



Oregon Health &  
Science University

Department of Medicine

Policy and Procedure Manual

Intern and Resident Training Program

2008-2009

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## I. Program Goals and Objectives

The goals of the Internal Medicine Residency program are to train outstanding specialists in internal medicine who:

- A. Provide Care consistent with health maintenance and health promotion through the:
  - i. Understanding and practice of immunization, patient education, and early detection.
  - ii. Understanding and application of principles of clinical epidemiology.
- B. Manage ill patients by:
  - i. Diagnosis and management of serious, acute disease in intensive and non-intensive inpatient care settings.
  - ii. Evaluation and management of chronic and terminal disease and the social and emotional components that accompany them in both inpatient and ambulatory care settings.
  - iii. Diagnosis, treatment, and management of acute ambulatory problems common to adult medicine including selected problems from gynecology, orthopedics, dermatology, psychiatry, ophthalmology, ears, nose, and throat, urology, and surgery.
  - iv. Diagnosis and treatment of medical problems in emergency care settings.
- C. Demonstrate understanding of the psychosocial aspects of practice through:
  - i. Understanding of common health and illness behaviors.
  - ii. Recognition and treatment of significant psychosocial factors in patient histories.
  - iii. Skill in the psychosocial aspects of the physician-patient encounter, including data gathering, teaching, and emotion management.
  - iv. Skill in interprofessional relationships.
- D. Maintain him or herself as a health care provider by demonstrating:
  - i. Ability to manage large volumes of patient data in a problem-oriented format and to use clinical record systems to monitor and evaluate quality.
  - ii. Capacity to initiate and direct his or her own learning in a systematic and continuing manner.
  - iii. Management of stress and time related to practice.
  - iv. An understanding and application of medical ethics.
- E. The objectives of the residency are to train medical graduates in the specific knowledge, skills, judgment, attitudes and behaviors that characterize the general internist. Specifically, at the conclusion of training, a resident will achieve the following milestones in each of the listed competencies.

i. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.

- 1) The resident will always obtain a history that is precise, logical, thorough, and reliable.
- 2) The resident will obtain the history in a purposeful and efficient manner.
- 3) The resident will demonstrate the ability to perform a properly sequenced physical exam that is complete, accurate, and directed toward the patient's problems.
- 4) The resident will demonstrate technical proficiency in the exam and will be able to elicit even subtle findings.
- 5) The resident will demonstrate proficiency in the performance of specified medical procedures.
- 6) The resident will provide proper explanation of the indications and purpose of medical procedures.
- 7) The resident will always integrate care with the patient's needs and wishes.
- 8) The resident will provide high quality, cost-effective, comprehensive acute and chronic care.
- 9) The resident will exhibit awareness of benefits and limitations of testing; and will prescribe drugs appropriately, while avoiding iatrogenic complications.
- 10) The resident will monitor and follow-up patients.
- 11) The resident will prepare case presentations and medical records that are accurate, complete, and concise.

ii. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- 1) The resident will demonstrate evidence of regular reading of the medical literature.
- 2) The resident will demonstrate possession of a comprehensive and well-applied medical fund of knowledge.
- 3) The resident will demonstrate the ability to critically appraise the medical literature.

iii. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.

iv. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health

professionals.

- 1) The resident will always demonstrate integrity, respect, compassion, and empathy for patients, while establishing trust.
- 2) The resident shall maintain effective communication and rapport with patients, family, peers and ancillary health staff.

v. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

- 1) The resident shall demonstrate responsiveness, reliability, commitment, cooperation, and respectfulness in the performance of their duties.
- 2) The resident shall maintain records that are legible and timely.
- 3) The resident shall work cooperatively and effectively with members of the health care team.
- 4) The resident will show respect and regard for the opinions and skills of professional colleagues.

vi. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value

## II. Administrative and Training Policies

### A. ABIM Training Requirements

- i. The 36 months of full-time medical residency education must include the following:
- ii. At least 30 months of training in general internal medicine, subspecialty internal medicine, critical care medicine, geriatric medicine, and emergency medicine. Up to four months of the 30 months may include training in primary care areas (e.g., neurology, dermatology, office gynecology, or orthopedics).
- iii. Up to three months of other electives approved by the internal medicine program director; and

- iv. Up to three months of leave for vacation time, parental leave, or illness.
- v. Vacation or other leave cannot be forfeited to reduce training time.
- vi. In addition, the following requirements for direct patient responsibility must be met:
  - 1. At least 24 months of the 36 months of residency education must occur in settings where the resident personally provides, or supervises junior residents who provide, direct care to patients in inpatient or ambulatory settings.
  - 2. At least six months of the direct patient responsibility on internal medicine rotations must occur during the R-1 Year.

B. Vacation

- i. Interns (PGY-1): Three weeks of vacation: scheduled by the Associate Program Directors using specified non-call rotations. Vacations will be divided into one one-week and one two-week blocks.
- ii. Residents (PGY-2/3): Three weeks of vacation: scheduled by the Chief Residents as one two-week and one one-week block or three one-week blocks. Requests for vacations will be submitted to the Housestaff Office in the early spring. Vacation schedules will be published with the block and call schedules on the On-Call website (<http://www.amion.com>). One of the 3 weeks can be used as flexible vacation leave as per iv below.
- iii. Clinic notification: It is the responsibility of housestaff to confirm that their respective clinics have been notified of any scheduled vacations or other non-emergent leave. Such confirmation avoids inconveniences to patients and clinic staff and assures continuity of care.
- iv. Flexible vacation leave: in lieu of a scheduled one-week vacation (7 days), PGY-2/3 residents may instead take flexible leave. The following rules apply:
  - 1. Vacation requests must be entered 6 weeks prior to planned leave. Any exceptions will be considered on a case-by-case basis.
  - 2. Residents can use 7 days of flexible vacation per academic year. Flex days must come from the same 7 day vacation block. Unused days cannot be transferred to the following academic year.

3. Flexible vacation can be taken in allotments ranging from one day to seven days in a row.
4. Flexible vacations cannot be taken out of ICU, ward or night float rotations. Vacations from Emergency Room rotations will require special arrangements but are not absolutely excluded.
5. Except during Ambulatory, Elective, and Kaiser rotations, residents on the same rotation should not take vacations simultaneously. Requests will be approved on a first come, first serve basis.
6. No more than two continuity clinics can be cancelled per year as a result of flexible vacation. Any additional cancellations will have to be made up.
7. It is the resident's responsibility to arrange any previously scheduled jeopardy coverage for shifts that fall on flexible vacation days.
8. The Housestaff Office will notify the affected rotation faculty and clinics of any flexible leave.
9. Use of flexible vacation days cannot result in resident being absent more than one week from any given rotation without special approval from the Program Director.

C. Exchange of Rotations and Call assignments

- i. Rotation and call assignments may be exchanged among willing residents.
- ii. The Program Director's office must be notified at least six weeks in advance of the start of the involved rotation or call assignment
- iii. All involved parties must agree in writing to any rotation assignment trades. These include: residents, division chiefs (or designees), assigned rotation attendings, and the Program Director (or designee). The Program Director must approve any such changes prior to individual residents making plans (e.g., airline reservations) based on a proposed exchange.

D. Leave Policies (See Table Below)

When interpreting the below leave policies, keep in mind that the ABIM (American Board of Internal Medicine) mandates that a resident can only miss 91 days of training time over 3 years in order to complete residency on time. This includes vacation, interviews, education leave, FMLA, sick leave, etc (See Table).

i. Interview Leave Policy

Residents will often need to leave assigned rotations in order to pursue future employment. The department recognizes this and is committed to residents both

realizing career goals in competitive positions, as well as maintaining the continuity and completeness of their medical education. Where possible, residents should attempt to schedule interviews during non-call months and on non-clinic days. Rescheduling of all continuity clinics should ideally occur 6 weeks in advance, but exceptions can be made on a case by case basis. Residents must obtain approval from the office of the Residency Program Director prior to confirmation of any plans. The program expects that residents attempt to find their own coverage whenever possible. The days that a resident spends traveling to and attending interviews and thus not doing their usual patient care and professional responsibilities can be categorized either as:

- **Non-Covered Days:** Days for which the resident has not arranged an exchange to cover patient care responsibilities.
- **Exchange Covered Days:** Days for which the resident has pre-arranged coverage via an exchange of work responsibilities with another resident.

**Non-Covered Days:** During the three years of residency, residents may use up to 10 days of interview leave for interviews or related activities during which they are absent from direct patient care and educational responsibilities. These 10 days may not occur during call months (ward, intensive care unit, and emergency department rotations). After permission is obtained from the Residency Program Director's office and the resident's team, they may occur during subspecialty consult rotations, geriatrics, Kaiser or ambulatory rotations. Residents should attempt to find coverage for these absences whenever possible (see exchange covered days below). If unable to find coverage, the first 10 days will not be counted toward the ABIM's 91 day limit on time away from training. If more than 10 non-covered days are required, residents must use available vacation days. If there are no vacation days available, additional interview days will be scheduled as "Leave Without Pay" (LWOP), but only with prospective approval by the Residency Program Directors office. These additional non-covered days will added to the 91 day limit on time away from training.

**Exchanged Covered Days:** As opposed to the 10 days of non-covered leave described above, residents may use an unlimited number of days for which they have arranged exchanged coverage with another resident. Residents on Elective should be approached first for exchange coverage, given their limited clinical responsibilities. A resident on Jeopardy may not cover for an interviewee. Those residents agreeing to cover for an interviewing resident can not leave a ward, intensive care unit, emergency department, Kaiser, or a scheduled continuity clinic. Those residents agreeing to cover for an interviewing resident can leave a subspecialty consult, geriatrics, or an ambulatory block provided that they obtain permission from the supervisory faculty and have received approval from clinic staff (if an ambulatory block is affected). If the covering resident is assigned to practice coverage or VA interim clinic, the

resident must obtain prior approval as soon as possible from the appropriate Continuity Clinic site director (Dr. Joseph Hardman at OHSU, and Dr. Linda Lucas at the VA). Additionally they need approval from the Residency Program Directors office. In return, the interviewing resident will repay these exchanged shifts from their days off, weekends, elective, and vacation time at some point during their residency.

ii. Family Medical Leave Act (FMLA) & Oregon Family Leave Act (OFLA)

Residents are allowed up to 12 weeks for Family Medical Leave for parental leave or medical illness. The specific OHSU policies regarding FMLA are located at:

[http://ozone.ohsu.edu/policy/pac/chapt\\_3/3-25-015.htm](http://ozone.ohsu.edu/policy/pac/chapt_3/3-25-015.htm)

iii. Leave to Attend Regional, National or International Conferences (Educational and scholarship leave)

OHSU Education Leave Policy (Housestaff Contract)

Residents will be granted up to five (5) days off/year with pay to pursue educational opportunities, unless, as determined by the Program Director, the resident's educational needs would not be best served by the requested leave. Additional time off may be granted at program level and is at the sole discretion of the Program Director, taking into consideration program requirements and needs and, to the extent practical and reasonable, distributed comparably among program participants. Time away from work for the above approved education purposes will not count against the individual's vacation or training time allotment for the year.

a. Types of Educational Leave

i. Presentation of a Poster or Paper at Regional/National/ International Meetings

Residents will be granted leave for the amount of time necessary to present the paper/poster and do related travel. This type of leave must be approved by the Program Director's office at least six weeks in advance. Residents should find their own coverage for these absences; however, use of Jeopardy to cover call responsibilities may be appropriate in special circumstances. Such coverage must be approved by the Program Directors office. An individual resident cannot use more than 2 days of Jeopardy for this type of absence over three years. Coverage of all other clinical responsibilities must be arranged in advance by the resident. If the absence will result in

missed continuity clinic, the clinic needs to be notified 6 weeks in advance, and the clinic will be rescheduled.

ii. Educational Conferences

(a) Specialty Sponsored Society Meetings and other Conferences

At the discretion of the Residency Program Director, with clear delineation of the unique offerings of the specific Society Meetings, residents may use their educational leave to attend such conferences. Attendance at specialty specific society meetings (e.g., American Society of Nephrology, Society of General Internal Medicine National Meeting) requires formal application to the Program Director's office at least 2 months in advance of the meeting date. If approved, all coverage arrangements are the resident's responsibility. These days will be counted as "Education" and not subtracted from vacation. Plans for coverage must be made by the resident and approved by the Program Directors. Ordinarily, attendance at CME conferences (including National ACP) will not be approved during residency.

(b) Regional ACP & SGIM Meetings

Residents on non-ward rotations may attend these meetings at the discretion and permission of the service attending for the month. It is the resident's responsibility to contact the attending in question at least 6 weeks in advance of the start of the rotation and to ensure that all clinical obligations (consult duties, continuity clinics, jeopardy) are addressed and covered or rescheduled. Since the Residency Program encourages the success of these local societies, attending these meetings will count as education days and non-subtracted from vacation. There is no limit as to how many ACP & SGIM regional conferences residents can attend during the three years, as long as the above coverage issues have been addressed.

iv. **End of Training Leave ("Terminal Leave") Policy**

Terminal leave is defined as leave occurring during the last days of training/employment, whereby a trainee will not be returning to work.

If a resident is required to be available to begin fellowship training on or before July 1 in the final year of residency in a city that requires relocation, they *must* use vacation (either fixed or flexible). Residents are responsible for arranging coverage of clinical duties for these days.

E. Religious holidays and observation.

Residents and interns may use vacation leave (fixed or flexed) to celebrate religious holidays or observe religious practices. If flexing vacation, the same rules apply in terms of coverage, notification, etc. (Section II.E.)

Leave Designation, Coverage, and Accounting of off-days

Type of leave	Training time <sup>1</sup> (total possible days during 36 months of training)	Non-training time <sup>2</sup> (total possible days during 36 months of training)	Coverage and scheduling	Leave accounting	Total possible non-training leave days <sup>3</sup> (during 36 months of training)
Vacation 2-week fixed		42	Scheduled	Vacation	42
Vacation 1-week fixed or flexible <sup>4a</sup>		21	Individually arranged	Vacation	21
Sick/FMLA <sup>5</sup>		42	Jeopardy and scheduling <sup>6</sup>	Sick leave, vacation	42
Interviews Jobs Fellowships Advanced degrees <sup>7</sup>	10 non-covered, unlimited exchange covered	Non-covered days > 10	Trades, Elective	Days 1-10: paid Days >10: vacation then LWOP Exch. Covered: not counted and paid	28
Religious		X	Trades, vacation	Vacation	N/A
Educational Leave	5 days/year	N/A	Trades, Elective	N/A	N/A
Terminal leave (end of June)		X	Trades, elective, vacation	Vacation	Residual unused leave, with approval
ACLS and Exams	X	N/A	Trades, Elective	N/A	N/A
				<b>Total leave allowed in 36 months of training (ABIM)</b>	<b>91</b>

Footnotes:

<sup>1</sup> Leave falling under the training time category is not deducted from total leave time allowed over 36 months

<sup>2</sup> Leave falling under the non-training time category is deducted from the total leave time allowed over 36 months.

<sup>3</sup> Total non-training time leave allowed over 36 months is 91 days. Any absences beyond 91 days will result in extension of the total residency training period beyond 6/30 of PGY3 year. This is an ABIM mandated policy, described in Section II. A

above.

- <sup>4a</sup> Residents can elect for the one-week vacation to be scheduled in a fixed manner or flexible manner, as described in Section II.B.4, above. No more than one week vacation (fixed or flexed) can be taken from a given rotation.
- <sup>5</sup> Sick Leave/Family Medical Leave Act. OHSU provides 14 days of paid sick leave per year (42 days over three years). Sick leave in excess of this amount will come from vacation time and leave without pay. If a resident were to use all his/her sick leave and vacation days over a three year period (42 + 63 = 105), they would exceed the total non-training leave time allowed. ABIM training requirements would dictate extension of training after 6/30 of the PGY3 year.
- <sup>6</sup> Randomly used sick leave days will be covered by the jeopardy schedule. Prolonged preplanned sick leave/FMLA should be requested and scheduled in advance in accordance with OHSU policy.
- <sup>7</sup> Up to 10 non-covered days for interviews can be taken as interview leave and will be considered part of training time (and thus paid). Any remaining non-covered interview days will be taken from vacation then leave without pay. All non-covered interview days beyond the first 10 will be non-training time. You may use an unlimited number of exchanged covered interview days that will be paid and considered as training time.

## F. Attendance at Departmental Teaching Conferences

- i. Attending the following conferences is expected. Only medical urgencies shall limit this responsibility.
1. Medical Grand Rounds: Tuesday, 8:00 a.m.
  2. Clinical Case Conference, Morbidity and Mortality, Autopsy, etc: Fridays at 12:00 p.m. in UHS 8B 60.
  3. Morning Report at assigned hospital: Monday, Wednesday, Thursday, Friday, 9:00 a.m. - 9:45 at OHSU and VAMC. Having an unstable patient is the only excused absence from morning report while on the wards. Consult residents should make every attempt to attend either morning report or noon conference each day (both if time and rounds allow).
  4. Radiology Conference (OHSU): Daily from 9:45-10:15 am. This is a required conference, considered a part of attending rounds.
  5. Ambulatory Pre-Continuity Clinic Conference: 1:05 pm at VA and 1:10pm at OHSU (to allow for travel time from noon conference) This is a requirement of the continuity clinic experience.
- ii. Optional, but encouraged conference:
1. Housestaff Noon Conference Series: Monday through Thursday. 12:00 pm - 1:00pm. (Currently held in the VAMC Bldg 101, Rm 201)
  2. Subspecialty Conferences: during respective subspecialty rotations.

## G. Delinquent Medical Records

- i. Timely completion of medical records has major fiscal and accreditation implications for our affiliated hospitals. Thus, medical charts must be completed promptly according to the policies of the affiliated teaching

hospitals. All charts should be reviewed daily while a patient is in the hospital, by intern, resident, and attending physician alike, in order to ensure that voice orders have been countersigned prior to discharge. It is a Department of Medicine and Residency Program policy that all discharge dictations be completed on the day of discharge. The house officer is expected to complete and sign their medical records on a weekly basis to accomplish this important part of his/her job. Failure to complete the medical record in a timely fashion is grounds for disciplinary action, including suspension.

- ii. Failure to complete medical records will result in suspension of clinical privileges. Any such suspension becomes part of the resident's permanent file and may be reported to outside healthcare organizations during future credentialing requests.

#### H. Evaluation, Promotion, and Certification

##### i. Faculty/Residents/Intern Evaluations

Residents are expected to complete evaluations of their intern, student, attending, and service at the end of each rotation period. Interns are expected to complete evaluations of their resident and faculty and to provide input regarding the performance of any student assigned to their service.

The faculty is expected to meet with learners (housestaff & students) at the outset, middle and end of each rotation. The initial meeting should be used to go over objectives of the participants, and expectations for the learners. The faculty should meet at the end of the rotation to review verbally and in writing, the progress and feedback of the learners, relating to the rotation. Supervising residents similarly should meet with interns and students.

If a resident receives an adverse evaluation or comments in an evaluation with which they have substantive disagreement, they may appeal the evaluation. The first, and mandatory step, is for the resident to discuss the evaluation with the faculty or resident completing the evaluation. Should such discussion not produce a satisfactory resolution, the resident may then appeal to the Associate Program Director assigned to the particular resident. If that discussion again does not produce a satisfactory resolution, the resident may appeal to the Residency Promotion Advisory Committee (RePAC). Finally, the resident may appeal a decision by the RePAC to the OHSU Director of Graduate Medical Education.

- ii. Qualifications of Physicians applying for the American Board of Internal

## Medicine Certifying Examination; Evaluation system.

The Department is responsible for verifying to the American Board of Internal Medicine (ABIM) that an individual trained in Internal Medicine is qualified. The ABIM, through testing mechanisms can examine components of an internist's cognitive abilities, such as medical knowledge, understanding of pathophysiology, organization, and ability to synthesize and, to some extent, demonstrate sound clinical judgment. However, only the candidate's teachers can attest to important attributes such as attitudes and habits, interpersonal skills, humanistic qualities, motor and technical skills. Attending physicians and supervising residents will complete detailed evaluations of the resident's performance on the ward, outpatient, and consultation services. Using this compiled data, the Program Director, with the advice of the faculty as constituted in the Residency Evaluation and Promotion Advisory Committee (REPAC), will determine a resident's suitability to higher levels of responsibility (promotion) and qualifications to sit for the Board examination (certification). In some cases, remedial action may be required before the resident can be judged to be qualified for promotion or for admission to the certification exam. It is important to understand that the standards for admission to the ABIM Certifying Exam are high and that completion of three years of training alone does not automatically qualify a resident. Any resident whose performance is not meeting standards will be counseled and an educational plan developed, to assist with his/her efforts to meet these standards.

The process of evaluation of clinical competency complies with guidelines of the American Board of Internal Medicine and the Accreditation Council on Graduate Medical Education (see [www.abim.org](http://www.abim.org) and [www.acgme.org](http://www.acgme.org))

### iii. Resident Files

All information contained in a resident's Departmental file is considered confidential and is protected by applicable federal and state laws. Only the Residency and Associate Program Directors, specified Education office staff and the members of Residency Evaluation and Promotion Advisory Committee are permitted access without express permission of the resident.

#### I. Rotation of House Officers from other Departments, on Internal Medicine Ward Services

It is the responsibility of the Department of Medicine to assure the highest quality of medical care to the patients of the Medical Service, and high

standards of teaching to the medical students while rotating on the Medical Service. The following statements define the Department's policies governing house officers from other departments who are regularly assigned to the Department's wards and clinics:

- i. The attending physician monitors the houseofficer's clinical competence.
- ii. If the house officer is found incapable of discharging expected responsibilities, the attending will notify the Program Director in Internal Medicine, the Chief Resident, or the Chairman of the Department, who will review the situation and contact the house officer's department.
- iii. If deemed necessary by the Chairman of the Department of Medicine or his designee, the house officer's department may be required to remove that individual.

#### J. Moonlighting

- i. The Accreditation Council for Graduate Medical Education (ACGME) requires all residency-training programs maintain a policy on housestaff moonlighting during residency. In accordance with this expectation we acknowledge that a resident's primary responsibility during residency training is to advance their knowledge and skills, by participating fully in the structured activities and experiences of the residency program. The Department of Medicine recognizes that residents may have a financial need to participate in moonlighting activities and that in addition; some residents may find such experiences to be educational. Therefore, the Department of Medicine permits moonlighting by licensed resident physicians. In turn, residents who would like to moonlight have an obligation to themselves, to their peers, and to the residency program to arrange and schedule any such moonlighting activity in a manner that in no way inhibits their full participation in the residency program. Inherently, the duties and activities of physicians are not reliably discharged within the confines of a predictable work schedule, thus the activities of the residency, including patient care and educational activities must always take priority over any moonlighting activity. The following statements provide guidelines regarding this practice.
  1. Housestaff must obtain written approval from the program director, or designee, in order to participate in moonlighting activities.
  2. Housestaff must have satisfactorily completed their internship, and be in good standing in the program and show full evidence of progress towards satisfying all requirements for admission to

the certifying exam of the American Board of Internal Medicine. This includes satisfactory performance\* on the In Training Exam as well as satisfactory performances on all clinical rotations.

Moonlighting activities should not be scheduled during any period when a resident is on call or on jeopardy call. This includes periods of call taken at home or on pager.

3. Residents should not schedule moonlighting activities that could interfere with the full discharge of their teaching, supervision, or patient care responsibilities.
4. Inpatient rotations are demanding experiences that require the full attention and effort of residents on those rotations. Because of the call frequency, the duty hour requirements hours, and the need for study, rest and reflection time, moonlighting is prohibited during such rotations.
  - (1) The Department of Medicine is required to monitor moonlighting activities that occur in any of our affiliated institutions (OHSU, VAMC, Kaiser). Moonlighting activity at any affiliated institution during any assigned rotation is forbidden if such moonlighting activity causes a resident to exceed the 80 hour per week duty hour limitation

- K. Policies and Procedures for Resident Probation, Suspension, Dismissal, Non-Renewal of Contracts, and Grievances.

The Department conforms with the OHSU GME policies on resident probation, suspension, dismissal, non-renewal of contracts and grievances. See the appendix and [http://ozone.ohsu.edu/policy/pac/chapt\\_3/3-80-010.htm](http://ozone.ohsu.edu/policy/pac/chapt_3/3-80-010.htm)

### **III. Medical Care Policies**

- A. Lines of Responsibility for Patient Care
  - i. The following sections describe the expected lines of responsibility for patient care involving the internal medicine residents of the Oregon Health Sciences University, as well as any residents from other Departments or affiliated residency programs who rotate through the principle teaching hospitals (University Hospital; VA Medical Center). These policies do not supersede the Medical Service By-laws of the principle or participating teaching hospitals, or other training sites and, in the case of the VA Medical

Center, are supplemental to the federal Department of Veterans Affairs regulations on resident supervision.

B. Definitions

- i. Intern: First year (PGY-1; R-1) house officer. The intern is supervised by a ward or ICU resident in certain specified case settings and by faculty in other settings (e.g., ambulatory care).
- ii. Ward or ICU Resident: Second or third year (PGY-2/3; R-2/3) house officer responsible for supervising one to three interns and assigned medical students on general medicine, subspecialty or ICU services.
- iii. Chief Residents: Fourth year (PGY-4; R-4) residents in Internal Medicine responsible with the Program Director for administration of the residency program. In addition, the Chief Medical Residents may act as Attending Physician (infra vide) on general medicine services.
- iv. Attending Physicians: Each patient care team has an assigned faculty physician who has overall responsibility for supervision of the patient care provided by the residents and medical students assigned to that service (e.g., general medicine service, ICU).
- v. Private Physician: Department of Medicine faculty physician who has established relationship to a patient admitted to a patient care service (e.g., primary care physician; managing consultant physician).

C. Inpatient Teaching Medical Services

- i. Patients may be admitted to the teaching services in the following hierarchical structures;
  1. Admitting physicians may admit to the inpatient teaching service. All direct patient-care responsibilities are conducted by the inpatient housestaff team under the direct supervision of the assigned teaching-attending.
  2. The admitting physician can admit to the inpatient team, and serve as the consulting physician, if they provide a necessary service in the direct care of that patient.
  3. The physician may admit a patient to him/her-self as a non-teaching patient, whereby that physician assumes all direct patient care responsibilities (see Non-Teaching Patients).
- ii. Admission & Daily Census Caps  
In compliance with the Residency Review Committee (RRC) requirements for house staff workload, the following admission and census caps are to be enforced on all inpatient medicine rotations;
  1. Interns:
    - a. May admit no more than 5 new patients per admitting day (24 hours). N.B. These limits may be increased by 2 in special rotations where each admission does not require a full work-up, providing it is educationally

justified. (e.g. intra-service transfers, bounce-backs, night-float transfers)

- b. May admit no more than 8 new patients in a 48-hour period.
  - c. Must not be responsible for the ongoing care of more than 12 patients.
2. Residents:
- a. May admit no more than 10 patients per admitting day (24 hours)
  - b. May admit no more than 16 new patients in a 48-hour period.
  - c. Must not be responsible for the ongoing care of more than 24 patients. (20 ICU patients)  
N.B. These limits may be increased by 2 in special rotations where each admission does not require a full work-up, providing it is educationally justified. (e.g. inter-service transfers, bounce-backs, night-float transfers)
- iii. The intern carries the responsibility for performing the initial history and physical examination on all new patients admitting to the teaching services. The intern is supervised by the resident(s) assigned to that team. The intern formulates a diagnostic impression and treatment plan. If the intern has already admitted 5 patients that admitting day, 8 patients in the previous 48 hours or is currently managing 12 patients or is otherwise occupied with complex, seriously ill patients, this responsibility should pass to the supervising resident.
  - iv. The resident(s) is (are) responsible for intern education and assuring the quality of intern care, as well as being continuously available to answer any questions the intern may have during those hours.
  - v. If the resident has already admitted 10 patients on an admitting day, 16 patients in the previous 48 hours or is currently managing 24 patients or is otherwise occupied with complex, seriously ill patients, the attending physician should be contacted for assistance. See the specific "cap" policies for each inpatient service.
  - vi. After discussion of the case between the supervising resident and intern, the intern or resident will notify the Attending Physician to review the history and physical findings, as well as to present the treatment plan. The supervising resident, in the case of medically stable patients, may delay this discussion to the next day's scheduled rounds. The Attending Physician is responsible for the quality of care provided to patients on their team and is at all times available by telephone, or if necessary, on site within 30 minutes, to directly supervise patient care.

- vii. Rounds:
  - 1. Work Rounds:
    - a. Work Rounds offer the housestaff teams the opportunity to complete and plan daily work while additionally allowing them to exercise autonomy in clinical care decisions and learning. Each ward team is expected to make daily work rounds together. These rounds should begin before other scheduled events of the day. The resident is responsible for coordinating the care provided patients by the team; responsibilities are delegated appropriately to ward team members.
    - b. In order to facilitate the flow of patients, all discharges (referrals, clinic appointments, pharmacy prescriptions, etc.) should be prepared the night before, and orders submitted following work-rounds on the morning of discharge.
  - 2. Radiology Rounds:
    - a. OHSU: radiology round should be considered the beginning of attending rounds and commence at 9:45 am with the post call team presenting their films. All films previously unviewed at the conference should be submitted for review. It is the expectation that housestaff have viewed these films previously, and should be prepared to interpret the films before those assembled.
    - b. VAMC: The ICU team reviews films daily with the ICU attendings and available radiology attending.
  - 3. Attending Rounds:
    - a. All new patients must be presented to the attending staff within 24 hours after admission. The resident should insure the efficiency of these sessions by delegating to the interns and medical students the responsibility for assuring that charts, flow sheets, x-rays, slides, etc. are available for rounds.
    - b. Post call attending rounds will begin between 7:00 am, and be completed by 9:30. OHSU teams will then review films at radiology conference at 9:45 am and end rounds by 10:00 am.
- viii. Ward Coverage - Weekends and Holidays

To insure the quality of patient care, a physician fully acquainted with each patient's problems will see the patient daily and no intern will provide sole coverage for a service without the support of a more senior resident or staff. Specifically, at least one physician from each service will be present for rounds on weekends and holidays.
- ix. Call schedules

## 1. VAMC Medicine Wards:

- a.. The call cycle for the general medicine wards at the VAMC is as follows
- Long Call/Post Call/Night Float Accept/Short Call/Rounds
- b.. **Long Call:** Admit hrs: 8am to 8 or 10pm (M-F), 8am-7am Sat-Sun.
- Maximum patients accepted: 10 (not including bounce backs)\*
  - LC team (Mon-Fri) will take any patient ready to be admitted by 8pm (i.e. if sign out is called and they have a bed assigned and ready). If the LC team has  $\geq 6$  admissions by 8pm they are done. If  $< 6$  admissions, the LC team will continue admitting up to 6 patients until 10pm
  - Pagers must be on at 8:00am
  - Once the LC team gets 10 admissions, medicine may not accept any further patients until night float arrives (M-F) or Moonfloat arrives (Sat-Sun) at 8pm.
  - On Saturday and Sunday, LC will take up to 10 new admits between 8am and 7am.
  - Moonfloat: On most Saturday and Sunday nights, there will be a moonlighter (moonfloat) coming in at 8pm. Moonfloat will help with cross-cover and admissions. They will admit up to 6 patients. If the long call team has reached or exceeded their team census cap of 16 by 8pm on Saturday or Sunday, the moonfloat physician will take over admissions until they have admitted 6. Admissions will then go back to the LC team until the admit cap of 10 is reached. If Moonfloat arrives at 8pm and the LC has not reached a census cap of 16 or an admit cap of 10, the LC team continues admitting until one of those occurs. When there is no Moonfloat, Medicine cannot accept patients beyond the LC admit cap of 10.
- c. **Night Float Accept:**
- Accepts patients on NF rounds 7am-8am, Monday through Friday, Saturday 8am-9am.
  - Maximum # patients accepted: 4 on M-F, 2 on Saturday, not including bounce backs\*
  - NFA accepts patients admitted by NF (Tues-Sat) or

Moonfloat (Mon).

- Night float sign out rounds will occur at the bedside between 7am and 8am M-F, 8am Saturday. NFA team should round with the NF team on all patients coming to their team that morning. The NF team will proceed to do similar but more abbreviated sign-out rounds with the SC team if there are additional patients.
  - On Saturday morning, the night float accept team will take up to 2 admissions (the 1<sup>st</sup> and 3<sup>rd</sup> patients admitted by night float) if their team census is < 12. If NFA team census is 12 or more, they will receive no admissions (except for bounce backs). In total, the Saturday NFA team can take no more than 3 admissions (from NF and bounce-backs combined).
- d. **Short Call:** Admit hours: Mon – Sat 7am-3pm Pager hours: 7am-6PM, Saturday 8am-4pm
- Maximum # patients accepted is 4 on M-F and 2 on Saturday not including bounce backs.\*
  - Patients are counted towards the admit cap as they arrive on the floor.
  - First 4 patients go to short call each weekday.
  - Overflow patients from the NF team who go to short call. The SC resident and interns must be available for NF rounds between 7 and 8:30 am to get sign-out on the night float patients admitted to them. These rounds will occur after the NF team has finished rounding with the NFA team.
  - On Saturday morning, the SC team will take up to 2 admissions (the 2<sup>nd</sup> and 4<sup>th</sup> patients admitted by night float) if their team census is < 12. If the SC team census is 12 or more, they will receive no admissions (except for bounce backs). In total, the Saturday SC team can take no more than 3 admissions (NF and bounce-backs combined).
- e. **Night Float (NF):** Admission hours: 8pm-7am, Mon-Fri.
- Pager hours: 8pm-8AM
  - Maximum patients accepted: Intern 5; Resident 8
  - NF patients get turned over to the NFA team (4 patients) then to the SC team (4 patients).

Team maximum is 16 patients. When total GM ward census reaches 55, the hospital will go on total ambulance divert.\*

**\*Bounce Back (BB=s):**

- BB patients refer to the following situations:
    - i. Patients that have been cared for by an intern on that service during the current rotation
    - ii. The intern is not scheduled to rotate off of the service within the next 24 hours.
  - There will be no credit towards admit caps for BB's
  - Teams will accept BBs every day except Post Call. Exception: When a team's census is 16 patients, they will not accept BBs as it would put them over the 16 team census cap.
  - In-house "BBs" refers to patients transferred from GM teams to the ICU or another non-medicine service requiring transfer back to general medicine during a given rotation. The patient never left the hospital.
    - i. These patients return to their previous GM team, except post-call.
    - ii. Patients must be staffed by the GM ward attending prior to ICU transfer in order to bounce back to the same team.
    - iii. If the primary team happens to be on call when the patient comes out of the ICU, the patient will count towards the team admit cap if they have been in the ICU greater than 72 hours (and/or have more than 3 ICU staff notes in their chart). If they have been in the ICU less than 72 hours (or have 3 or less ICU staff notes), they will not count towards the admit cap if the primary team is on call when the patient comes out of the ICU. If another team is accepting the patient, the patient will count towards that team's admit cap regardless of their ICU length of stay and then will bounce back to the primary team the following day.
- f. **Clinics:** Residents will attend clinic only on the Rounds/Clinic day. Residents should check out their patients before going to clinic (by 12pm) so that there is coverage while they are gone, but expect to return after clinic to wrap up, follow-up on consults and studies and prepare discharges for the following day. Pager status should be changed to "out of hospital, not available" while in clinic to protect patient care time.
- g. **Moonfloat:** On Saturday and Sunday nights there is a hired moonfloat at the VA. The hours are from 8pm to

8am. They provide no cross coverage of medicine housestaff patients but they may be cross covering the hospitalist patients. The Moonfloat will admit up to 6 patients. Moonfloat physician will start taking admissions when the LC team has reached their cap of 10 patient admissions, OR, when the LC team has reached their team census cap of 16 regardless of number of admissions. If the LC team has reached census cap of 16, Moonfloater will admit the next 6 patients. If additional patients need to be admitted, the LC team will then have to start admitting again until they reach their admit cap of 10. The moonfloat will be at home until called in for admissions or for a cross-cover issue on a hospitalist patient. **In the event of an emergency, the LC resident or the rapid response team will be asked to provide immediate clinical assistance while the moonfloat physician drives in.**

- i. On Sunday morning at 8am, the moonfloat physician will meet with the Sunday LC team in their office to sign out patients admitted by moonfloat the night before. The LC team resident and interns should be present at the verbal sign out. The Attending does not need to be present. **\*\*\* Physician to physician sign-out is required.** If there are no admissions, the moonfloat physician should page the long call resident (text page okay) to let them know.
- ii. On Monday morning at 7am, the moonfloat physician will meet with the night float accept team (1 attending, 2 interns) in their team office to verbally sign out up to 4 patients admitted the night before. The NFA attending and interns should be at these rounds. **\*\*\* Physician to physician sign-out is required.** If there were no admissions, the moonfloat physician must page the NFA Attending to let them know.
- iii. If the moonfloater actually admitted 6 patients on Sunday night, the additional 2 patients will go to the Monday SC team (quick verbal sign-out).

## 2. VAMC MICU/CCU:

### a. Basics

- i. Teams: There are 3 housestaff teams of one PGY-2 or PGY-3 resident and one intern each. These teams

rotate for 4 weeks in the ICU. In addition there is one PGY-2 or PGY-3 resident who rotates in the ICU on a 2 week day float rotation. The team also includes a Critical Care fellow.

- ii. Rounds: There are rounds from 8:30 (changed from 8:00) - 9:30 a.m. every day with a CCU attending, and from 9:30-11:00 a.m. with a MICU attending. The post-call, short call, and day float residents, and fellow participate in these rounds. Each day there are also Transition of Care Rounds from 4 to 5 p.m. led by the fellow and when possible an attending. The purpose of these rounds is not to repeat the morning rounds, but to discuss the essential aspects of patients necessary to transfer care to the long call team for the night. The short call, day float, and long call teams will all participate in these rounds.
- iii. Codes: The code pagers will be held by the day float resident and the short call resident/intern from 7 a.m. until 4 p.m., and by the long call intern and resident from 4 p.m. until 7 a.m.

**b. Long call**

- i. Every day of the week the long call team arrives at 4 p.m. and participates in Transition of Care rounds with the other team members as described as above.
- ii. Completes work on admissions handed off from short call, and admits patients from 4 p.m. until 7 a.m. the next morning or until the census/admission cap is reached.
- iii. Rounds on the post-call morning with the rest of the team members.
- iv. Leaves the hospital by noon on the post call day.

**c. Short call**

- i. Every day of the week the short call intern or resident (usually will be a day off for one of them) arrives at 7 a.m. and participates in morning rounds.
- ii. Short call is responsible for admissions between 7 a.m. and 4 p.m. In order to facilitate short call leaving as close to 5 p.m. as possible, short call will be responsible for 2 admissions during the day that are completed (all documentation completed). For additional admissions short call stabilizes patients and does the basic initial work of the admissions, and then hands the rest of the work of the

admission/documentation of to long call. The day float resident and fellow helps short call with admitting since this is frequently one resident or intern alone.

For the 2 admissions to be completely admitted by short call they need to arrive in the unit by 3 p.m. For admissions arriving after 3 p.m. short call will stabilize them and write holding orders, and long call will complete the admissions/documentation.

- iii. When possible staffs patients with MICU/CCU attending on the same day of admission. When this is not possible the day float resident will present the patients admitted by short call the next morning on rounds.
- iv. Short call participates in Transition of Care rounds between 4 and 5 p.m. (new admissions should be included in these rounds) with the rest of the team members, and after these rounds turns their pagers off and leaves at 5 p.m.

**d. Day float resident**

- i. The day float resident will be a PGY-2 or PGY-3. The rotation will be two weeks long. The resident will work Monday through Saturday, and will have a day off on Sunday. Hours will be 7 am to 5 pm. All clinics will be cancelled during the 2-week block.
- ii. Pre-rounds on and presents Long Call's patients (as Long Call will not arrive until 4 p.m.), and on patients that Short Call (completely) admitted the prior day but were unable to staff (the post-call team will present the admissions that were started by Short Call and completed by Long Call). Participate in morning rounds. Cares for Long Call's patients until the Long Call team arrives at 4 p.m. and Transition of Care Rounds take place.
- iii. Helps short call with new admissions (along with the fellow).
- iv. Contributes to teaching during rounds/other times.
- v. Helps the post-call team with work/ helps them leave the hospital by noon. Helps with calling consultants, communicating with families, following up on studies, performing procedures, helping with work on transferring patients to the floor.
- vi. Participates in Transition of Care rounds (4-5 p.m.)
- vii. Helps the fellow and teams with decisions about redistribution of patients when necessary.

**e. Census and admission caps**

- i. The total census cap for the entire ICU is 15 patients.
- ii. The admission cap Long Call is 6 patients.
- iii. Short call can completely admit up to 2 patients as long as they arrive in the unit by 3 p.m. For additional admissions (after 2 patients or after 3 p.m.) short call will stabilize the patients and do the basic initial work of the admissions, and long call will complete the admissions and documentation.
- iv. If there are questions (i.e. if a 7<sup>th</sup> patient arrives to the hospital in unstable condition, likely should not be transferred to another hospital) please direct them to the appropriate MICU or CCU attending on call, or if needed to Dr. Sharon Anderson.

**f. Signout**

- i. To make transitions of care as smooth as possible, please maintain a printable signout list on the computer (VA website->My Documents->Common->Medicine signouts->VA MICU signouts).

**3. University Hospital Medicine Wards:**

- a. The is a 5 day admitting cycle on the University Hospital wards is as follows:

Long Call,- Post Call,- Rounds/off - Short Call - Rounds/Clinic

- b. **Long Call:** Admit hours: 8:00 am -7 am Pager hours: 8 am-12 pm (day later)
  - i. Maximum patients accepted: Intern 5, Resident 10
  - ii. If the team reaches the maximum census cap (12) at any time during the admit day, the resident/Intern should still admit a minimum of 5 new patients.
- c. **Short Call:**
  - (a) Maximum patients accepted: 4.
  - (b) SC takes the first 4 admissions of the day, then admissions go to long call. Short call count as an admission when the resident receives a call from the ED AND the patient is a definite admission (e.g. NOT subject to ED discharge and expected to have a bed by 5pm). Patients should be admitted even if they do not yet have a bed assignment. You can confirm the time of the bed assignment from bed control. Patients coming

from any other location(clinic, ICU, etc) will need to be on the floor beforebeing considered an admission to short call.

- d. **Team Cap:** Long call will admit up to 10 patients or as many patients as they can take to fill their service to its census cap (12) and the following day's short call (max 4 patients) (Example: Start LC with 8, you can take 4 + 4 or 8 total. 4 will roll over to SC). You should call the CHS service directly to let them know you are at capacity so that they may take the admissions after you have capped. Please forward the admit pager to the CHS when you have capped.
- e. **Cross-Cover Resident** (Sunday-Thursday nights with Pager hours 2000-0800)  
There will be a resident that provides cross-coverage on all of the University Ward GM team patients except for those of the long call team that night. This resident will not admit any new patients. The long call resident on that day will provide supervision for any intern assigned to this shift. The resident will be excused from all clinical duties for the remainder of the day after signing out to the respective teams at 0800 the subsequent morning. A virtual pager is assigned to this service (18272) and the resident should ensure that the OHSU operators are forwarding it to their individual pager at the start of the shift. Residents available to work this shift include those on consult services, Ambulatory/CIM rotations and can be from any of the three classes (PGY-1, 2, and 3).
- f. **Clinical Hospitalist Service/CHS (formerly PHP):**
  - i. The CHS is primarily a service implemented to work with NON-GENERAL MEDICINE pts (e.g. co-management with surgery, onc).
  - ii. Please contact the chief residents with any questions about transfers to/from the CHS service.
  - iii. There is 24/7 coverage of the CHS service. Once the teaching service exceeds the 10th admit or your team + short call admits the rest of the admits will go the CHS.
  - iv. Please inform the CHS and AOD (administrator on duty) as you are approaching the admit prior to your

last one so the ER, admitting and the CHS will know the status of admissions.

4. **UH MICU Team:**

- a. **Teams:** MICU 1-4, composed of one PGY-2/3 resident and one PGY-1 resident each. These 4 teams will assume collective responsibility for all patients admitted to the teaching service of the MICU. The primary purpose of the team designation is to facilitate call scheduling and optimize continuity of patient care.
- b. **Call schedule:** the MICU will operate with a Night Team who will admit patients at night Sunday-Friday evening and cross-cover the patients on the teaching MICU service.
  - i. **Long call [LC] (Sunday-Friday):**
    - a. Admit 7AM-7PM
    - b. Sign out 7:30-8PM with Night Team, ICU fellow – everyone meets in the team room for this signout. Ideal signout occurs by going bedside to bedside.
    - c. Depart by 9:00PM (ACGME 10-hour duty rule).
    - d. Patients arriving between 7PM and 8PM should be assessed and stabilized by member of LC team and ICU fellow.
    - e. Long call (Saturday only):
    - f. Admit 7AM-7AM
    - g. Sign out 7-7:30AM with Sunday LC team and ICU fellow
    - h. Present new patients 7:30-9AM
    - i. Depart by 10AM Sunday.
  - ii. **Night Team [NT] (Sunday-Friday):**
    - a. Admit 7:30PM -7AM
    - b. Sign in 7:30-8PM
    - c. Make night rounds every night with the ICU fellow. Rounds should be made at the start of your shift and again mid-morning (suggested 0400) to facilitate patient care goals. You are encouraged to start progress notes on the patients during these rounds (writing down vitals, meds, labs, etc.) to help facilitate pre-rounds for the day team.
    - d. The night team should ensure that transfer orders have been completed on all possible

transfer patients prior to the day team arriving. The list of possible transfers will be determined by the attending and fellow on evening rounds.

- e. Sign out 7-7:30AM with LC and SC team and ICU fellow: sign outs should be brief, problem focused, with identification of near-term management issues and critical changes in status overnight.

- iii. **Short call [SC] (Monday-Saturday):** Admit 7-3PM; depart by 5PM; short call admits up to 2 patients prior to long call accepting new admissions.

- iv. **Rounds day:** 7-5PM; team was long call (#1 above) day prior; present new patients from day prior; no new admissions. Participate with entire ICU team in care of patients.

**c. Census and admission caps:**

- i. Total ICU census: 20 patients (restricted to the Kohler Pavilion 12th floor MICU. If a patient is assigned a bed outside of 12K, please call the AOD and ask for a 12K bed. If no bed available, please call your attending for input. If patient ultimately is on the MICU service outside of 12K, please forward name and MR to the chief resident on call for OHSU.

- ii. Short call: 2 admissions

- iii. Long call (12 hour call): 6 admissions

- iv. Long call (24 hour call): 8 admissions

- v. Night Team: 6 admissions

**d. Attending Rounds:**

- i. Monday-Saturday: Patient care rounds will start at 0800 with the team moving to radiology rounds at 0830. Didactic sessions will occur daily at 1230.

- ii. Sunday: Rounds begin at 0800 in the ICU physician workroom.

e. **Role of PCC Fellows:** Fellows should do evening rounds with the night team every night – the night team are part of the overall care of the patients and should know all the patients well. In addition, the fellow will round with the charge nurse sometime between 0300 and 0430 (workload permitting) to confirm the plan of care for all patients.

**5. UH CCU-Cardiology Team**

**a. Basics**

- i. Team is composed of 4 residents, 1 Cardiology PA, and 1 CCU fellow

- ii. Team total census is 14 patients for the resident team. Once the census exceeds 14, future admits will be distributed among the CCU fellow and the CHS service (the non-teaching hospitalist service). Typically, the CCU fellow and PA take admit numbers 15-20 and then the CHS takes any admits over 20 but the distinction between the fellow and the CHS is up to the discretion of the CCU attending. If a pt goes to the CHS (non-teaching service), a cardiology consult is usually obtained (thus pt will not be followed by CCU team but rather the inpatient cardiology consult service).
- iii. Once a pt is admitted or transferred to the fellow/PA or CHS service, that pt is to remain on that service and not be back-transferred to the resident service even if the resident census falls to less than 14.
- iv. The patients are considered to be on one team and all residents should know and actively manage ALL of the patients (no separate teams). The patients are to be distributed evenly amongst the residents but given the frequent hand-offs, all residents must be familiar with every patient on the census.
- v. Patients include CCU, Regular Cardiology, Congenital, and Heart Failure pts
- vi. One resident is the night resident for one week of the 4 week block
- vii. Attending rounds will begin at 8am every day
- viii. No clinics are to be scheduled during this block

**b. Long Call**

- i. (From Sundays-Fridays) Admits patients from 7 am- 8 pm (start admitting once short call has capped)
- ii. Sign-out to night team 8:30-9 pm and out of hospital by 9pm
- iii. Patients arriving between 8 pm-9 pm should be assessed and stabilized by the long call resident and the cardiology fellow (the night team will then complete the admission and paperwork)
- iv. On Saturdays, the long call resident will admit 7am – 7am (stay overnight). Rounds at 8 am with attending and team. Out of hospital by 12 pm to meet the 24+6 work hours rule.

**c. Rounds Day**

- i. No admissions on this day in the call cycle

- ii. On weekend days when there are only 2 residents on (the long call resident and the rounds resident), the total census is to be divided among the Rounds and Long Call residents for managing/note writing

**d. Night Team**

- i. Provides night coverage Sunday through Friday nights
- ii. On Saturday nights, admissions and cross cover will be performed by the long call CCU resident with supervision by the cardiology fellow.
- iii. Signs in at 8:30 pm with the long call resident, cardiology fellow
- iv. Admits pts from 8:30 pm- 7 am
- v. Presents only new overnight admissions to the entire CCU team/attending from 8am-9am. The night resident will then leave the hospital at the latest 9:30 am. The CCU team will continue rounding on old pts at 9am.
- vi. Leave hospital by 9:30 am

**e. Hot Spots**

- i. The team census is never to exceed 14 at any point. A patient is considered discharged when the discharge order has been written in the chart. If the cardiology attending wishes to admit more pts above the census cap of 14, these pts will be admitted and managed strictly by the cardiology fellow/PA and the CHS.
- ii. The Cardiology fellow should be available at all times to the CCU team for questions, assistance with patient care. This includes times when the fellow is in clinic, post-call, or has the day off (ie another fellow should be made available to provide assistance to the team).
- iii. At critical transition points (ie when one of the day residents is transitioning to nights), his/her patients must be divided among the other residents.
- iv. There will be a day in the call cycle when the post-long call resident has the day off. His patients must be assigned to the other daytime residents prior to that resident leaving the hospital on long call.
- v. Transferring a patient to General Medicine requires Chief Resident approval first
- vi. Ideally patients should only be admitted to 11K and 12K but the final decision will be at the discretion of the attending.

vii. Pre-rounding on old patients should be done prior to beginning rounds with the attending at 8am. The first pts rounded on should be on the new overnight admissions and this part of rounds should end by 9am (to ensure the night resident is out of the hospital by 9:30 am).

D. Inpatient Non-Teaching Patients:

- i. All routine direct patient care, family communication, and completion of the medical record are the sole responsibility of the supervising staff physician. Interns and residents are to have no role in the routine care of non-teaching service patients, unless to perform in the role of a consulting physician while on a consult services.
- ii. Patients at the University Hospital not admitted to the teaching service are to be managed by the staff physician or corresponding fellow (e.g. Bone Marrow Transplant service, Heme/Onc, routine post-angiography, , etc.). In the event of urgent need for evaluation until the fellow or attending can evaluate these patients, housestaff may be called to evaluate these patients.
- iii. In the event that non-teaching service patients require more intensive care than can be provided without housestaff involvement, the patient will be transferred to the appropriate teaching service.

E. Outpatient Services

- i. General Medicine Clinic (Continuity Care Clinics):
  1. Interns begin orientation to their continuity clinic in the first few weeks of residency. In mid-July, interns will commence a weekly continuity clinic, either at the Portland VAMC or the OHSU Internal Medicine Practice at Marquam Hill. There are no clinics during ICU rotations. On average an intern should not see more than 2 new patients and 4 return patients per half-day session.
  2. During the second year of training, residents add a second clinic (two continuity clinics per week) in addition to continuing in their primary clinic. Residents rank order their choices of second clinics from a list and are assigned their second site based on the priorities of all residents. During ICU months, there are no clinics scheduled. During specified ward rotations the resident attends one clinic per week, alternating between their respective continuity sites.
  3. In order for these clinics to operate efficiently, it is imperative that the residents' attendance be consistent. Therefore, the General

Medicine Clinic will take precedence. During a resident's absence from inpatient duties, cross coverage is provided by the long call team.

4. Ambulatory Care Conference: This is a mandatory conference. There is a weekly web based curriculum, covered synchronously in all clinics. It is the expectation that housestaff participate fully in the development and discussion of the curriculum.
5. When patients are hospitalized from General Medicine Clinic, the clinic physician will communicate his/her plans and preferences for the receiving team in writing and verbally. Conversely, it is IMPERATIVE that when GMC patients are admitted, their clinic physicians be notified.
6. Residents serve as the primary care physician for their own panel of patients. Residents are expected to follow clinic policies for continuous care for their own patients, including timely answering of pages placed by clinic support staff on behalf of those patients (or responsible hand-off of patient care coverage if not available to the clinic support staff.) In addition, residents will participate in a practice coverage system to facilitate timely "between visit" care for patients when the primary resident physician is not available. Tasks include but are not limited to reviewing test results, answering patient phone calls, reviewing prescription refill requests, and seeing urgent care patients.

- ii. All outpatient care occurs with direct and on-site supervision by an Attending Physician. Housestaff (interns and residents) are responsible for the initial evaluation, including history and physician examination, and the ordering of appropriate laboratory tests, and the initiation of an appropriate therapeutic plan, including pharmacological therapy. The primary physician/patient interaction will occur between the resident and the patient, but supervising faculty will exercise full responsibility for the care of the patient.
- iii. The on-site faculty will always be available in the practice to provide supervision of patient care. Each case will be discussed with an Attending Physician. Patients will be examined and additional data gathered as the Attending judges to be appropriate.

F. Order writing:

- i. House officers with primary responsibility for a patient's care, (interns, residents) will write all orders on patients admitted to teaching services. Supervisory faculty (attendings) must be consulted on issues of substantive import, including establishment of DNR status and performance of complex, high-risk procedures. It is the expectation that

residents and attending physicians performing consultations will not write orders, unless specifically directed to do so by the primary team. Prudence dictates that there are certain exceptions to this policy. These include:

1. Simple pre- and post- procedure orders.
2. Specific chemotherapy orders.
3. Emergency orders, where the responsible intern or resident is not immediately available and delay would jeopardize patient care.
4. Housestaff is unavailable (e.g. days-off, time in clinic). In these situations the attending physician may write orders.

G. Emergency Care Services:

During Emergency Room rotations, interns are expected to have all substantive portions of the history and physical examination, and diagnostic and therapeutic plans confirmed and discussed with the attending physician assigned to the emergency room. Residents are expected to staff all cases verbally with the attending physician present in the emergency room, but need not have the attending physician see every patient, based on the policies of the respective ERs.

H. Autopsies

The Department of Medicine and Residency Program strongly encourages faculty and housestaff to obtain autopsies. Although the decision of when to obtain an autopsy rests with the ward team, It is expected that faculty and residents make every effort to attend autopsies on their patients for review of its findings. It is desirable for the patient's physician to personally review the results in the autopsy room. Autopsy reports are available in the computerized record within 48 hours of completion of the autopsy. If there are questions, please page the Pathology resident assigned to the autopsy service.

I. Contingency Plan for Unexpected Absences of Residents/Interns

- i. Coverage for Short Term Absences (<24 hrs.): None, unless on-call, then the jeopardy system would apply.
- ii. Coverage for Long Term Absences (>24 hrs.): Jeopardy system (below)

J. Resident **Jeopardy** System

i. Description and Utilization

There is a back-up schedule for housestaff coverage (*Jeopardy*).

Resident jeopardy should be used *only* in the event of housestaff illness or personal emergency, during specified acute patient care rotation, (e.g. Wards, Emergency Care, Intensive Care Unit). However, the program may use jeopardy for unanticipated coverage needs as well. The "Jeopardy-Call" schedule is published at the beginning of the academic year, and is available on Amion.com. ([www.amion.com](http://www.amion.com)). All requests for jeopardy coverage must go through the chiefs. **No exceptions!** There is a chief resident available, 24 hours a day, 7 days a week. The paging operators know who is on call (or check Amion.com). If jeopardy is called because of illness, the resident should expect to check in daily with the chiefs and together decide how much longer jeopardy needs to be in place. It is courteous to communicate with the person who has been jeopardized to cover you, but doesn't replace communication with a chief resident. Interns and residents should not schedule any events that will potentially conflict with their jeopardy schedule.

ii. Jeopardy Coverage Rules

1. OHSU-Providence Portland Jeopardy Policy
  - a. Each program is responsible for covering their respective residents while rotating at the other institution.
  - b. For the OHSU, this will be the jeopardy resident assigned for that time period.
2. OHSU-Kaiser Jeopardy Policy
  - a. The Residency Program Jeopardy is not used for Kaiser. Kaiser has an internal jeopardy schedule that involves the 8 residents assigned during a given rotation period.
3. Emergency Medicine
  - a. (UH MICU; VA GM)
    - I. Emergent Absences - Medicine Jeopardy schedule covers this.
    - II. Anticipated/Advanced Absences are to be provided for/arranged by the EM Program
  - b. ED Rotations - Covered by Jeopardy schedule
4. Family Practice (VA ICU; UH GM)
  - a. Family practice covers their own jeopardy
5. Psychiatry (VA GM wards)
  - a. Emergent Absences - Medicine Jeopardy schedule covers this.
  - b. Anticipated/Advanced Absences are to be provided for/arranged by the Psychiatry Program
6. Neurology
  - a. When neurology interns require jeopardy when on

appropriate medicine rotations, they are covered by Medicine Jeopardy Schedule

#### **IV. ADMINISTRATIVE PROCEDURES**

##### **A. Documentation of Procedures.**

The Department of Medicine uses an internet-based Procedure Log (E-Value) to record housestaff procedures. The site is located at: <http://www.e-value.net>. It is the expectation of the Residency Program that all housestaff routinely document the performance of procedures completed during their housestaff training. This is necessary not only for ACGME/RRC accreditation of the Residency Program, but is crucial for future employment opportunities of graduating housestaff. Future hospital privileges of graduating (and long since graduated) housestaff are directly linked to the number and spectrum of procedures documented during the housestaff years. When queried for credentialing information, the residency program prints a summary report from those entered on the web-based procedure log. Only privileges for recorded procedures will be granted.

##### **B. License to Practice Medicine.**

OHSU will provide a limited license for interns and residents while in training. An application to apply for a full medical license may be found at the Oregon State Board of Medical Examiners website: [www.oregon.gov/BME/phyapphomepg.shtml](http://www.oregon.gov/BME/phyapphomepg.shtml)

The Oregon State Board of Medical Examiners processes applications in an ongoing basis. It takes them approximately 8-12 weeks to process your application. Notary Publics are available in the office of GME and in the Medicine Housestaff Office if needed. A full medical license is required for moonlighting.

##### **C. Salary.**

The Oregon Health Sciences University pays all salaries. The current pay scale is published at: [www.ohsu.edu/ohsuedu/academic/som/GME/current-hr.cfm#Salary](http://www.ohsu.edu/ohsuedu/academic/som/GME/current-hr.cfm#Salary)

#### **V. Residency Committees**

##### **A. Residency Advisory Committee (RAC)**

The Department Residency Advisory Committee continuously examines the internship and residency programs, meeting monthly throughout the year. In addition to the faculty members, the Chief Residents, and the Chief Residents-Elect, there are representatives from each of the three training levels on the Committee. The RAC is structurally divided into subcommittees: the Ambulatory RAC, and the Inpatient / Sub-specialty RAC. These committees review the organization of the educational program and patient care activities. Housestaff representatives are chosen in early August each year.

B. Residency Promotion Advisory Committee (RePAC)

The Residency Promotion Advisory Committee is responsible for advising the Program Director on the progress and promotion of individual residents as they advance through the training program. The REPAC provides advice and assists the program in developing its evaluation system and in assessing the effectiveness of the evaluation methodologies used. The RePAC assists the Program Director in development of individual educational plans for residents who are experiencing difficulties. The RePAC is composed of faculty from the Department and is chaired by a member who is not a Program Director or Associate Program Director. The Program Directors, Associate Program Directors and Chief Residents serve as *ex officio* members.

## VI. Appendix: OHSU GME policies

### I. RESIDENT PROBATION, SUSPENSION, DISMISSAL AND NON-RENEWAL OF CONTRACTS (9/2001)

#### **POLICIES AND PROCEDURES FOR RESIDENT PROBATION, SUSPENSION, DISMISSAL AND NON-RENEWAL OF CONTRACTS**

1. Each residency program is responsible for implementing policies and procedures for addressing resident promotion, probation, suspension, dismissal and non-renewal of contracts. Program policies and procedures must be consistent with University policies and procedures, Division of Graduate Medical Education (AGME@) guidelines and ACGME requirements.

All Program Directors, faculty and Program Coordinators responsible for residents' contracts will have the opportunity to receive training regarding the implementation of University policies and procedures. Training will be provided by GME in conjunction with the OHSU Legal Department.

2. Some residents will encounter difficulty during their training. These problems generally fall into three specific areas: academic, disciplinary, and impairment.
  - a) Academic difficulties involve problems with resident performance that are specific to their development as a physician and involve cognitive and psychomotor performance, along with certain professional attitudes and behaviors. Residency programs identify academic problems through their evaluation systems. The results of such evaluations help inform residents about their progress in meeting the specific program standards for advancing, promotion and, ultimately, satisfactory completion of the program. The collective judgment of the faculty provides the basis for such decisions. Residents with academic problems are not generally subject to probationary status, but should be managed by an educational plan designed to address the identified deficiencies. Continuation in a program is contingent on a resident successfully addressing such deficiencies and meeting the specific academic standards for that program.
  - b) Disciplinary problems involve violations of laws, institutional and departmental policies, and contractual agreements. Certain professional behaviors, because of their potential for serious adverse effects on patients and other health care workers may also give rise to disciplinary actions. Disciplinary problems, since they involve alleged violations of laws or institutional policies, require due process and evidentiary hearings. The ultimate guilt or innocence and thus disposition of a resident accused of a disciplinary problem is not determined by an academic judgment, but rather the weight of the evidence.

c) Impairments generally refer to specific medical or psychological issues that interfere with performance. While impairment problems may impact on academic performance, they also have implications for a resident's ability to safely perform their patient care duties. Impairments require specific, precise diagnosis, appropriate treatment, and, when requested, appropriate accommodations.

3. Program Directors shall notify the Director of GME as soon as a decision is made to: (1) delay the promotion or progression of a resident for academic reasons; (2) place a resident on probation for disciplinary reasons; (3) substantially alter or limit a resident's duties, including a leave of absence due to a perceived or confirmed impairment, (4) to not renew the resident's appointment or to seek dismissal or suspension of the resident from the program. Notification should include: a description of the adverse action to be taken and the reasons for the action, a copy of the notice to the resident, and a summary of the plan for remediation addressing and resolving the problem, including and the timetable for a final decision about the resident's continuation in the program, if applicable. The Director of GME should be notified of any subsequent change when the status of the resident is changed (i.e., from probation to full status). In addition, the Program Director must, prior to any action, notify the Director of GME of the intention to not renew the resident's appointment or to seek dismissal or suspension of the resident from the program.
4. Programs shall notify residents promptly in writing about any decision to: (1) delay their promotion or progression for academic reasons; (2) place them on probation for disciplinary reasons; (3) substantially alter or limit the resident's duties, including a leave of absence, due to a perceived or confirmed impairment. In addition, Programs must notify a resident of their intent: (1) to not renew their appointment, or (2) to seek their dismissal or suspension from the program. Non-renewal of contract is generally restricted to issues of academic performance. For non-renewal of contract, the program should notify the resident **at least four months** prior to the end of the current contract period (usually March 1). However, if the primary reason(s) for the non-renewal occurs or is being formally addressed within the four months prior to the end of the contract, the program should provide the resident with as much written notice as the circumstances will allow prior to the end of the contract.
5. The Director of GME shall submit a semi-annual report to the Oregon Board of Medical Examiners (OBME) that provides data about the status of residents in each of the programs. The identity of the residents with specific academic, disciplinary and impairment issues will not be disclosed in these reports, unless such problems have led to non-renewal, probation, suspension or dismissal. The Director of GME will request confirmation of these summary data from individual programs prior to submission to OBME.

## II. OHSU Grievance Procedure

### OREGON HEALTH & SCIENCE UNIVERSITY HOSPITAL HOUSE STAFF GRIEVANCE PROCEDURE (As Taken From the House Staff Appointment Agreement)

**i. PURPOSE:**

The purpose of the procedure is to secure at the lowest possible level equitable solutions to individual grievances which may arise about the interpretation or application of the House staff Appointment Agreement.

**ii. DEFINITION:**

A grievance shall mean any dispute or controversy about the interpretation or application of the House staff Appointment Agreement. The non-renewal of a House Officer's Appointment upon expiration of the one year term is not grievable under these procedures nor are questions about the Hospital or Oregon Health Sciences University policy, quality of patient care, adequacy of facilities, operations of ancillary and support services, etc., grievances in this context. Concerns about such matters must be pursued by other means. The "due process" procedure for a House Officer to be terminated or suspended without pay for cause is provided for separately and does not come under the provisions of the Grievance Procedure.

**iii. PRELIMINARY PROCEDURE:**

No matter shall be submitted for the Grievance Procedure unless it has first been discussed personally by the House Officer and his/her Program Director. If the Program Director is personally involved in the matter, then the Director of Graduate Medical Education shall be substituted for the Program Director. Both parties shall make a good faith effort to resolve the grievance in an informal manner. If the grievance is not resolved, the House Officer may proceed to Step One of the Grievance Procedure.

**iv. STEP ONE:**

The grievance shall be submitted with ten (10) calendar days following the grievable event or within ten (10) calendar days after the House Officer first becomes aware of such an event, whichever is longer. The grievance shall be in writing and must contain a statement of the grievance, the facts upon which it is based, and the remedy sought. The grievance shall be filed with the Director of Graduate Medical Education.

The grievance shall be heard by a committee consisting of one (1) uninvolved House Officer and one (1) member of the Active Medical Staff appointed by the Director of Graduate Medical Education, and one person from the Active Medical Staff or House staff mutually acceptable to and agreed upon by the two aforementioned appointed members. The Director of Graduate Medical Education shall be the Chairman of the Committee, shall attend to the administrative matters and may participate in the deliberations but shall not have a vote.

The Committee shall be formed within fourteen (14) calendar days of the filing of the

grievance. The Committee shall hear the case as promptly as is practicable with due notice to all parties and in any event within ten (10) calendar days after constitution of the Committee unless delay is mutually agreed upon by all parties. Evidence and argument may be submitted in writing or personally or both. Either party or both may be assisted by counsel or other advisor of choice. The attorney or counsel will not actively participate in the proceedings unless authorized by the committee chair. A record of the hearing shall be kept.

The Committee shall decide whether the subject is grievable or not. Should the Committee decide that the matter is not grievable, the proceeding shall be stopped. The decision of the Committee in this regard is final. If the Committee finds the matter grievable, they are to recommend a remedy or procedure acceptable to settle the dispute. All committee decisions and recommendations shall be decided by a majority vote of the voting members of the Committee. The decision and the recommended action shall be in writing and shall be delivered to the parties involved in the dispute and to the Director of the Health Care System, Oregon Health Sciences University. The Director of the Health Care System shall review the Committee recommendation and within five (5) calendar days notify in writing the parties involved in the dispute and the Director of Graduate Medical Education of his/her approval of the Committee recommendation; and, if disapproval, of his/her decision on the grievable matter.

If no notice of appeal, as provided for in Step Two, is filed within five (5) calendar days of the Director's of the University Hospital written decision, the decision of the Director of the Health Care System shall be final. The Director of Graduate Medical Education shall be responsible for seeing that any necessary action to resolve the grievance in accordance with the decision is carried out.

**v. STEP TWO:**

If any party to the grievance is dissatisfied with the decision resulting from the procedure in Step One, he/she may appeal the case to the President of the Oregon Health Sciences University. The notice of appeal to the President shall be submitted in writing within five (5) calendar days following receipt of the decision in Step One. The President or his/her designee shall review the record of the case as presented to the Committee in Step One. The President may call for further evidence or argument at his/her discretion. The President may affirm, reverse, or modify the decision. The decision of the President is final.