



2009-2010

Pediatric Residency Training Program  
Housestaff Orientation Manual  
RRC Requirements

**2009-2010 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 competent to handle any pediatric problem in an efficient and thorough manner.
2. To develop, enhance, and promote sensitivity and empathy for every patient and family and to follow the traditions of the biopsychosocial model at all times; To practice family-centered care.
3. To provide an atmosphere of scientific inquiry, to promote the development of pediatrician/scientists, and to promote habits of life-long learning.
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 intellectual achievement.
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.

## 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 17).
- 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.
- 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 Hospital and community offices; Rochester General provides the same coverage when a resident is working at Rochester General Hospital. 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**

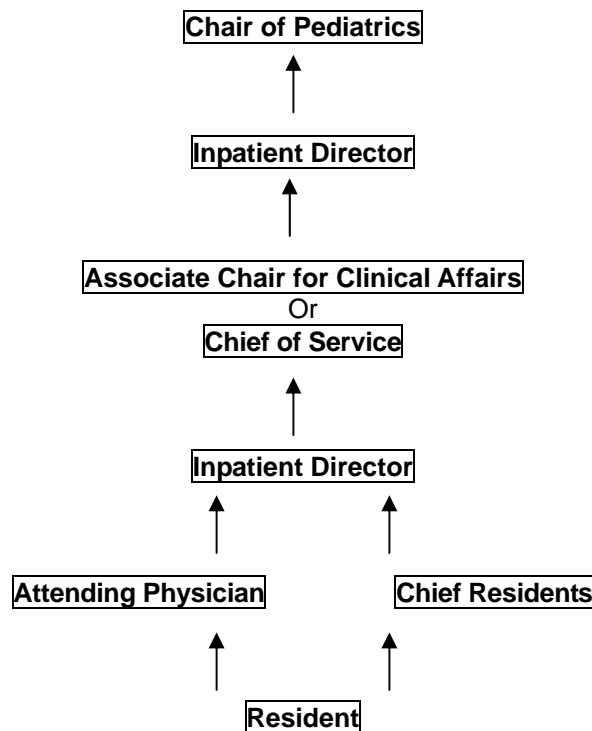
House Staff responses to lawyers and insurance companies made independently of those made by the attending physicians on the case are not appropriate and are not permitted. Therefore, any requests from lawyers or insurance companies received by a House Officer should either be directed to the attending 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 Christine Burke in 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.
- B. 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 float or baby float duty, they are supervised by the admitting physician of record, intensive care unit, or emergency room attending faculty.
- G. 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.
- H. All pediatric residents supervise the activities of medical students in conjunction with the assigned attending faculty member.
- I. An in-house attending is always available in the Emergency Department and in the PICU to assist with emergencies.
- J. 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.
- K. One of the pediatric program directors is always available to discuss and resolve resident-related issues.

### SUPERVISORY ALGORITHM



## 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.

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. Please pay particular attention to the highlighted area in #2.

### 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.

## **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 SICK/PULL CALL RESIDENT**

**PULL CALL POLICY**

**I. OPERATIONAL DEFINITIONS:**

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

B. The Pull Call resident will be used only if the resident who is requesting coverage and the Chief Resident cannot arrange an appropriate switch in the schedule.

C. Each Pull Call resident and intern will receive 24 hours per week free of both pager call and all clinical responsibilities averaged over 4 weeks. Every effort will be made to rearrange schedules, etc., to minimize the clinical burden to others and to minimize use of the Pull Call resident.

D. How much illness or absence from clinical responsibility is allowed before a person will be required to "make-up" time out of his/her vacation or extend his/her residency?

1. The American Board of Pediatrics has stated that all residents must have completed a minimum of 33 months of active residency. If residents have one month of vacation per year, there is obviously little room for flexibility. If more time is missed for any reason, the resident will be required to "make-up" the appropriate amount of time. Decisions regarding make-up of individual days missed will be made on a case by case basis in conjunction with the resident involved, Chief Resident, and Program Director.

**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 Resident and the resident involved will work to arrange for further coverage and discuss the need for make-up of missed time.

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. Pull Call will only be used in emergent situations.

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. Pull Call will only be used in emergent situations.

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 cannot

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 requires Pull Call coverage for 3 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 3<sup>rd</sup> absence) to discuss impact on educational experience and residency requirements, as well as need for additional support.
2. 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 3<sup>rd</sup> day to explain their absence and ensure proper medical care is sought. As stated above, this individual will also be required to meet with a Chief Resident and the Program Director upon their return to discuss impact on educational experience and residency requirements as well as need for additional support.
3. If a resident's *illness* results in absence for 5 or more *consecutive* days, this individual will be 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. As stated above, this individual will also contact the Program Director on the 3<sup>rd</sup> day of absence, and meet with a Chief Resident and the Program Director upon their return to discuss impact on educational experience and residency requirements as well as need for additional support.

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 the on-call Chief Resident as soon as possible. This should be done in all absences regardless of the anticipated need for coverage.
- B. The resident will explain to the Chief Resident the reason for absence and expected duration of absence.
- C. As stated above, if a resident misses 3 or more *consecutive* days, he or she will be asked to contact the Program Director on the 3<sup>rd</sup> day to discuss his or her medical situation and ensure proper medical care is sought.
- D. As stated above, if a resident misses 5 or more *consecutive* days due to illness, the Program Director will require a note from the resident's medical care provider.
- E. As stated above, if a resident requires coverage for 3 or more days during an academic year, the resident will meet with a Chief Resident and the Program Director as soon as possible (ideally within 1 week after the 3<sup>rd</sup> absence) to discuss impact on educational experience, residency requirements, and need for additional support.
- F. Note: 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, the resident for whom coverage is required needs to "make-up" missed time to fulfill residency requirements, and the covering resident has missed extensive Elective or Newborn Nursery time while covering one resident.

#### IV. 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, etc., to minimize the clinical burden to others and to minimize use of 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. "First Pull Call" and "Second Pull Call" designations when more than one resident from a given year is on Pull Call
5. Previous day and following day activities/responsibilities
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. (In the event that it is impossible for this individual to take call, he/she may be responsible for repaying whoever ultimately takes the call responsibility.) 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 20 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 will 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/or 3 or more days during one academic year so that appropriate actions may be taken as described above.

#### V. RESPONSIBILITIES OF PULL CALL RESIDENT

A. A resident on Pull Call will turn his or her pager on at 8PM on the Sunday before their Pull Call Coverage begins (Tuesday evening for PGY1's). 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 Sunday evening before their Pull Call coverage begins (Tuesday evening for PGY1's), 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 on Monday morning at 6AM (Wednesday morning for PGY1's).
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.

- B. The Pull Call resident's coverage responsibilities begin at 7AM on Monday (Wednesday for PGY1's). The earliest the Pull Call resident will be required to be in the hospital will be 7AM.
- C. Residents on Pull Call must be available on pager 24 hours a day (starting Sunday at 8PM and ending the following Monday at 7AM; Tuesday to Wednesday for PGY1's). The resident will return the page within 20 minutes, and arrive at the designated site within 1 hour of the page.
- D. 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.
- E. The Pull Call resident's coverage responsibilities end at 7AM on the Monday following the week of call (i.e. the resident covers through Sunday night [PGY2-4] or Tuesday night [PGY1]). The exception is that when necessary, he or she will round post-call.
- F. 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.
- G. If a resident is found to be unavailable for Pull Call, the Chief Residents will refer the matter to Program Director as a violation of the professional code of conduct.
- H. 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 resident for whom coverage is required needs to "make-up" missed time to fulfill residency requirements and the covering resident has missed extensive elective time 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.
- I. Resident Directed Changes: A resident that wishes to make changes to the Pull Call schedule must contact other members of the program with the appropriate level of experience to arrange a switch. If this change is agreed upon, the resident requesting the change must notify the Chief Resident, who will update the schedule. Any changes in the Pull Call Schedule must be approved by the Chief Resident.

### **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 sick 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.

**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**

Employment Assistance Program (EAP). The program may be contacted by calling 275-4987. 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 sick-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-float 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.

### **LEAVE-OF-ABSENCE POLICY**

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. In addition, the American Board of Pediatrics requires 33 months of active residency time (22 months for Med/Peds residents). If 3 months of vacation time are taken out of a total of 36 months of residency, there is obviously little leeway here. Furthermore, unless the leave is certified as disability (e.g. 6 weeks of maternity leave) or sick 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.

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

Prior to beginning your leave you must complete a leave form available in the program directors' offices and you will need to speak with the Program Director. Also, you will need to speak with the Program Director 4 months prior to residency completion to establish your termination date.

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 Senior Chief Residents before the deadline that is established each spring, in order to have the request considered for incorporation into the year-long schedule for the following academic year. Submitting such a request after the deadline will generally **not** result in revision of the year-long schedule by the Chief Residents. Therefore, any resident who determines a personal need to revise his or her clinical responsibilities after publication of the year-long schedule is expected to submit to the Chief Residents the proposals for substitutions and exchanges that s/he has arranged privately. The Chief Residents will review each proposal with an eye toward support for the resident's request while also striving to meet the requirements of the pediatric residency curriculum and preserving a satisfactory

degree of coverage on the clinical services. The Chiefs will respond to each request as quickly as possible. The resident should propose acceptable alternatives or s/he will be expected to fulfill the clinical duties that are published in the schedule. Requests for **urgent** leaves of absence, for medical or other reasons, will continue to be facilitated by the Program Director and Chief Residents, so that they may be enacted as quickly as possible.

### **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 our 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.
4. 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 15.)

### **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 house officer 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 will periodically assess the residents' working hours. Twice each academic year, interns and residents will be asked to anonymously record how they spend their time during a 2-4 week period. **Please make sure you fill in these sheets carefully and honestly. Do not inflate your hours.** Their time sheets will be reviewed for compliance and then filed in the Office of Medical Education. 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, "**self**" 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 a self elective be completed before the resident begins the experience. For all "self" 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 a self-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 self-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 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 meet with the pediatric residency training program director and the chair of pediatrics 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**

- 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 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, ad 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 URM 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 URMC 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 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 ad hoc committee determines that the department either failed to follow procedures or lacks adequate documentation for its decision, 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.

Approved by GMEC 9/14/98

Updated by GMEC 3/1/99, 2/12/01, 10/18/04, 9/12/05

## **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) **Growth Chart must be completed as part of the initial record. Growth parameters and percentiles should also be noted in the Intern's Admission Note.**
- 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) Flow Sheets of physical and lab findings, weights, I & O's, and any therapies should be maintained where appropriate, e.g., patients in congestive failure, in diabetic ketoacidosis, on TPN and babies under 2 months of age, as well as patients in the PICU and ICN/SCN. Pre-printed flow sheets for TPN patients are available on the floors or through the Nutritional Support Team.
- E) 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.
- F) 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 written with the latter faxed to the primary care physician at discharge. Discharge summaries are the responsibility of supervisory residents. This past year, a number of residents participated in a QI project to improve Discharge Summaries. The new summaries will be in place by the start of the new academic year and should allow you to be more succinct, efficient, and informative. 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. OFF Service/Interim Summary Notes

Interim summary/Off-Service Notes are completed in the portal discharge summary section and printed and placed in the chart at the end of each residents rotation. A handwritten summary may also be used. 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 CIS. 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. 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.**

### **NEW NY STATE PRESCRIPTION BLANKS**

**Why the new regulations?** They will provide improved protection against fraud.

**What does it mean for residents?**

- For residents who have their own license, you can order your own prescription blanks (free of charge) from the NY State Dept of Health. If you do have your license already, this is by far the easiest and most hassle-free. You do not need a DEA number to order your own blanks.
- The new NY State Rx blanks **MUST** be used for all controlled substances (no more triplicates). You will need to write the institution's DEA number or your own, if you have one.
- When at RGH, you must use the RGH prescription blanks, stamped with your stamper. The patient's name must be written in rather than using one of the sticker labels.
- The hospital already has new NYS institutional blanks that we can sign out from the pharmacy. Our pediatric pharmacists have checked out multiple pads for us that we can each go by and get, but you must sign for them. You can go by and see Matt or Keith in the peds pharmacy office.
- The new blanks are also available at RGH.
- One caveat to all the new changes is when we are working in a clinic other than Strong or RGH. For example, if you are working in a private pediatrician's office for your second, the SMH or RGH institutional blanks are not to be used there. The physician you are working with would have to write all scripts for you, **UNLESS** you have your own NYS personalized scripts with your name on it (obtained from the NYS DOH as mentioned above).

### **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.

You will receive a blue book to carry with you to get verification of completed procedures. This blue book needs to be turned in to the residency office in early November and early May so a Delineation of Competence form can be generated for your semi-annual review with the Program directors.

### **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. The intern should attempt to review all blood smears and microscopic examinations which he/she orders.
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. There is a special form for initial consultation requests which should be completed and placed in the chart by the requesting house officer.
4. 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.
5. 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.

- e. When a house officer is called to see a baby in the newborn nursery or brings a baby back to the NICU for a "2-hour observation," a note needs to be documented on the chart. It does not need to be an extensive history and physical, but it should simply reflect why you were called, what you observed, and what you did. Also document the indication for any tests that you may order. Besides covering yourself, this is especially helpful for attending physicians who round the next morning.
6. **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 in 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.
7. **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. The benchmarks for attendance are 80% for the interns and 65% for senior residents (because the curriculum is repeating at 1 to 1 1/2 year intervals).

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 RGH.

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

	5 Month Attendance		
	MR	Noon	GR
R1	29	28	9
R2	17	11	5
R3	24	15	8

	11 Month Attendance		
	MR	Noon	GR
R1	64	61	20
R2	37	24	11
R3	52	33	17

- 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. Resident Report for inpatient R2s and R3s at SMH with an evidence-based mentor takes place on Friday mornings from 8:30 AM to 9:00 AM. SMH inpatient interns have similar rounds with a faculty member on Friday from 8:30 AM to 9:00 AM.

10. Medical Students:

- a. Fourth Year Students rotate on pediatric units as acting interns. Pl-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:

Two years ago, the senior residents were asked to participate in a group QI project about hand-offs, which have been quite variable and which have been identified as a major cause of sentinel events or errors by JACHO. In addition, only 8% of medical schools teach anything about hand-offs. The senior residents, both pediatric and medicine-pediatric, came up with a standardized template for hand-offs, one that can be taught to medical students as well. You will each receive a card outlining the process and also helpful hints about sign-offs. The Hand-off process is called DATAS:

### **D**escriptive identification of the patient

Who the patient is, and why they're admitted

### **A**ctive patient issues

What is currently going on with the patient

### **T**o-do and follow-up issues

Results, notes, discussions to address

### **A**nticipatory guidance

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

### **S**pecial 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.**

## 13. Stat Transfer Summary Procedure:

Transfer summaries should be done either in provider portal or by hand. 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 provider order entry (CPOE) portal of the CIS program.

CIS help can be obtained by paging 5-1616, pager 7411 or 220-3817 24 hours a day. If you cannot find something, try the G-Search Option and then type in a few letters of the order you are unable to locate.

**Verbal orders are to be used only in an emergency where you do not have access to a computer and the patient needs this intervention immediately.** These orders must be entered and electronically signed as soon as possible and certainly within 24 hours.

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 three categories of medication orders relative to turn around time: STAT, ASAP 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.
- Orders marked ASAP are reviewed and the medication dispensed within sixty minutes of receiving the order.
- 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.

### **MEDICAL 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 new E-Value 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 Program Directors will meet with all residents twice a year (grouped by year of training) and review evaluations.
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. 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 form for 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.

# **Pediatric Residency Review Committee Requirements**

# ACGME Program Requirements for Graduate Medical Education in Pediatrics

*Common Program Requirements are in BOLD*

*Effective: July 1, 2007*

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## Introduction

Residency programs in pediatrics must provide three years of consecutive training that involve progressive responsibility.

### A. Duration and Scope of Training

1. Programs must provide residents with a broad exposure to the health care of children and substantial experience in the management of diverse pathologic conditions. This must include experience in child health maintenance and those conditions commonly encountered in primary care practice. It must also include experience with a wide range of acute and chronic medical conditions of pediatrics in both the inpatient and ambulatory settings.
2. Each program must describe a core curriculum that complies with the Review Committee's requirements and in which all residents participate. All residents in the program must have a minimum of 18 months of training in common. In addition, programs that utilize multiple hospitals or that offer more than one track must provide evidence of a unified educational experience for each resident.
3. The first year should include an introduction to the basic experiences on which the rest of the training will be based. During the last 24 months of training, the program must require residents to supervise the activities of more junior residents within the approved inpatient and outpatient educational settings.
4. Throughout the three years of training, the goal should be the achievement of competency in patient care, medical knowledge, professionalism, communication, practice-based learning and improvement, and systems-based practice.

### B. Goal of the Residency

1. The goal of residency training in pediatrics is to provide educational experiences that prepare residents to be competent general pediatricians able to provide comprehensive and coordinated care to a broad range of pediatric patients. The residents' educational experiences must emphasize the competencies and skills needed to practice general pediatrics of high quality in the community. In addition, residents must become sufficiently familiar with the fields of subspecialty pediatrics to enable them to participate as team members in the care of patients with chronic and complex disorders.
2. Residents must be given the opportunity to function with other members of the health care team in both inpatient and ambulatory settings to become competent as leaders in the organization and management of patient care.

## **I. Institutions**

### **A. Sponsoring Institution**

**One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites.**

**The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program.**

### **B. Participating Sites**

- 1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years.**

**The PLA should:**

- a) identify the faculty who will assume both educational and supervisory responsibilities for residents;**
  - b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;**
  - c) specify the duration and content of the educational experience; and,**
  - d) state the policies and procedures that will govern resident education during the assignment.**
- 2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).**
  - 3. An accredited program may be independent or may occur in two or more sites that develop formal agreements and conjoint responsibilities to provide complementary facilities, teaching staff, and teaching sessions. When participating sites are utilized and a single program director assumes responsibility for the entire residency, including the appointment of all residents, the determination of all rotations, and the assignment of both residents and members of the teaching staff, the participating site may be proposed as *integrated*. Ordinarily, a hospital may not be an integrated part of more than one pediatric residency, and a program may not propose the primary teaching site of another accredited program as an integrated participant. The Review Committee must approve the designation of a participating hospital as integrated. In making its determination, the Review Committee will consider the proximity of the hospital to the primary teaching site and the duration of rotations**

planned. Normally, at least three months of required experience should occur at a hospital that is designated as integrated. A significant increase in the time spent at an integrated hospital should receive prior approval from the Review Committee. Within a single program some participating hospitals may qualify as integrated, while others are merely affiliated with the program.

- I.B.*
4. Although no limit is placed on the duration of rotations to sites that are integrated with the primary hospital's pediatric program (although the duration must have Review Committee approval), rotations to participating sites that are not integrated with the primary hospital may not exceed a total of nine months during the three years of training. No more than three months of these outside rotations may be in sites that do not have their own pediatric residency.
  5. Rotations to other programs should enrich but not replace core experiences. When residents rotate to a site that has its own accredited pediatric residency, the rotating residents must be fully absorbed into the prevailing pattern of instruction and patient care at the same level as the pediatric residents of that host program.
  6. Residency programs that offer training to residents from other pediatric residencies must provide instruction and experience equivalent to that given to their own residents. They should enter into agreements with other programs only if they are prepared to absorb those residents into the prevailing pattern of education and patient care.

## II. Program Personnel and Resources

### A. Program Director

1. **There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.**
  - a) Given the differences in training programs, there may be flexibility in defining program leadership, with a suggested minimum of 0.75 full time equivalent (FTE) dedicated to this aspect of the residency program. In order to provide this level of leadership, the program director should devote at least 0.5 FTE of his/her professional effort to this activity. In a residency program of fewer than 31 residents (each resident in a combined program considered as 1.0 FTE), there should be a total of 0.75 physician faculty FTEs dedicated to the operation of the program. In a program of 31-60 residents, this should be 1.0 faculty FTEs. For programs with 61-90 residents, support should be 1.25 faculty FTEs, and for those with over 90 residents, 1.5 FTEs. If the program director is unable to fulfill commitments beyond 0.5 FTE, additional time should be provided by key faculty members designated as associate program directors. Associate program director time should be provided in increments of no less than 0.25 FTE. This level of program leadership should be supported financially by the sponsoring and/or participating sites.

*II.A.*

2. **The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.**
3. **Qualifications of the program director must include:**
  - a) **requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;**
  - b) **current certification in the specialty by the American Board of Pediatrics, or specialty qualifications that are acceptable to the Review Committee; and,**
    - (1) **If Board certification is lacking, the Review Committee will review active participation in national societies, evidence of ongoing scholarship through contributions to the peer-review literature, and presentations at national meetings.**
  - c) **current medical licensure and appropriate medical staff appointment.**
4. **The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:**
  - a) **oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;**
  - b) **approve a local director at each participating site who is accountable for resident education;**
  - c) **approve the selection of program faculty as appropriate;**
  - d) **evaluate program faculty and approve the continued participation of program faculty based on evaluation;**
  - e) **monitor resident supervision at all participating sites;**
  - f) **prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;**
  - g) **provide each resident with documented semiannual evaluation of performance with feedback;**
  - h) **ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;**
  - i) **provide verification of residency education for all residents, including those who leave the program prior to completion;**

*II.A.4.*

- j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:**
  - (1) distribute these policies and procedures to the residents and faculty;**
  - (2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;**
  - (3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,**
  - (4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.**
- k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;**
- l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;**
- m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;**
- n) obtain review and approval of the sponsoring institution's GMCC/DIO before submitting to the ACGME information or requests for the following:**
  - (1) all applications for ACGME accreditation of new programs;**
  - (2) changes in resident complement;**
    - (a) A modest change in the resident complement may be made without prior Review Committee approval if the program has the necessary resources to train the additional resident(s) without diluting the experience of those already in the program, and if the change has the approval of the designated institutional official of the sponsoring institution. A program that plans to implement such an increase should review the most recent letter of notification from the Review Committee for any citations pertaining to resources. Any such citation should be addressed prior to implementing an increase in complement. Proposed increases must be reported electronically through ADS.**
  - (3) major changes in program structure or length of training;**

*II.A.4.n.*

- (4) progress reports requested by the Review Committee;**
  - (5) responses to all proposed adverse actions;**
  - (6) requests for increases or any change to resident duty hours;**
  - (7) voluntary withdrawals of ACGME-accredited programs;**
  - (8) requests for appeal of an adverse action;**
  - (9) appeal presentations to a Board of Appeal or the ACGME; and,**
  - (10) proposals to ACGME for approval of innovative educational approaches.**
- o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:**
- (1) program citations, and/or**
  - (2) request for changes in the program that would have significant impact, including financial, on the program or institution.**

**B. Faculty**

- 1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location.**

**The faculty must:**

- a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and**
  - (1) In addition to the key faculty, all programs should have a minimum of one person (e.g., a senior resident, chief resident, or junior faculty) who functions as a liaison between the residents and faculty. Support, based on program size, should be as follows: fewer than 31 residents, one FTE; 31–90 residents, two FTEs and for greater than 90 residents, three full-time equivalents. These numbers reflect minimum support.**
  - (2) A measure of the commitment of the teaching staff to the pediatrics program is the degree to which patients under their care are available for resident education.**
- b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.**

*II.B.*

- 2. The physician faculty must have current certification in the specialty by the American Board of Pediatrics, or possess qualifications acceptable to the Review Committee.**
  - a) Each time the program is evaluated by the Review Committee, it is the responsibility of the program director to provide evidence of appropriate qualifications for the teaching staff who lack Board certification (e.g. participation in national societies, evidence of ongoing scholarship through contributions to the peer-review literature, and presentations at national meetings).
- 3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.**
- 4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.**
- 5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.**
  - a) **The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.**
  - b) **Some members of the faculty should also demonstrate scholarship by one or more of the following:**
    - (1) **peer-reviewed funding;**
    - (2) **publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;**
    - (3) **publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,**
    - (4) **participation in national committees or educational organizations.**
  - c) **Faculty should encourage and support residents in scholarly activities.**
- 6. General Pediatricians**

Within the primary hospital and/or integrated participating hospitals, there must be teaching staff with expertise in the area of general pediatrics who will serve as teachers, researchers, and role models for general pediatrics. To maintain their clinical skills, these physicians should have a continuing time commitment to direct patient care. Hospital-based as well as community-based general pediatricians should participate actively in the program as leaders of formal teaching sessions, as outpatient preceptors, and as attending physicians on the general inpatient services. The number of general pediatricians actively involved in the teaching program must be sufficient to enable each resident to establish close working relationships that

foster role-modeling. Where teaching staff participate on a part-time basis, there must be evidence of sufficient involvement and continuity in teaching.

## *II.B.* 7. Subspecialty Faculty

Similarly, within the primary hospital and/or integrated participating hospitals, there must be qualified teaching staff with subspecialty expertise who will serve as teachers, researchers, and role models for the residents. Specifically, there must be teaching staff with training and/or experience in behavioral and developmental pediatrics and in adolescent medicine. Within the primary hospital and/or integrated participating hospitals, there must also be teaching staff in at least five of the listed pediatric subspecialties (see Section IV.A.5.b)(1)(f)(ix)) from which the four required one-month rotations must be chosen. These pediatric subspecialists must function on an ongoing basis as integral parts of the clinical and didactic components of the program in both outpatient and inpatient settings.

## 8. Other Faculty

A surgeon having significant experience with pediatric patients must play a major role in the residents' education with respect to surgical diagnoses and preoperative and postoperative care. A pathologist and a radiologist who have significant experience with pediatric problems and who interact regularly with the pediatric residents are also essential.

## 9. Faculty Development

Since the faculty is expected to be role models for residents, they should demonstrate the knowledge, skills, and attitudes needed to provide an environment in which the competencies become habits of practice. To accomplish this there must be a structured program for faculty development that addresses clinical, teaching, research, and leadership skills. Teaching and evaluation of competencies must be included as part of this program.

## **C. Other Program Personnel**

**The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program.**

1. Teaching by other health professionals such as nurses, pharmacists, social workers, child-life specialists, physical and occupational therapists, speech and hearing pathologists, respiratory therapists, psychologists, and nutritionists is highly desirable.
2. Each residency should have a minimum of one FTE designated for administrative support. For programs of 31-60 residents, this support should be 1.5 FTE; for programs of 61-90 residents, two FTEs; and for programs of more than 90 residents, three FTEs. These positions should be financially supported by the sponsoring and/or participating sites.

## **// D. Resources**

**The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements.**

### **1. Inpatient and Outpatient Facilities**

- a) The inpatient and outpatient facilities must be adequate in size and variety, and must have the appropriate equipment necessary for a broad educational experience in pediatrics.
- b) There must be an emergency facility that is appropriately equipped and staffed for the care of pediatric patients. The program must also have an intensive care facility that is appropriately equipped and staffed for the care of a sufficient number of seriously-ill pediatric patients to provide adequate experience for the number of residents in the program.

### **2. Patient Population**

The pediatric patients that must be available for resident education range in age from infancy through young adulthood. Programs must provide residents with patient care experience in both inpatient and outpatient settings. Insufficient patient experience does not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which might also jeopardize the educational experience.

## **E. Medical Information Access**

**Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available.**

## **III. Resident Appointments**

### **A. Eligibility Criteria**

**The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.**

### **B. Number of Residents**

**The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. The program's educational resources must be adequate to support the number of residents appointed to the program.**

### *III.B.*

1. The Review Committee for Pediatrics does not approve a specific number of resident positions. At the time of program review, the Committee will judge the adequacy of the program's resources to support the number of resident positions proposed.
2. Because peer interchange is a very important component of the learning process, each program is expected to recruit and retain a sufficient number of qualified residents to fulfill the need for peer interaction among those training in pediatrics.
3. Residents at more than one level of training must interact in the care of inpatients, allowing for frequent and meaningful discussion during all phases of the training program (e.g., neonatal, outpatient, inpatient, and emergency services). To achieve this, a program should offer a minimum total of 12 resident positions (i.e., four at each level, exclusive of subspecialty residents). Except for periods of transition, the same number of positions should be offered in each of the three years of training. An inability to recruit the required minimum number of residents and/or a high rate of resident attrition from a program over a period of years will be a cause of concern to the Review Committee. The Review Committee will consider the presence of residents from combined pediatrics programs (e.g., medicine-pediatrics or pediatrics-emergency medicine), when it evaluates the adequacy of the resident complement and of peer interaction. The total number of residents from combined programs should not be so large as to have a negative effect on the education of categorical residents.

### **C. Resident Transfers**

1. **Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.**
2. **A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.**

### **D. Appointment of Fellows and Other Learners**

**The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines.**

## **IV. Educational Program**

### **A. The curriculum must contain the following educational components:**

1. **Overall educational goals for the program, which the program must distribute to residents and faculty annually;**

IV.A

2. **Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;**
3. **Regularly scheduled didactic sessions;**
  - a) Departmental conferences, including regular morbidity and mortality conferences, seminars, teaching rounds, and other structured educational experiences must be conducted on a regular basis and with sufficient frequency to fulfill educational goals.
  - b) Reasonable requirements for resident attendance should be established for the various conferences; their attendance should be documented, and there must be appropriate faculty participation.
4. **Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,**
5. **ACGME Competencies**

**The program must integrate the following ACGME competencies into the curriculum:**

**a) Patient Care**

**Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents:**

- (1) must be able to provide family-centered patient care that is culturally effective and developmentally and age appropriate;
- (2) must be exposed to sufficient numbers of patients ranging in age from infancy through young adulthood, and representing a diverse population of varying complexity in various clinical settings. The resident must have breadth and depth of inpatient experience in the format determined by the Review Committee. A minimum of 40% of clinical training should be devoted to ambulatory experiences. These experiences include all assignments in the continuity practice, emergency and acute care, and community-based practices, as well as the ambulatory portion of normal/term newborn, developmental/behavioral, adolescent medicine, and other subspecialty experiences;
- (3) must be given progressive responsibility under close faculty supervision within a team that fosters peer and supervisory interchange. The availability of consultative resources appropriate to the patient base must be ensured,

while allowing residents to participate in the full spectrum of patient care from admission through discharge in the inpatient setting, and from intake through follow-up in the outpatient setting;

*IV.A.5.a).*

- (4) must have a satisfactory patient care experience that includes: sufficient numbers of patients, diversity of diagnoses, and acuity/complexity of the patients. Faculty must document the fact that residents possess the necessary knowledge, skills, and attitudes to provide longitudinal primary care to patients;
- (5) should demonstrate competence in the following elements of patient care:
  - (a) gathering essential and accurate information about the patient;
  - (b) interviewing patients/families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease;
  - (c) performing complete and accurate physical examinations. Residents must be evaluated performing histories and physical examinations. This must be accomplished through direct observation using a structured approach with different evaluators in different settings.
  - (d) making informed diagnostic and therapeutic decisions;
  - (e) developing and carrying out management plans;
    - (i) Residents must have the opportunity for independent evaluation, management, and coordination of care under the guidance of faculty. Residents must demonstrate progressive autonomy over the course of training that affords them the ability to act in a supervisory role under faculty guidance. A minimum of five supervisory months is required during the last 24 months of training.
    - (ii) Supervising residents/faculty must document the residents' ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. This may be accomplished through direct observation in the clinical setting supplemented by one of the following: chart reviews or chart stimulated recall; faculty review of completed case-based modules; an observed structured clinical encounter; or some combination of these or other methods.
    - (iii) Residents should participate in the following:
      - (a) independent evaluation and development of a differential diagnosis, diagnostic work-up, therapeutic management, coordination of care, and discharge planning under faculty guidance;

IV.A.5.a).(5).(e).(iii)

- (b) diagnosis and management of acute episodic medical illness, such as meningitis, sepsis, dehydration, pneumonia, diarrhea, renal failure, seizures, coma, hypotension, hypertension, and respiratory illnesses;
- (c) diagnosis and management of acute problems associated with chronic diseases, such as diabetic ketoacidosis, status asthmaticus, status epilepticus, oncologic therapy and complications, congenital heart disease, cystic fibrosis, chronic renal disease, gastrointestinal disorders, hepatic failure, metabolic disorders, neurologic disorders, and rheumatologic disorders;
- (d) pediatric aspects of the management of surgical patients, both preoperatively and postoperatively, including interaction with the surgical team.

(iv) In addition to the above, each resident should demonstrate the following:

- (a) the ability to determine which patients require in-hospital care and why, including medical, psychosocial, and environmental considerations;
- (b) the skills in deciding which patients may be managed on a general inpatient service and which require higher levels of care and expertise in a critical care unit;
- (c) the ability to select and interpret appropriate studies in the evaluation of patients;
- (d) the ability to utilize best evidence to determine therapeutic management; and,
- (e) the appropriate use of consultants.

(f) prescribing and performing all medical procedures;

- (i) These educational experiences should be graduated so that residents build and maintain skills throughout the training program. Residents should be supervised until they can demonstrate the necessary skill for independent practice.
- (ii) The program must document instruction in the performance of procedures including indications, contraindications, and complications. As part of procedural competence, residents must be able to obtain informed consent and address the pain that is associated with procedures. Residents must use the on-line log provided by the ACGME to record their procedures. The program director must have documentation showing the competence of each resident for each

procedure. The program must also document that residents have completed training in both Pediatric Advanced Life Support and the Neonatal Resuscitation Program.

IV.A.5.a).(5).(f)

(iii) Residents must have sufficient training in the following skills:

- (a) basic and advanced life support;
- (b) endotracheal intubation;
- (c) placement of intraosseous lines (demonstration in a skills lab or PALS course is sufficient);
- (d) placement of intravenous lines;
- (e) arterial puncture;
- (f) venipuncture;
- (g) umbilical artery and vein catheterization;
- (h) lumbar puncture;
- (i) bladder catheterization;
- (j) gynecologic evaluation of prepubertal and postpubertal females;
- (k) wound care and suturing of lacerations;
- (l) subcutaneous, intradermal, and intramuscular injections;
- (m) developmental screening test;
- (n) procedural sedation;
- (o) pain management; and,
- (p) reduction and splinting of simple dislocations/fractures.

(iv) In addition, residents should have exposure to the following procedures or skills:

- (a) circumcision;
- (b) tympanometry and audiometry interpretation;
- (c) vision screening;
- (d) hearing screening;

IV.A.5.a).(5).(f).(iv)

(e) simple removal of foreign bodies (e.g., from ears or nose);

(f) inhalation medications;

(g) incision and drainage of superficial abscesses;

(h) chest tube placement; and,

(i) thoracentesis.

(g) counseling patients and families; faculty must document effective counseling of patients and families by residents, as well as their ability to deliver bad news, based on direct observation and comment from patients and families;

(h) providing effective health maintenance and anticipatory guidance;

(i) A continuity clinic where the resident assumes responsibility for the comprehensive care of a group of patients is an essential component of training.

(ii) Residents must be able to:

(a) develop therapeutic relationships with patients and families;

(b) coordinate the care of children with complex and multiple problems;

(c) provide child health supervision with an emphasis on age and developmentally appropriate anticipatory guidance and screening;

(d) provide anticipatory guidance regarding developmental issues and preventive health care;

(e) implement age-appropriate screening, including oral health;

(f) manage patients with chronic disease by coordinating the care rendered by other health care providers.

(i) using information technology to optimize patient care.

**b) Medical Knowledge**

**Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents:**

(1) must demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to pediatrics.

IV.A.5.b).(1)

(a) Inpatient

- (i) Resident experience on the inpatient service must be for a minimum of five months. A variety of patient experiences will meet this requirement, including general pediatric patients, mixed non-intensive care subspecialty patients, or a single group of non-intensive care subspecialty patients. No more than one of the five required months may be devoted to the care of patients in a single subspecialty. The patient population available for resident education on the inpatient service must be of sufficient number, age distribution, and variety of complex and diverse pathology.
- (ii) Residents at more than one level of training must interact in the care of inpatients. A first-year resident should have direct responsibility for an average daily minimum of five inpatients. If the minimum number of patients is not met, resident inpatient logs will be required to attest to the adequacy of the experience.
- (iii) Residents on the inpatient service must be supervised by pediatric faculty who have extensive experience in and knowledge of the care of pediatric patients with illnesses of sufficient severity to warrant hospitalization. The utilization of general pediatricians in this role is encouraged, provided that consultative services from pediatric subspecialists and other specialists appropriate to the patient population are readily available.
- (iv) Regularly-scheduled teaching rounds must be conducted by qualified generalists and subspecialists who are directly involved in patient care. These rounds must be held at least three times per week, and may not be replaced by rounds that are primarily work oriented. Rounds should be targeted to the knowledge and skills required of a general pediatrician, and should emphasize the appropriate utilization of subspecialist colleagues. The correlation of the pathophysiologic basis of the disease process should be stressed. During ward rotations, there must be teaching rounds that are patient based, and that address such areas as interpretation of clinical data, pathophysiology, differential diagnosis, cost-effective management of the patient, and the appropriate use of technology and disease prevention.
- (v) *In-house call or night call* is defined as those duty hours beyond the normal workday when residents are required to be available on site in the assigned hospital. In addition to providing patient care, the purposes of night call include the following: 1) learning the evolution of disease through continuity of patient care over an extended period of time; 2) cumulative acquisition and maintenance of skills; and 3) fostering progressive independent decision-making. A night-float system may be used. *Night-float* is defined as those duty hours restricted to evening and overnight hours in a block format when

residents are required to be present in the assigned institution. During a night-float rotation, residents do not typically have daytime responsibilities. Structured night-float rotations for which there are formal goals, objectives, and a specific evaluation component, and which provide an educational experience (i.e., both rounds and conferences with faculty), may count for 1 of the 5 required months of non-intensive care inpatient experience.

*IV.A.5.b).(1)* (b) Emergency and Acute Illness Experience

- (i) Residents must have a minimum of four months experience in emergency and acute illness. Two of these months should be in emergency medicine, of which the equivalent of one month may be completed longitudinally. At least one of these months must be a block rotation in an emergency department that serves as the receiving point for EMS transport and ambulance traffic and which is the access point for seriously-injured and acutely-ill pediatric patients. This may be either a pediatric emergency department or a combined pediatric/adult emergency department. Assignment to an acute care center or walk-in clinic to which patients are triaged from the emergency department will not fulfill this requirement.
- (ii) The remaining two months of required experience may be in the emergency department or, if patients are available in sufficient numbers, in another setting where acutely-ill pediatric patients are seen. Optional sites may include walk-in clinics or acute care centers. Preferably, this experience should be a block rotation, but integration into other longitudinal experiences is acceptable if the required duration and the educational goals and objectives can be both met and documented, with appropriate supervision ensured.
- (iii) The experience must be designed to develop resident competence in managing unselected and unscheduled patients with acute illness and injury of varying degrees of severity, from very minor to life-threatening.
- (iv) Specific objectives of this experience must include, but not be limited to, the development of skills in the following: resuscitation, stabilization, and triage of patients after initial evaluation; interaction with other professionals involved in emergency care in the emergency department, including the trauma team and emergency physicians; specialists in surgery, anesthesia, radiology, relevant pediatric and surgical subspecialties; dentists and others as appropriate. There must also be interaction with emergency medical personnel in the provision of pre-hospital care for acutely-ill or -injured patients, which includes either preparation of patients for transport or receipt of patients who have been transported via the EMS system.

*IV.A.5.b).(1).(b)*

- (v) Residents must have first-contact evaluation of pediatric patients and continuous on-site supervision. It is not an adequate educational experience if the pediatric resident functions only on a consultative basis or deals only with a pre-selected patient population. Residents in these settings must have on-site supervision by board-certified emergency medicine specialists with expertise in the care of pediatric patients, or by members of the pediatric teaching staff who have documented experience in the care of acute pediatric illnesses and injuries.
- (vi) Residents should have the opportunity to work on a multidisciplinary clinical team to learn the role of the general pediatrician in such a setting. A system for patient outcome feedback to the resident should be established. A resident's performance must be evaluated on a regular basis by staff directly involved in the acute and emergency care experience, and appropriate feedback must be provided to the resident and to the program director.
- (vii) The residents' major responsibility must be for an appropriate range of pediatric patients, although they may be called on to care for some adult patients to ensure adequate volume and diversity. Programs that share the emergency and acutely-ill patient base with other training programs, such as emergency medicine, pediatric emergency medicine, and family medicine, must document that a sufficient and appropriately-diverse pediatric patient population is available to the pediatric residency program.
- (viii) The comprehensive experience for all residents should include, but not be limited to, the following disorders, and should emphasize the pathophysiologic correlates of the clinical situations:
  - (a) acute major and minor medical problems, including but not limited to respiratory infection, respiratory failure, cardiopulmonary arrest, dehydration, coma, seizures, diabetic ketoacidosis, asthma, skin disorders, pyelonephritis, sepsis, shock, fever, and childhood exanthems;
  - (b) acute manifestations or exacerbations of chronic diseases;
  - (c) acute major and minor surgical problems, including but not limited to appendicitis, bowel obstruction, burns, foreign body inhalation and ingestion, abscess drainage, and head trauma;
  - (d) poisonings and ingestion;
  - (e) physical and sexual abuse;
  - (f) minor trauma (including splinting, casting, and suturing);

- IV.A.5.b).(1).(b)(viii)*
- (g) major trauma (including active participation with the trauma team);
  - (h) participation in pre-hospital management and transport;
  - (i) acute psychiatric, behavioral, and psychosocial problems; and,
  - (j) admission or discharge planning, including communication with the personal physician.

(c) Continuity Experience

- (i) A program must document one half-day session per week for a minimum of 36 clinic weeks per year throughout the three years of training for each resident. The program must provide adequate continuity experience for all residents to allow them the opportunity to develop an understanding of and appreciation for the longitudinal nature of general pediatric care including: aspects of physical and emotional growth and development; health promotion and disease prevention; management of acute, chronic, and end-of-life medical conditions; family and environmental impacts; coordination of patient-centered care both within the practice and with multidisciplinary providers; and practice management. The scope of each resident's continuity clinic patient population must be documented with a log that includes age, diagnoses, and encounter dates.
- (ii) Residents must be exposed to a continuity-patient population sufficient in number and of adequate variety to meet the educational objectives. It must include well patients and those with complex and chronic problems. Patients initially managed in the normal newborn nursery, emergency department, inpatient service, intensive care unit (pediatric and neonatal), subspecialty clinics, and other sites may be enrolled in the residents' panels. Inherent in the principle of continuity of care is that patients are seen on a regular and continuing basis. Isolated block experiences alone will not satisfy this requirement. Ideally, residents should participate in the care of their patients through any hospitalization, assess them during acute illnesses, and be available to facilitate other services, such as school-related evaluations and specialty referrals.
- (iii) Residents must see progressive numbers of continuity patients, with a minimum of three patients per session in PGY-1, four in PGY-2, and five in PGY-3. Where residents participate in more than one half-day of continuity clinic per week (i.e., two sessions in same setting or one session in each of two settings), the total number of patients seen per week of clinic may be substituted for the number seen per session.
- (iv) The curriculum should emphasize the generalist approach to common office-based pediatric issues, including anticipatory guidance, developmental and behavioral issues, and immunization practices and

health promotion, as well as the care of children with chronic conditions. Residents must learn to serve as the coordinator of comprehensive primary care for children with complex and multiple health-related problems, and to function as part of a health-care team. Subspecialty consultants and allied health personnel must be available to residents in the care of their continuity patients.

*IV.A.5.b).(1).(c)*

- (v) Residents must assume responsibility for the continuing care of a group of patients throughout their training, either as an individual practitioner or as a team member. In an effort to foster a continuity experience that emulates a pediatric practice setting, the concept of group or team practice will be supported. If a team practice is implemented, there must be a regular and formal mechanism for sharing information among the team members.
- (vi) Regardless of the setting, there should be a continuity relationship among the resident(s), preceptor(s), and a group of patients. To enhance the communication that is essential to continuity of experience, team size should not be excessive, and must include a preceptor or a small group of preceptors to enhance the resident-preceptor relationship. Consistency of preceptors over time is desirable.
  - (a) The preceptors' responsibilities include, but are not limited to, mentoring the residents in communication skills, quality improvement skills, practice management system complexities, and patient advocacy (refer to competencies in Practice-Based Learning and Improvement and Systems-Based Practice).
  - (b) The number of teaching staff in the continuity clinic must be sufficient to ensure an appropriate educational experience for all residents present. Teaching staff who serve as attendings in the continuity clinic must have expertise in the area of general pediatrics, and must be able to function as role models in general pediatrics. They must be actively involved in direct patient care to maintain their expertise and credibility.

(d) Normal/Term Newborn Experience

Residents must have the equivalent of at least one month in the care of normal/term newborns. This may not be part of a neonatal intensive care unit (NICU) rotation, but it may be combined with another experience over a longer period of time if an equivalent duration is demonstrated and if the educational goals of both experiences can be met. If competence in newborn care cannot be achieved in one month, it is desirable for a program to incorporate additional newborn experience. Faculty with expertise in general pediatrics should be involved in this training through teaching and/or supervision. The experience should also include at least the following:

IV.A.5.b).(1).(d)

- (i) recognition and appropriate intervention for high-risk infants;
- (ii) distinguishing well from ill infants;
- (iii) performance of a physical examination on newborn infants, which includes assessment of gestational age and the appropriateness of intrauterine growth;
- (iv) identification of common anomalies, birth defects, and syndromes, including counseling the parents;
- (v) provision of routine newborn care;
- (vi) recognition and treatment of common physiologic deviations in the newborn;
- (vii) identification and management of infants of mothers with substance abuse and/or sexually transmitted diseases (STDs) or other infections;
- (viii) routine newborn screening and appropriate follow-up of infants with positive test results;
- (ix) preventive measures, including immunization schedules and safety issues, such as counseling parents on the importance of infant safety seats and knowledge of normal infant nutrition, including breast feeding and knowledge of normal newborn growth and development; and,
- (x) discharge planning.

(e) Community and Child Advocacy Experiences

- (i) Residents must be provided structured educational experiences, with planned didactic and experiential opportunities for learning and methods of evaluation, which prepare them for the role of advocate for the health of children within the community. These experiences should include both didactic and experiential components that may be integrated into other parts of the curriculum (e.g., continuity, adolescent, behavior/development) or they may be designed as distinct longitudinal or block rotations.
- (ii) Residents must be supervised by pediatricians and other health professionals experienced in the relevant content areas. The curriculum should include, but not be limited to, the following subjects:
  - (a) community-oriented care with focus on the health needs of all children within a community, particularly underserved populations;

IV.A.5.b).(1)(e)(ii)

- (b) culturally-effective health care;
- (c) effects on child health of common environmental toxins, such as lead, and also of potential agents used in bioterrorism;
- (d) the role of the pediatrician as a consultant to schools, in early childhood education and in child care settings;
- (e) the role of the pediatrician in child advocacy, including the legislative process;
- (f) the role of the pediatrician in disease and injury prevention; and,
- (g) the role of the pediatricians in the regional emergency medical system for children, as well as their role in handling mass casualties.
  - (i) These experiences should utilize settings within the community, such as community-based primary care practice settings; community health resources and organizations, including governmental and voluntary agencies (e.g., local and state public health departments, services for children with disabilities and special health care needs, Head Start, schools, including elementary school through college, day care settings, home health services, hospice, facilities for incarcerated youth, and facilities for treatment and management of substance abuse).

(f) Subspecialty Education

- (i) The curriculum must be designed to teach each resident the knowledge and skills appropriate for a general pediatrician, including the management of psychosocial problems that affect children with complex chronic disorders and their families. The experiences should include appropriate reading assignments, subspecialty conferences, and other activities that familiarize the residents with the techniques and skills used by the subspecialists.
- (ii) Although it is not possible for each resident to have a formal rotation through every subspecialty, it is required that all residents be exposed to the specialized knowledge and methods of the pediatric subspecialties through longitudinal experiences on the general inpatient and intensive care services and in outpatient settings. Residents should be taught when to seek consultation, when to refer to the subspecialist, and how to manage chronic illness as a team member with the subspecialist and other allied health professionals.

*IV.A.5.b).(1).(f)*

- (iii) All of the formal subspecialty rotations must involve an adequate number, variety, and complexity of patients to provide each resident with an appropriately broad experience in the subspecialty.
- (iv) During these rotations, residents must be given appropriate patient care responsibilities with an opportunity to evaluate and formulate management plans for subspecialty patients. In the outpatient subspecialty clinics and with appropriate supervision by a subspecialist, residents should function as the physician of first contact.
- (v) Pediatric subspecialty faculty must be directly involved in the supervision of residents, and be readily available for consultation on a continuing basis.
- (vi) Intensive Care Experience (NICU and PICU)
  - (a) The intensive care experiences must provide the opportunity for residents to deal with the special needs of critically-ill patients and their families. The intensive care experience must be for a minimum of five and a maximum of six months.
  - (b) This must include a minimum of three and a maximum of four block months of neonatal intensive care (Level II or III) and two block months of pediatric intensive care. Night and weekend responsibilities when the residents are predominantly responsible for the NICU are included in the allowable maximum intensive care experience, with 200 hours being considered the equivalent of one month. However, when a resident is covering the entire inpatient service, including neonatal intensive care or the delivery room, these hours need not be included in the calculation of time in intensive care. Hours covering the PICU are not included in calculation of time in intensive care.
  - (c) To provide additional experience for those who may need it for future practice, one additional elective block month in critical care may be allowed. As is the case with any block month, it may include call. For a program that trains pediatricians to practice in non-urban areas that require the primary care pediatrician to resuscitate critically-ill infants and children, the program may petition the Review Committee for approval to offer additional critical care experience, providing appropriate justification.
  - (d) The curricula in neonatal and pediatric intensive care must be structured to familiarize residents with the special multidisciplinary and multiorgan implications of fluid, electrolyte, and metabolic disorders; trauma, nutrition, and cardiorespiratory management; infection control; and recognition and management of congenital

anomalies in pediatric patients. It also must be designed to teach the following:

*IV.A.5.b).(1).(f).(vi).(d)*

- (i) recognition and management of isolated and multi-organ system failure and assessment of its reversibility;
  - (ii) understanding of the variations in organ system dysfunction by age of patient;
  - (iii) integration of clinical assessment and laboratory data to formulate management and therapeutic plans for critically ill patients;
  - (iv) invasive and noninvasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral, and metabolic functions;
  - (v) participation in decision making in the admitting, discharge, and transfer of patients in the intensive care units;
  - (vi) resuscitation, stabilization, and transportation of patients to the ICUs and within the hospital;
  - (vii) understanding of the appropriate roles of the generalist pediatrician and the intensivist/ neonatologist in these settings;
  - (viii) participation in preoperative and postoperative management of surgical patients, including understanding the appropriate roles of the general pediatric practitioner and the intensivist in this setting;
  - (ix) participation, during the neonatal intensive care experience, in perinatal diagnostic and management discussions;
  - (x) resuscitation and care of newborns in the delivery room; and,
  - (xi) evaluation and management, during the pediatric intensive care experience, of patients following traumatic injury.
- (vii) Adolescent Medicine
- (a) Residents must receive an experience in adolescent medicine that will enable them to recognize normal and abnormal growth and development in adolescent patients. The experience must include, as a minimum, a one month block rotation to ensure a focused experience in the area of adolescent medicine. This experience must be supervised by faculty qualified to teach adolescent medicine.

*IV.A.5.b).(1).(f).(vii)*

- (b) Residents must receive an integrated experience in this area that incorporates adolescent issues into ambulatory and inpatient experiences throughout the three years (e.g., inpatient unit, community settings, continuity clinic, and subspecialty rotations).
- (c) Residents must receive instruction and experience in the following:
  - (i) normal pubertal growth and development and the associated physiologic and anatomic changes;
  - (ii) health promotion, disease prevention, and anticipatory guidance of adolescents;
  - (iii) common adolescent health problems, including chronic illness, sports-related issues, motor vehicle safety, and the effects of violence in conflict resolution;
  - (iv) interviewing the adolescent patient with attention to confidentiality, consent, and cultural background;
  - (v) psychosocial issues, such as peer and family relations, depression, eating disorders, substance abuse, suicide, and school performance; and
  - (vi) male and female reproductive health, including sexuality, pregnancy, contraception, and STDs.
- (viii) Developmental/Behavioral Pediatrics
  - (a) Residents must have an adequate experience in developmental/behavioral pediatrics to ensure that the resident recognizes normal and abnormal behavior, and understands child development from infancy through young adulthood. The experience must include, as a minimum, a one-month block rotation that is a focused experience in behavioral/developmental pediatrics. The experience must be supervised by faculty qualified to teach developmental/behavioral pediatrics.
  - (b) Residents must receive instruction in the intrinsic and extrinsic factors that influence behavior to enable them to differentiate behavior that can and should be managed by the general pediatrician from behavior that warrants referral to other specialists. Clinical and didactic components of behavioral, psychosocial, and developmental pediatrics should be integrated, when possible, into the general educational program and into each patient encounter.
  - (c) Residents must have an integrated experience that incorporates behavioral and developmental issues into ambulatory and inpatient

experiences throughout the three years (e.g., inpatient unit, community setting, continuity clinic, and subspecialty rotations).

*IV.A.5.b).(1).(f).(viii)*

- (d) The program must include instruction in at least the following components to enable the residents to develop appropriate skills:
  - (i) normal and abnormal child behavior and development, including cognitive, language, motor, social, and emotional components;
  - (ii) family structure, adoption, and foster care;
  - (iii) interviewing parents and children;
  - (iv) psychosocial and developmental screening techniques;
  - (v) behavioral counseling and referral;
  - (vi) management strategies for children with developmental disabilities or special needs, within the context of the medical home;
  - (vii) needs of children at risk (e.g., those in poverty, from fragmented or substance abusing families, or victims of child abuse/neglect);
  - (viii) impact of chronic diseases, terminal conditions, and death on patients and their families; and,
  - (ix) recognition and coordinating care for childhood and adolescent mental health problems that require referral for diagnosis and treatment.

(ix) Additional Required Subspecialty Experience

- (a) Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), residents must commit to at least seven months in subspecialty rotations, four of which must be taken at the primary teaching site and/or integrated hospitals.
- (b) Within these seven months, each resident must complete a minimum of four different one-month block rotations taken from the following list of pediatric subspecialties or closely allied specialties:

- Allergy/Immunology
- Cardiology
- Endocrinology
- Genetics
- Gastroenterology

Hematology/Oncology  
Infectious Diseases  
Nephrology  
Neurology  
Pulmonary  
Rheumatology

*IV.A.5.b).(1).(f).(ix)*

- (c) For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.
- (d) The additional three months may consist of single subspecialties or combinations of specialties from either the list above or the list below. Combinations of subspecialties may be structured as block or longitudinal experiences and, where appropriate, may be combinations of inpatient and outpatient experiences or all outpatient.

Pediatric Anesthesiology  
Child Psychiatry  
Pediatric Dermatology  
Pediatric Ophthalmology  
Pediatric Orthopaedics and Sports Medicine  
Pediatric Otolaryngology  
Pediatric Radiology  
Pediatric Surgery  
Pediatric Physical Medicine and Rehabilitation

- (e) During the three years of training, no more than three block months, or its equivalent, may be spent by a resident in any one of these subspecialties. Subspecialty research electives that involve no clinical activities need not be counted as one of these three block months.

(x) Elective Experiences

Electives should be designed to enrich the educational experience of residents in conformity with their needs, interests, and/or future professional plans. Electives must be well-constructed, purposeful, and effective learning experiences, with written goals and objectives. The choice of electives must be made with the advice and approval of the program director and the appropriate preceptor.

- (2) Residents must have didactic experiences to critically evaluate and apply current medical information and scientific evidence for patient care.

- (a) Faculty must document a resident's ability to access, appraise, and apply knowledge from the medical literature. Faculty evaluations must address the ability of residents to apply best medical evidence to the care of

patients. Evaluation must be based on direct observation and precepting in a clinical setting.

*IV.A.5.b)(2)*

(b) In addition, the program must evaluate the competence of residents in performing an evidence-based exercise. This exercise may include, but is not limited to, a journal club presentation or other structured exercise in which best evidence is applied to a focused clinical question. The evaluation should be based on predetermined criteria.

**c) Practice-based Learning and Improvement**

**Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet the following goals:**

**(1) identify strengths, deficiencies, and limits in one's knowledge and expertise;**

**(2) set learning and improvement goals;**

**(3) identify and perform appropriate learning activities;**

**(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;**

(a) Residents are expected to participate in a quality improvement project.

**(5) incorporate formative evaluation feedback into daily practice;**

(a) Residents are expected to use evaluations of performance provided by peers, patients, superiors and junior colleagues to improve practice.

**(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;**

**(7) use information technology to optimize learning; and,**

**(8) participate in the education of patients, families, students, residents and other health professionals.**

(a) This should be documented by evaluations of residents' teaching abilities by faculty and/or learners.

**(9) take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation specific goals and objectives and attendance at conferences;**

Documented meetings between an individual resident and mentor or advisor for purposes of feedback and guidance must occur at least twice a year. Documentation of an individual learning plan for each resident must occur annually.

**IV.A.5. d) Interpersonal and Communication Skills**

**Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to:**

**(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;**

(a) Residents are also expected to communicate in a developmentally appropriate manner in creating and sustaining such therapeutic relationships.

**(2) communicate effectively with physicians, other health professionals, and health related agencies;**

**(3) work effectively as a member or leader of a health care team or other professional group;**

**(4) act in a consultative role to other physicians and health professionals; and,**

**(5) maintain comprehensive, timely, and legible medical records, if applicable.**

Teaching of this competency must begin with role modeling. Role modeling should be supplemented by direct observation of resident communication skills in real or simulated situations.

Written evaluations based on direct observation must document effective communication with patients/families, supervisors, fellow residents, allied health professionals, non-medical staff, and referring physicians. These assessments must address effective communication of health care information in the resident's role as primary caretaker, consultant, team member, and team leader as appropriate. Written evaluations of a resident's communication skills by patients/families and members of the health care team must also be sought.

In addition, the program must evaluate each resident's skill in written documentation and timely completion of medical records.

IV.A.5. e) **Professionalism**

**Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate:**

- (1) compassion, integrity, and respect for others;**
- (2) responsiveness to patient needs that supersedes self-interest;**
- (3) respect for patient privacy and autonomy;**
- (4) accountability to patients, society and the profession; and,**
- (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.**
- (6) high standards of ethical behavior which includes maintaining appropriate professional boundaries.

The program must document teaching of this competency. This may consist of, but is not limited to, traditional lectures, case-based teaching modules, discussion of vignettes, or role playing exercises that address aspects of ethical and professional behavior.

Written evaluations of a resident's professional behavior by patients/families and members of the health care team based on direct observation must document elements of this competency.

Discussion of critical incidents (especially positive or negative behaviors) must be part of the ongoing mentoring of every resident.

f) **Systems-based Practice**

**Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:**

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;**
  - (a) Residents are expected to know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare cost, assuring quality, and allocating resources.
- (2) coordinate patient care within the health care system relevant to their clinical specialty;**

IV.A.5.f)

- (3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;**
- (4) advocate for quality patient care and optimal patient care systems;**
- (5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,**
- (6) participate in identifying system errors and implementing potential systems solutions.**
- (7) know how to advocate for the promotion of health and the prevention of disease and injury in populations;

The program must ensure structured educational experiences to address the following:

- (a) patient advocacy within the system (understanding the epidemiology of major health problems and health literacy awareness in the community);
- (b) risk management;
- (c) cost effectiveness, balancing cost and quality;
- (d) health care organization, financing, and practice management, including the organization and financing of health care services for children at the local, state, and national levels and the role of the pediatrician in the legislative process;
- (e) the organization and financing of clinical practice, including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system; and,
- (f) systems approach to examining health care delivery practices, system errors and system solutions to error prevention.

The program must document teaching of this competency. These sessions may include, but are not limited to, traditional conferences or completion of case-based learning modules.

The program must also document experiential learning for the element that addresses the system causes of health care errors. Examples include, but are not limited to, a resident presentation at morbidity and mortality conference that focuses on potential system errors, or resident participation in an institutional process that identifies a system-based cause of an adverse patient outcome.

Faculty should assess resident progress in this domain. In addition, evaluations by other health professions must be obtained to assess residents' ability to function as part of an interdisciplinary team.

#### **IV. B. Residents' Scholarly Activities**

- 1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.**
- 2. Residents should participate in scholarly activity.**
- 3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.**

#### **V. Evaluation**

##### **A. Resident Evaluation**

##### **1. Formative Evaluation**

- a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.**
- b) The program must:**
  - (1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;**
  - (2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);**
  - (3) document progressive resident performance improvement appropriate to educational level; and,**
  - (4) provide each resident with documented semiannual evaluation of performance with feedback.**
- c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.**

##### **2. Summative Evaluation**

**The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident's permanent record maintained by the institution, and must be**

accessible for review by the resident in accordance with institutional policy.  
This evaluation must:

- V.A.2.
- a) document the resident's performance during the final period of education, and
  - b) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision.

## **B. Faculty Evaluation**

1. At least annually, the program must evaluate faculty performance as it relates to the educational program.
2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.
3. This evaluation must include at least annual written confidential evaluations by the residents.

## **C. Program Evaluation and Improvement**

1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:
  - a) resident performance;
  - b) faculty development;
  - c) graduate performance, including performance of program graduates on the certification examination; and,
  - d) program quality. Specifically:
    - (1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and
    - (2) The program must use the results of residents' assessments of the program together with other program evaluation results to improve the program.
2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

V.C.

3. One outcome measure of the quality of a residency program is the performance of its graduates on the certifying examinations of the American Board of Pediatrics. In its evaluation of residency programs, the Review Committee will take into consideration the information provided by the American Board of Pediatrics regarding resident performance on the certifying examinations. A program will be judged deficient if, during the most recent five years, the rate of those passing the examination on their first attempt is less than 60% and/or if less than 80% of those completing the program take the certifying examination.

## **VI. Resident Duty Hours in the Learning and Working Environment**

### **A. Principles**

1. **The program must be committed to and be responsible for promoting patient safety and resident well-being and to providing a supportive educational environment.**
2. **The learning objectives of the program must not be compromised by excessive reliance on residents to fulfill service obligations.**
3. **Didactic and clinical education must have priority in the allotment of residents' time and energy.**
4. **Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.**

### **B. Supervision of Residents**

**The program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities.**

1. There must be a written document disseminated to residents and faculty which outlines the supervisory lines of responsibility.

### **C. Fatigue**

**Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.**

### **D. Duty Hours (the terms in this section are defined in the ACGME Glossary and apply to all programs)**

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

VI.D.

1. **Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.**
2. **Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call.**
3. **Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.**
  - a) The Review Committee will not consider requests for a rest period of fewer than 10 hours.

**E. On-call Activities**

1. **In-house call must occur no more frequently than every third night, averaged over a four-week period.**
2. **Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care.**
  - a) While continuity of care remains a priority, morning and afternoon continuity clinics after residents have had a 24-hour duty period may be cancelled up to a frequency of one time per month (four weeks) per resident. Post-call residents may not attend other clinics, such as subspecialty clinics.
3. **No new patients may be accepted after 24 hours of continuous duty.**
  - a) A *new patient* is defined as any patient for whom the resident has not provided care during the previous 24 hour period, or who is not a part of the resident's continuity panel or the panel of the resident's continuity team, if such exists.
4. **At-home call (or pager call)**
  - a) **The frequency of at-home call is not subject to the every-third-night, or 24+6 limitation. However at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.**
  - b) **Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.**
  - c) **When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.**

**VI. F. Moonlighting**

- 1. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.**
- 2. Internal moonlighting must be considered part of the 80-hour weekly limit on duty hours.**

**G. Duty Hours Exceptions**

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

- 1. In preparing a request for an exception the program director must follow the duty hour exception policy from the ACGME Manual on Policies and Procedures.**
- 2. Prior to submitting the request to the Review Committee, the program director must obtain approval of the institution's GMEC and DIO.**
- 3. The Review Committee for Pediatrics will not consider requests for exceptions to the 80 hour limit to residents' work week.**

**VII. Experimentation and Innovation**

**Requests for experimentation or innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee. In preparing requests, the program director must follow Procedures for Approving Proposals for Experimentation or Innovative Projects located in the ACGME Manual on Policies and Procedures. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.**

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