the GMEC's decision from the Associate Dean for Graduate Medical Education. **Failure to request an appeal within the prescribed time frame will operate as a waiver of appeal.** The Office for Graduate Medical Education will provide a copy of the resident's file and all documentation from the ad hoc Committee's review of the resident's initial appeal to the Dean of the School of Medicine and Dentistry.

The process of this final appeal is at the discretion of the Dean; the Dean's decision is final. He/she has the authority to confirm, reverse or modify the GMEC's decision. He/she will make the decision within 10 working days of receiving the file and will notify the resident of his/her decision with a copy to the ADGME.

Policy Inconsistency and Modification

In the event that any of the terms of this policy are inconsistent with the terms of any other policy including but not limited to the impairment and professional misconduct policy, the Dean of the School of Medicine and Dentistry shall have the authority to resolve the inconsistency. This policy may be modified or amended at any time. Updated versions of this policy will be posted periodically on the University of Rochester website.

INTERN (PL-1) RESPONSIBILITIES

A. General

The intern is the primary physician for each in-patient and most ambulatory patients seen on this service. It is his/her responsibility to complete a history and physical examination on each patient, initiate a formulation of the problems that brought the patient to our attention, institute a plan of diagnosis, and initiate and supervise therapy. Activities of interns are immediately supervised and coordinated by a supervisory resident and attending physician or preceptor.

Although, in the current era, many of the inpatients are admitted with an established diagnosis and management plan, approach each new patient as a new patient for you. The diagnosis and care plans may not always be complete or accurate. Formulate your own differential diagnosis and plan of management and present your thoughts to your senior resident and the attending of record.

B. Inpatient Responsibilities

1. **Charting** - The intern is responsible for maintaining the chart on each patient. Since the purpose of the medical record is communication, **legibility is necessary.**

A) The Admission Work-up should include:

- 1) **Date, time**
- 2) **Source of information**
- 3) **Introductory information, including referring physician, age, sex, chief complaint in**

- patient's or parent's words.
- 4) Present illness - including significant past history and pertinent R.O.S. (positives and negatives).
 - 5) Past history:
 - birth history
 - hospitalizations and major illnesses
 - surgery
 - immunizations
documentation of specific dates of immunizations should be in the patient's chart or arrangements made for immunizations to take place during or shortly after discharge.
 - current medications
 - development (motor, language, personal/social)
 - behavioral problems
 - school history
 - allergies
 - medications
 - 6) Complete R.O.S. (need not repeat those in history of present illness)
 - 7) Social history
 - 8) Family history; family tree
 - 9) Physical examination, including:
 - **statement about general appearance first**
 - all vital signs (including blood pressure)
 - height (and percentile) - charted
 - weight (and percentile) – charted
 - head circumference (and percentile) – charted
 - BMI when appropriate
 - developmental assessment - appropriate for age and degree of illness
 - 10) Laboratory data
 - 11) Problem list with an assessment and plan for each problem
(Use the S.O.A.P. format; Subjective, Objective, Assessment, Plan). If S and O are the same for several problems, write "as above".
- B) **Weight percentage should be recorded in your objective assessment.**
- C) Progress Notes are the intern's responsibility. These should include pertinent physical, laboratory and non-medical findings affecting the child's course, as well as Assessments and Plans for ongoing diagnostic and therapeutic activities. All patients will require daily notes which reflect your thoughts on diagnosis and management. Exceptions can be made for certain surgical and chronically ill patients. Both the date and time of the note should be recorded.
- D) Transfer Notes are required on any patient being moved from one ward to another, or into or out of the PICU. This problem-oriented note is basically an abbreviated off-service note.
- E) Patient Discharges should be planned well in advance by house staff in consultation with attending physicians. For many patients with lengthy hospitalizations and chronic illnesses, discharge planning may require social work and visiting health nurse referrals, arrangements for home medical equipment, and extensive parental education and counseling. Unit secretaries should be notified about discharges as early in the morning as possible in order to expedite arrangements for elective admissions. A discharge order and brief discharge note (including weight, medications, and follow-up) must be given to the primary care physician at discharge. Discharge summaries are the responsibility of supervisory residents and should be succinct, efficient, and informative. Interns, particularly those in the second-half of intern year, may be asked to write summaries with the supervision of the senior resident. The standard instruction sheet should be completed by the intern and a copy will be sent to the

private physician along with the medication reconciliation form. The primary care physician should be directly notified of the discharge.

In the current era it is not uncommon for discharge notes to be initiated soon after admission. If this is done, it is imperative that the discharge notes be kept up-to-date as changes in the diagnosis and management may occur after admission.

2. Interim Discharge Summary Notes

The summaries should include:

- Patient's name and hospital number
- Date of Admission
- Attending physician
- Problems on Admission, listed
- Brief Admitting history and pertinent physical findings
- Current Problems, listed
- Hospital Course, by problem - with current plans, pending studies, etc.
- Current medications

3. Medication Order Dose Calculation Policy

All medication orders are to be entered electronically through the computerized provider order entry (CPOE) of eRecord. Once you have been trained in the program, you will receive a password allowing you access to the CPOE program. Most medications are prescribed in a units-per-patient-weight format. You will be prompted by the CPOE program as to selection of the appropriate units/wgt. Children weighing greater than 40 Kg may meet or exceed the adult maximum dose. Therefore, if calculations per weight exceed the adult maximum dose, the program will allow you to override the calculated dose and allow the appropriate dose to be entered. The CPOE program is continually being updated with safety guard rails around minimal and maximal doses. All Medication orders are to be entered electronically. *Most* medications are prescribed in a units-per-patient-weight format but exceptions exist (e.g. mg/BSA, etc). Pay careful attention to units when using your reference source. Documentation of that calculation will help insure appropriate dosing and facilitate checking of dose orders.

MEDICATION ERRORS

When errors are made in dosage, calculations, preparation, frequency, etc., the pharmacist or nurse will contact the ordering physician or the resident on call for clarification. All interns are required to complete a pharmacy exam and computerized provider order entry (CPOE) training successfully during orientation prior to entering orders on patients.

The following medications are commonly prescribed by unit doses rather than by dose per weight, these do not require exact calculation (except for premature infants).

- activated charcoal
- nebulized respiratory therapies (except atropine)
- metered dose inhalers
- multi-vitamin preparations
- oxygen
- topical medications
- pancreatic enzymes
- newborn 1-time dose of IM Vit.K
- Immunizations

OUTPATIENT PRESCRIPTIONS

R-1s write prescriptions for medications that patients take home. R-1s will document in the progress notes, discharge form, medication reconciliation form, ED or outpatient record the medication(s), dose(s), frequency(s) and route(s) prescribed and the name of the supervising physician. Patient weight should be included on the prescription. **If the patient has a chronic illness requiring long-term medication, provide for at least a 1-month initial supply as well as several refills.**

CREDENTIALING

All residents must document that they have completed required procedures under supervision. Upper level residents cannot supervise interns for procedures for which they have not been credentialed themselves. Of note, residents should NOT be credentialed unless the procedure was done as intended and done properly, including a discussion of indications, contraindications, complications, and outcomes.

New interns will log their procedures into MedHub. An email will be generated to the supervising individual to confirm successful completion of the procedure. If credentialing is being done by a person other than a pediatric resident or faculty member, please give the person's name and email address to Michelle Cray so that confirmation can be obtained.

FLOOR POLICY

1. Procedure Notes: Any procedure performed on a patient should be documented in the medical record in the form of a procedure note at the time a procedure was done. If the procedure was supervised by an upper level resident or attending physician, that individual should co-sign the procedure note in the chart.
2. Labs: Appropriate lab tests are to be ordered and recorded promptly by the pediatric intern. The intern must check and document in the chart the results of any lab test or radiologic study on the day of the examination.
3. Communications with the attending physicians: All patients are admitted to the pediatric medical services to either a full-time faculty member or a physician in private practice. Hence, there is always a designated pediatrician legally responsible for each child. The supervisory resident (PAO – pediatric admitting officer, or delegate) is responsible for being in contact with the patient's attending at the time of admission.

Following the initial workup of new patients and the formulation of the house staff plan, a member of the house staff team, usually the resident, will communicate with the attending physician to discuss the plans of care and management. For elective admissions, the attendings are encouraged to notify the house staff on the day prior to admission so that the intern and resident may formulate a plan in advance. **In all cases, the interns and residents are encouraged to present their plan for diagnostic and therapeutic intervention before hearing the attending's plan for the patient's hospitalization.** Any important developments in the clinical course or laboratory findings should be discussed with the attending physician. Critical changes in condition should be communicated immediately, regardless of the time of day or night. Extensive diagnostic activities and consultations must be discussed with the attending physician prior to initiation.

4. Consultations: Consultations are to be obtained to enhance the care of the patient. The consultation should be cleared with the appropriate attending. A note should be placed in the chart by the intern or resident stating the reason for the consult and the specific questions being asked.
5. Liaison with the Parents: Parental communication is the responsibility of the intern, resident, and the attending physician. Current status of the patient, anticipated diagnostic activities, planned therapy, and anticipated duration of hospitalization are among those communications to be handled by the

intern with the family. In those cases in which the patient is the responsibility of a private attending physician, it is the intern's responsibility to communicate with the appropriate physician regarding his desires in the matter of intern/parent interaction, as well as reporting those interactions that have taken place. Family-centered rounding will facilitate this communication.

6. When A Nurse Calls For A Physician To See A Patient:

- a. The nurses will observe patients for changes and notify physicians when there has been a significant change in a patients' clinical condition or status.
- b. The nurse will notify the responsible R-1 unless, in the nurse's judgment, the patient requires immediate evaluation by a more senior physician. Whenever an R-1 is asked to see a patient, that R-1 is required to do so and to document his/her findings in a "Called-to See" note which should document the date and time that the patient was seen and include any new findings. Also included are: 1) the R-1's impression of the patient's condition and 2) alternative plans for treating that patient. These notes may be very brief if, for example, no change in condition is observed and no change in plans is made, but the documentation is essential and should be done as quickly as possible after the patient is seen with a recorded date and time. PICU and NICU will be excluded from this guideline because the residents are in constant contact with patients in these units and with the nurses caring for them, but any important changes in a patient's status should be documented as above as soon as possible.
- c. If a R-1 is called to see a patient, a more senior physician must be consulted. The senior physician may choose to discuss the situation by telephone or to see the patient him/herself and shares the responsibility for the assessment and plan. The R-1 must document this consultation as part of the "Called-to-See" note including the name of the physician consulted.
- d. No student will evaluate any patient alone. If a nurse feels that a patient needs to be seen, the most junior MD available should be notified, unless circumstances require immediate evaluation by a more senior physician. The MD may delegate the initial evaluation to a medical student, or see the patient with the student if a student is involved in the care of the patient and the clinical situation allows. Nursing may insist upon an immediate MD evaluation if they feel it is necessary. The student making an initial evaluation must notify the responsible MD as soon as the evaluation is complete and the supervising MD must review the evaluation and co-sign the students "Called-to-See" note. If an R-1 is supervising a medical student, the regulations regarding notification of a more senior physician still apply.

7. Work Rounds: On work rounds, we recommend that each patient be presented in a brief fashion that includes age, diagnosis, length of hospital stay, medications, plus a very brief account of the course. The intern should then present a plan of care, modified, if necessary, by the supervising resident. The intern should have received sign-out and briefly examined his/her patients prior to work rounds. It is suggested that interns be able to give complete presentations on new patients of about three to five minutes, as well as one minute capsule summaries for each on-going patient under their care, when appropriate. Work Rounds should occur at the bedside as much as possible (Family-Centered Care). In Family-Centered Work Rounds, presentations at the bedside should be done in language which the family can understand, and the family should be given the opportunity to alter any historical facts and discuss the diagnosis and care plan.

8. Quality Assurance: Primary care physicians and other attendings frequently do not receive final diagnostic reports on their patients. It is up to the house officer who is filling out the diagnostic requisition to list the attending's name in the space provided to insure that the final report gets directed to the appropriate place. When seeing a patient in the ED, please list the patient's primary care pediatrician, or if there is no primary doctor designated, list the ED attending's name in that spot. For inpatients, also list the primary care physician or the inpatient attending, whichever seems most appropriate or both. You should also still sign your name as the physician requesting the exam. For continuity clinic patients please list either the name of the continuity house officer or the attending on

service at the time. If you list both names, they will both receive the final report. This is a simple thing to do and greatly facilitates follow-up and patient care.

9. Conferences:

- a. Morning Report, Noon Conferences and Grand Rounds: Attendance at Morning Report and Grand Rounds is MANDATORY for all residents unless attending to a child with an acute emergency. Attendance at noon conference is mandatory unless you are post-call, wherein you should be out of the hospital by 9:30 AM to 10:00 AM (**27 hours after arrival**). An acute care curriculum has been developed specifically for interns, to be held during the summer months. Intern attendance at these conferences is also mandatory when not post-call. Arrange your day to be at these conferences. Supervising ward residents are responsible to cover for Interns for this acute care conference series. A core curriculum on a yearly plus repeating cycle has been developed.

Unless you are on a rotation that precludes attendance at conference (e.g. Noon Conferences when you are on the night float rotation, when you are in ED, NICU, etc.), you are expected to be at Morning Report, Noon Conference, and Grand Round.

You need to card swipe for Morning Report and Noon Conference attendance and to sign the attendance sheet for Grand Rounds. Rochester General Hospital is looking into a swipe system. In the meantime, sign the conference attendance logs when you are at RGH.

Your conference attendance will be monitored at your semi-annual reviews. This is an element of professionalism (showing up).

- b. Attending Rounds: The floor attending may attend work rounds with each team, but 3 formal teaching rounds, with an emphasis on bedside teaching, should occur each week.

Interns and medical students are responsible for presentation of cases at work and attending rounds. Presentations should follow a classic outline and be appropriately detailed as regard to history, physical findings, and lab data. The intern should be prepared to present at the bedside and without the chart, to demonstrate physical findings and to discuss earlier personal experiences and pertinent medical literature as they relate to the patient.

IT IS MANDATORY THAT THE SENIOR RESIDENT AND THE INTERNS MEET WITH THE ATTENDING PHYSICIAN AT THE BEGINNING OF EACH BLOCK TO DISCUSS MUTUAL EXPECTATIONS OF PERFORMANCE. SENIOR RESIDENTS AND, AT TIMES, INTERNS, SHOULD BE ASKED TO CONTRIBUTE INFORMATION OR ANSWER PARTICULAR QUESTIONS RELATED TO THE PATIENT UNDER DISCUSSION AT ATTENDING ROUNDS. ATTENDING ROUNDS SHOULD BE CASE-BASED AND EVIDENCE-BASED AND, AT LEAST IN PART, SHOULD TAKE PLACE AT THE BEDSIDE AS MUCH AS POSSIBLE.

- c. Senior Report takes place on Mondays and Thursdays from 8:30-9:00. Intern Report takes place on Thursdays from 8:30-9:00.

10. Medical Students:

- a. Fourth Year Students rotate on pediatric units as acting interns. PI-1's should interact with 4th year externs as peers, as much as possible. Supervising 4th year externs is clearly the responsibility of the Resident, not the PL-1. H&P's done by 4th year Externs do not require an intern H&P. A 4th year student may never take responsibility for patient evaluation alone.
- b. Third Year Clerks rotate on inpatient units at SMH and RGH. Responsibility for 3rd year student education is divided between interns, residents, chief residents, attendings and the Director of Medical Student Education. Clerks are assigned to be "on call" with one of the interns on that floor, and are expected to admit and work-up one patient each time "on call." Assignment of

patients for the clerk should be cleared with the resident. The resident has responsibility for reading and evaluating students' write-ups and teaching physical findings. Interns should try to discuss the case with the clerks, read and co-sign notes, and help demonstrate physical findings as time permits. Patients admitted by clerks will still have a complete intern H & P. Clerks may write orders, to be co-signed by either the intern or resident. The intern should also attempt to involve the student in any procedures involving patients the student is following. In addition, clerks may request interns' help in gaining skills at procedures on other patients. The clerk may present patients on rounds and at conferences.

11. Medical Records:

Each chart is reviewed by Medical Records staff after discharge for delinquencies. For interns, this usually represents signatures. Make sure to sign all orders with date and time, notes, and medical student notes before the patient is discharged.

12. Hand-offs:

Residents are expected to update hand-offs in eRecord for all patients each shift using eRecord Hand Off Tool in the DATAS format:

Descriptive identification of the patient

Who the patient is, and why they're admitted

Active patient issues

What is currently going on with the patient

To-do and follow-up issues

Results, notes, discussions to address

Anticipatory guidance

What might come up....what to do (or not do) about it

Special instruction

D/C planning, code status, etc.

In order to standardize signout and to enhance efficiency and safety, DATAS should be used at all handoffs. With all hand-offs, the "Covering Provider" section of eRecord must be updated.

13. Stat Transfer Summary Procedure:

Transfer summaries should be done in eRecord. The summaries should be in the chart within 2-3 hours of transfer. Verbal signout must be given prior to transfer of patient care.

MEDICATION SYSTEM GUIDELINES

Each day there are over one thousand new medication orders written, over five thousand doses of medication dispensed and only a slightly lesser number of doses administered. Understanding and complying with the medication system guidelines is essential for a safe, effective and efficient system. All staff members involved in the medication system (physician, nurse, unit secretary, pharmacist and pharmacy technician) need to understand the interrelation of each others responsibilities and work cooperatively to ensure that the medication orders are appropriate and carried out in an accurate and timely manner.

ORDER ENTRY

All orders for patients must be entered into the computerized patient care system eRecord.

All narcotic orders must be renewed every 7 days; all other medications must be renewed or canceled every 30 days.

DISPENSING OF MEDICATION

- If upon review of a medication order the pharmacist or nurse requires clarification, he or she should contact the physician. If upon receiving clarification a change in the order is required, the pharmacist or nurse should request that the physician revise the order. If this is not possible and it is emergent that therapy begin, the pharmacist or nurse should ask the physician to give a verbal order to the patient's nurse if the physician does not have access to a computer.
- If the pharmacist is unable to contact the physician, he or she should contact the patient's nurse and explain the nature of the problem which prohibits the dispensing of the medication. The pharmacist and nurse should agree on what action is needed to be taken (and by whom) to resolve the problem.
- There are two categories of medication orders relative to turn around time: STAT and ROUTINE.
- STAT orders are reviewed and the medication dispensed within thirty minutes of receiving the order.
- Whenever possible the pharmacist should be called when a STAT order is being sent to the pharmacy.
- ROUTINE orders are reviewed and the medication dispensed within three hours of receiving the order.
- Routine orders are prioritized to ensure that the patient with the most urgent medication needs are met first. Critical care drugs and injectable antibiotics receive a higher priority than oral maintenance medications. Orders for patients in the intensive care areas receive a higher priority than orders received from other areas. In all cases, the medication should be dispensed within the three hour time frame.

Pregnant house staff are not permitted to administer cytotoxic drugs.

TEACHING MODULES FOR MEDICATION ORDERS

All incoming interns are required to complete a computerized provider order entry module during orientation and to successfully complete the medication ordering exam before they may order medications for their patients.

DRUG RENEWAL ORDERS

The CPOE system requires medication renewals. Unless you otherwise specify in your order a shorter expiration date, all drugs automatically expire after 30 days, and all controlled substances expire after 7 days. The purpose of this system is to force you to review the patient's medication list and discontinue any drugs that are no longer appropriate. You may also wish to adjust the doses based on a new patient weight.

MEDICATION RECONCILIATION

In order to reduce medication errors, medication reconciliation must be done by all providers on all patients upon admissions, transfer of care, and discharge. It also must be done in the Emergency Room and Outpatient settings.

EVALUATION POLICIES

Residents are now evaluated using a competency-based form as mandated by the ACGME, Pediatric RRC, and the American Board of Pediatrics. The competency-based assessment includes:

1. Patient care
2. Medical knowledge
3. Communication and interpersonal skills
4. Professionalism
5. Practice-based learning and improvement
6. Systems-based care

RESIDENT EVALUATIONS

Welcome to our new Competency-based Evaluation Plan using the MedHub system.

This curriculum is designed to provide **rotation-specific, focused, essential, and measurable or observable objectives** that are linked to **specific learning activities** and **rotation-specific evaluation tools**.

This approach:

1. Defines what the faculty and the program believe is most important for you to learn.
2. Makes the evaluation process simpler and more rational.
3. Provides residents with a fairer evaluation method.
4. Should reduce angst and stress for teacher and learner alike.

At least two to three days before the start of your next rotation you (and the attending on service) will receive:

1. An **individual learning plan (ILP)** with 8-12 essential objectives (EOs) which must be met by the end of the rotation and also a list of **lower priority** objectives which you need to review and **prioritize according to** your own learning needs.
2. A planning table that identifies what learning opportunities are used to meet the EOs and the means by which you will be evaluated.

At the beginning of the rotation, please review the **ILP** with the faculty member on service. Discuss the EOs and also the lower priority (non-essential) objectives you deem important for your own education and **formulate a plan to meet these objectives**. At the same time, you may receive a rotation-specific mini-CEX card which identifies observable objectives for which you will need to obtain sign-off during the rotation. You are responsible for completing the card. A compilation of reading materials linked to the EOs may also be provided.

Formative evaluation (how to improve your performance) during the rotation is **key** and may occur daily but certainly should occur at the mid point of the rotation to make sure that you are on track in learning the EOs. Concurrently, you and your supervisor can assess whether you are meeting your personalized objectives.

Two to three days before the end of the rotation, you should meet with your supervisor for a **summative evaluation**, which will indicate your success in achieving the essential and your personalized objectives. Objectives not met at this time should be achieved before the end of the rotation.

Split rotations (2 week blocks) may preclude completion of all of the EOs in the first block. In this case, you will be evaluated on the completed objectives, and a partial evaluation form with notes for continued learning will roll over to the second split block. When you complete the rotation later on, you will receive the standard end-of-rotation evaluation.

For **repeating rotations** (inpatient, ED, continuity care, and illness clinics) you will receive an online, rollover, **self-evaluation** form which needs to be completed for each block of these rotations. This form, which is another type of ILP may substitute for ILPs on some repeating rotations and will be reviewed with you on a semi-annual basis with your program director. The expected level of competency that should be achieved by the end of the third year is indicated for each item. For the NICU, the PICU, and the ED, a rolling evaluation form will be sent to the appropriate faculty, and you will be evaluated on completed objectives. These forms will then roll over to future blocks in these areas so continued learning can be documented.

The new curriculum is obviously a work-in-progress. As you know, we value your input as adult learners. Please provide us with informal feedback at any time if you identify problems.

The faculty will also receive the ILPs and planning tables just prior to the rotation and an evaluation form just before the end of the rotation. Their input is also crucial to continuous quality improvement of our residency program.

As soon as a faculty mentor completes an evaluation of your performance, you will have access to that evaluation on the E-Value system.

Residents are required to fill out self evaluation forms semiannually before meeting with the program directors.

One formal review of intern charting by a supervising physician should be done once on each inpatient rotation. The completed form is then sent to the residency program office and is placed in the resident's file. Although this documentation is important to evaluate patient care activities, the best method to correct any deficiencies should be immediate feedback from the supervising physician.

6-MONTH/YEARLONG INTERN/RESIDENT EVALUATIONS

1. Computer printout summaries will be generated every six months and placed in each resident's file.
2. The Clinical Competence Committee (CCC) meets twice a year to assess each resident's progress in the program and provides the Program Director with recommendations for promotion, remediation, probation, or dismissal.
3. The Program Directors will meet with all residents twice a year (grouped by year of training) and review evaluations and CCC recommendations.
3. **Each resident will review and then sign his or her evaluation form.** The completed forms will be placed in the resident's file.

RESIDENT EVALUATION OF ATTENDING

1. In the on-line evaluation systems, you will receive an evaluation form for your attending physician on each rotation.
2. **It is imperative for on-going assessment of, and improvement in, your residency training program that this form be completed for each rotation.**
3. These evaluation forms are anonymous

4. The evaluations of attending faculty are also competency-based.
5. Semi-annually copies of the evaluation of attending faculty will be sent to the faculty member's division chief for review for assessment of teaching skills and inclusion in the faculty member's file.
6. After a faculty member receives 5 evaluations, he or she will have access to their anonymous evaluations.

HOUSE STAFF EVALUATION OF ROTATIONS OR ELECTIVES

1. In a similar vein, it is imperative that the house staff evaluate all rotations at the completion of each rotation. These evaluation forms will be distributed on-line to the residents at the end of each rotation, and will be reviewed annually with each division.
2. These evaluations are anonymous but will be reviewed each year by 2 members of the Educational Committee (Educational Triad) who will then meet with the rotation faculty to discuss what works well and what needs improvement. A written summary of this meeting outlining what was discussed, including any necessary remediation plans, will be reviewed by the division faculty and then distributed to the residents and all of the Educational Committee members.

HOUSESTAFF EVALUATION OF THE RESIDENCY PROGRAM

Near the end of each year, an evaluation of the Residency Program will be distributed to each Resident. Completion is mandatory for advancement and graduation.

NOTE: Evaluations are difficult but necessary both for improvement of resident performance and for accreditation. Seek specific data from your attending physician and senior resident and make sure that you are an active participant in the process by completing peer evaluations and faculty and rotation evaluations for each block.

ACGME Requirements For Pediatric Residency