

TABLE OF CONTENTS

Policies & Procedures

Resident Recruitment/Selection/Eligibility

Promotion of Residents

Non-Renewal of Resident Contracts

Residency Closure/Reduction

Resident Credentialing/Appointment

Resident Permit/Licensure

Moonlighting

Duty Hours

Due Process

Problem Resolution/Grievance

Physician Impairment

Anti-Harassment and Non-Discrimination Policy

Position Description

Resident Recruitment/Selection/Eligibility

AMEP programs recruit/select from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities including motivation and integrity. Programs will not discriminate with regard to gender, race, age, religion, sexual orientation, color, national origin, disability, or veteran status. In order to determine that all candidates making application for openings in the Residency programs meet the necessary qualification, the selection of Residents for each program is coordinated with the ERAS (Electronic Resident Application System). Final decision on acceptance of an appropriate candidate is made by the Program Director.

Applicants with one of the following qualifications are eligible for appointment to accredited residency programs:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications:
 - Currently have a valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) or
 - Have a full unrestricted license to practice medicine in a U.S. licensing jurisdiction.
4. Graduates of medical schools outside the United States who have completed a Fifth Pathway program provided by an LCME-accredited medical school.

Candidate must meet with reasonable accommodation, all duties and responsibilities as described in AMEP GME Policy #8825 – Supervision of Residents.

Candidates for available positions are requested to complete an application through the Electronic Residency Application Service (ERAS) and include but not limited to:

- A minimum of two letters of recommendation;
- ECFMG certificate or full unrestricted license to practice medicine in a U.S. licensing jurisdiction, if a foreign graduate;
- Results of USMLE or Comlex (NBOME) scores or diploma or medical school transcript
- Other pertinent supporting documentation.
- Each program may have additional requirements.
- If a transfer resident, a letter of recommendation from the previous Program Director.
- Documentation as listed below to meet The Texas State Board of Medical Examiners transcript curriculum verification process for international graduates. If an international graduate medical school transcript does not meet the Basic Science and Clinical Sciences/Clerkship requirements the following must be provided:
 - a. A statement from the applicant explaining how the applicant satisfied the guidelines as to course content. Each page of an applicant's statement should carry the applicant's signature and a date.
 - b. A statement provided by the applicant's medical school, submitted directly to AMEP, verifying the applicant's explanation of how the applicant satisfied the guidelines as to course content.

Applications will be reviewed by respective programs and applicants who meet initial program criteria will be invited for an interview. The AMEP Resident contract and Institutional Resident Manual will be available for applicants to review.

Each program has a mechanism to rank candidates through the National Residency Matching Program.

Candidates that match are sent an Agreement.

Candidates for unmatched positions are handled the same as in procedures 1, 2, and 3 listed above.

Resident's Transferring From Other Residency Training Programs

- To determine the appropriate level of education for a resident who is transferring from another residency program, a written verification from the previous program director must be received regarding educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six areas (patient care, medical knowledge, professionalism, interpersonal & communication skills, systems-based practice and practice based learning) prior to acceptance into the program.
- In addition, the program director of the previous program must provide, in writing, any time off the resident had during their training experience at the previous program

Promotion of Residents

Resident physicians may be promoted to the next year of training if their performance indicates their ability to perform at the next higher level.

1. The Program Director is responsible for the decision of the resident promotion.
2. Residency contracts are one year in length, and promotion results in issuance of a new contract for the upcoming year. Promotion contracts will issued by mid-January, or 5 months prior to the beginning of the next academic year. Signed

contracts are due back to the GME Administrative Office no later than 4 months (120 days) prior to the beginning of the next academic year.

3. The Program Director will obtain, from the faculty, as well as from other pertinent sources and/or relevant committees, information on the performance of each resident regarding promotion.
4. The Program Director will also take into account the appropriate program and institutional guidelines set by the Accreditation Council for Graduate Medical Education (ACGME), the Residency Review Committee (RRC), specialty board guidelines, institutional resources, relative merit of individual compared to other applicants, and program guidelines in making the decision.
5. The Program Director may offer a resident additional time in any given Post Graduate Year prior to considering promotion of said resident. The added time would be used to allow the resident to achieve the required level of proficiency for promotion. A resident accepting this condition should be given a summary of deficiencies, a delineation of the remediation program and the criteria for advancement.
6. If the resident is not promoted, he/she will receive written notice at least four months (120 days) prior to the end of current residency term as to his/her status in the program. A decision not to promote a resident is subject to the due process and appeal procedures set forth in the Austin Medical Education Programs Resident Manual.

Non-Renewal of Resident Contract

1. Written notice of intent will be given no later than four months (120 days) prior to the end of resident's current contract.
2. If the primary reason(s) for non-renewal extends into or occurs within the four months prior to the end of contract, the program will provide a written notice of the intent to not renew as the circumstances will reasonably allow, prior to the end of the contract.
3. The Resident will be allowed to implement the Due Process Procedure as outlined in the Austin Medical Education Programs Institutional Resident Manual when they have received a written notice of intent not to renew the contract.

Residency Closure/Reduction

1. In the event that AMEP reaches a decision to reduce the size of a residency program or to close a residency program, all residents in training or applying for such programs, will be notified as soon as possible.
2. Program closure would be anticipated prior to resident recruitment and match for the subsequent year. In the event of closure, the following steps would be taken:
 - No resident would be recruited for the next PGY1 year.
 - In the event of such a reduction or closure, all residents already in the program will be allowed to complete their GME educational program at AMEP or, where this is impossible, will be assisted in enrolling in an ACGME accredited program in which they can continue their GME education.
 - Full closure of a program will occur at least twelve plus three months after notification of residents.
3. Resident reduction will occur through systemized attrition and through an anticipated decrease in the residents recruited for the subsequent years.

Resident Credentialing/Appointment – Employed Residents

Resident credentialing/appointment information will include the following:

Resident General Information

- ❖ ERAS Common Application Form or comparable documents.
- ❖ Dean's Letter
- ❖ Letters of Recommendation (2)
- ❖ Curriculum Vitae
- ❖ Medical School Diploma (notarized copy) or Certified Copy of Medical School Transcript authenticating "Degree Awarded."
- ❖ Valid ECFMG Certificate (IMG's only)
- ❖ Valid Work Authorization Documentation (Social Security Card, Green Card, DS-2019 (J-1 Visa), Work Permit, etc.)
- ❖ Seton Healthcare Network Resident Appointment Form
- ❖ Passport sized photo

Resident Contract

TSBME Resident Permit/License

See Resident Permit/Licensure below for further details

Institutional DEA number & Signature

See Resident Permit/Licensure below for further details

Malpractice Liability Certificate

Residents are provided with "claims-made" professional liability insurance through Ascension Health. The liability coverage only covers the resident in respect to his/her duties while in training with Austin Medical Education Programs.

Current appropriate Advanced Life Support certification

- Internal Medicine & Transitional Year – BLS & ACLS
- Family Practice – BLS, ACLS, NRP & PALS
- Pediatrics – BLS, NRP & PALS
- Surgery – ATLS & ACLS
- OB/GYN – NRP, BLS & ACLS

Resident's Transferring From Other Residency Training Programs

To determine the appropriate level of education for a resident who is transferring from another residency program, a written verification from the previous program director must be received regarding educational experiences and a statement regarding the performance evaluation of the transferring resident, including an assessment of competence in the six areas (patient care, medical knowledge, professionalism, interpersonal & communication skills, systems-based practice and practice based learning) prior to acceptance into the program.

In addition, the program director of the previous program must provide, in writing, any time off the resident had during their training experience at the previous program.

All of the above must be submitted to the AMEP GME Administrative Office prior to the resident beginning his/her rotation with Austin Medical Education Programs. If any documentation is missing, the resident will not be able to begin his/her training.

The program director will approve the resident credentials by signing the bottom of the resident check sheet.

Any resident who did not begin residency training upon immediate graduation from medical school and has previous clinical US experience will be subject to a National Practitioner Databank Query. This query will be performed by the SETON Medical Staff Office.

Resident Permit/Licensure

In order to train with Austin Medical Education Programs all residents must have a current permit or license from the Texas State Board of Medical Examiners. In addition, if a resident has a Texas Permit they must have an Institutional DEA which will be issued when resident begins training with AMEP or if a resident has a Texas License they must also possess a DEA and Texas DPS license.

1. Texas Basic Postgraduate Resident Permit & Institutional DEA

All residents who are not fully licensed to practice medicine in the State of Texas must apply for and obtain a Postgraduate Resident Permit annually from the Texas State Board of Medical Examiners through the AMEP Graduate Medical Education Office. The AMEP Graduate Medical Education Office will provide applications for the Postgraduate Resident Permit to the resident in their initial packet of information. AMEP will pay the annual permit fee. This permit does not allow a resident to practice clinical medicine outside of his/her educational training program. Once permanent medical licensure in Texas is obtained by the resident, the AMEP Graduate Medical Education Office must be sent a copy of the current physician permit, showing the resident's license number, issue date and the expiration date of the license. Residents must also obtain their DEA and DPS registration numbers when fully licensed by the Texas State Board of Medical Examiners (see F – DPS & DEA registration numbers)

The Texas State Board of Medical Examiners requires that all Program Director complete the "THECB Coursework Verification Form" on all international graduates to verify the applicant's curriculum meets their requirements as determined by a committee of experts selected by the Texas Higher Education Coordinating Board. If an international graduate medical school transcript does not meet the Basic Science and Clinical Sciences/Clerkship requirements the following must be provided:

1. A statement from the applicant explaining how the applicant satisfied the guidelines as to course content. Each page of an applicant's statement should carry the applicant's signature and a date.
2. A statement provided by the applicant's medical school, submitted directly to AMEP, verifying the applicant's explanation of how the applicant satisfied the guidelines as to course content.

Below is the list of basic science and clinical science experiences a graduate must have. Please include a certified transcript with this statement.

	Basic Sciences		Clinical Sciences/Clerkships
	Biochemistry		Family Medicine ¹
	Biology/Histology ²		Internal Medicine
	Gross Anatomy ³		Introduction to Patient/Physical Examination ⁴
	Immunology/Microbiology ⁵		Obstetrics/Gynecology
	Neuroscience ⁶		Neurology
	Pathology		Pediatrics
	Pharmacology		Psychiatry
	Physiology		Surgery

1. Community Medicine or Emergency Medicine will satisfy this requirement.
2. Because Biology is a pre-requisite to medical school, there is not need to find a course with the exact title "Biology." A course titled (or encompassing) Microanatomy will satisfy the Histology requirement.
3. Human Anatomy or Morphology will satisfy this requirement.
4. Because this should be a component of each clinical clerkship, there is no need to find a course with this exact title.
5. Completion of both Immunology and Microbiology taken separately will satisfy this requirement.
6. a. Neuroanatomy that is included as a part of Anatomy (basic science) in combination with Neurology (clinical clerkship) satisfies this requirement.
b. Completion of both Neuroanatomy and Neurophysiology taken separately will satisfy this requirement.

Institutional DEA Number

Those residents covered under a Postgraduate Resident Permit will be assigned an Institutional Drug Enforcement Administration ("DEA") controlled substances registration number. This is a three-digit suffix number to be used in conjunction with the DEA institutional registration number of the Seton Healthcare Network. This number will be assigned at General House Staff Orientation and will provide the resident prescription writing privileges in the Seton Healthcare Network.

IMPORTANT NOTE: Prescription order forms must show in addition to a legal signature:

1. prescribing physician's name printed in full and legible;
2. DEA number for controlled drugs; and

3. patient's name and address.

2. TEXAS MEDICAL LICENSE – DEA – TEXAS DPS

The AMEP Graduate Medical Education Office must be notified immediately by a resident upon receiving their medical license from the Texas State Board of Medical Examiners and a copy of the physician permit portion of the license must be submitted to this office. It is the personal financial responsibility of the resident to obtain or renew his/her medical license. The Texas State Board of Medical Examiners' address is: P.O. Box 2018, Austin, TX 78768-2018.

DPS & DEA REGISTRATION NUMBERS

Since the Seton Healthcare Network Institutional DEA number cannot be used once individual medical licensure is obtained, all eligible residents are responsible for obtaining their individual Texas Department of Public Safety (DPS) registration number to dispense and prescribe controlled substances and Federal Drug Enforcement Agency (DEA) registration number once licensed in Texas. A fee is charged by the Federal DEA and the Texas DPS for each of these numbers and the resident is financially responsible for payment of this fee. The AMEP Graduate Medical Education Office must be provided copies of these documents when obtained.

Moonlighting

To provide the Residents with the Austin Medical Education Programs policy regarding "Moonlighting." Austin Medical Education Programs does not require residents to moonlight.

Moonlighting" is defined as any activity associated with the practice of medicine outside assigned duties as a resident at AMEP for which compensation is received in cash or kind in exchange for work (internal or external).

Internal Moonlighting – Moonlighting within resident's primary training program.

External Moonlighting – Moonlighting outside resident's primary training program

Procedure:

EXTERNAL MOONLIGHTING:

When a resident "externally moonlights," it should be with the knowledge that:

1. Independent licensure is required for external moonlighting by the State of Texas for the practice of medicine is mandatory;
2. Neither AMEP nor the resident's department will have a moral, legal and/or ethical obligation to the resident or the resident's patients during the time the resident is moonlighting. This means that malpractice coverage, worker's compensation coverage and/or any other fringe benefits ordinarily afforded the resident will not be in effect;
3. No resident may "moonlight" during assigned duty time;
4. Permission of the residency Program Director must be obtained prior to arranging to "moonlight." A written statement must be in the file of the resident signed by the Program Director that he/she is aware that the resident is "moonlighting, assuring moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program." The resident's performance will be monitored for the effect of moonlighting activities upon their performance and adverse effects may lead to withdrawal of permission.
5. Individual Program Directors may forbid moonlighting; and,
6. The U.S. Code of Federal Regulations clearly prohibits foreign exchange visitors (i.e., J1 visa holders) participating in programs of graduate medical education from pursuing work outside of their training programs. Therefore, any resident holding a J1 visa may not moonlight or earn extra income under any circumstances.

The educational experience and instruction received in the program and the stipend and benefits provided herein are the sole remuneration and benefit to which a resident is entitled for services rendered or provided pursuant to the AMEP training program. Residents are prohibited from accepting fees or other remunerations from any patient for services rendered as a part of the training program. A basic post-graduate resident permit, issued by the Texas State Board of Medical Examiners, does not authorize a resident to engage in medically related activities outside the confines of their formal residency training. If a resident has, or subsequently obtains a Texas medical license, the resident shall not engage in medically related employment outside the training program which interferes in any manner with the duties and responsibilities of the resident provided herein or puts the resident in violation of AMEP's policy on Resident Duty Hours The resident must keep his/her Program Director apprised of the general aspects of his/her practice of medicine outside the training program.

If, in the opinion of the Program Director or the Executive Director, such employment in medically related activities or any other employment interferes with the resident's timely performance of his/her duties and responsibilities provided herein or causes the resident to not be in compliance with AMEP's policy on Resident Duty Hours, disciplinary action may be taken by AMEP against the resident. The professional liability insurance coverage provided to the resident under this agreement shall not provide professional liability insurance coverage for the resident in any medical practice or activity which is not conducted in the course and scope of the AMEP residency program.

DUTY HOURS

Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. Each program must ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of patients.

1. Supervision of Residents

- a. All patient care must be supervised by qualified faculty. The program director must ensure, direct, and document adequate supervision of residents at all times. Residents must be provided with rapid, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- c. Faculty and residents must be educated to recognize the signs of fatigue and adopt and apply policies to prevent and counteract the potential negative effects.
- d. Monitoring Supervision – The Institution will assure adequate supervision of residents through the current Hospital Discharge Medical Records Review Policy (#8635)
- e. A summary of the medical records review will be reported to the GMEC quarterly.

2. Duty Hours

- a. Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. 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.
- e. Monitoring Duty Hours
Program directors will be responsible for monitoring the duty hours of their residents after each rotation. Residents will complete a self-evaluation or Resident Work Hours Survey after each rotation which will minimally include the following:
 - ❖ Were your work hours limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities;
 - ❖ Were you provided one day in 7 free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.Program Directors will review and sign all resident self- evaluations.
- f. Reporting Duty Hours to DIO and GMEC Program Directors will immediately report any duty hour violation to the DIO. In addition, Program Directors will submit a quarterly report on Duty Hours for their program to the GMEC, specifically noting any violations and corrective actions taken.

3. On-Call Activities

The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal workday when residents are required to be immediately available in the assigned institution.

- a. In-house call must occur no more frequently than every third night, averaged over a four-week period.
 - b. 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 as defined in Specialty and Subspecialty Program Requirements.
 - c. No new patients, as defined in Specialty and Subspecialty Program Requirements, may be accepted after 24 hours of continuous duty
 - d. At-home call (pager call) is defined as call taken from outside the assigned institution.
 1. The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.
 2. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour limit.
 3. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
4. Moonlighting
- a. Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
 - b. The program director must comply with the sponsoring institution's written policies and procedures regarding moonlighting, in compliance with the Institutional Requirements III. D.1.k.
 - c. Moonlighting that occurs within the residency program and/or the sponsoring institution or the non-hospital sponsor's primary clinical site(s), ie, internal moonlighting, must be counted toward the 80-hour weekly limit on duty hours.
5. Oversight
- a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
 - b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.
6. Duty Hours Exception

The AMEP Institutional GMCEC will not grant exceptions to the 80 hour limit.

DUE PROCESS

In the event that any of the following disciplinary actions are taken against a resident, the resident may appeal the determination: suspension; termination; non-renewal of contract; or a determination that the resident is ineligible to sit for a Board exam (hereinafter referred to as a "qualified disciplinary action").

A resident may, within thirty (30) days of receipt of the written notice of a qualified disciplinary action, request in writing a hearing by the Appeals Committee. Such notice of appeal shall be a petition in writing to the Executive Director. The Appeals Committee shall consist of:

1. The Executive Director;
2. Two (2) program directors, other than the resident's program director, selected by the Executive Director; and
3. Three (3) house staff officers selected by the Housestaff Association. This is usually the president and vice-president, unless either is the appealing resident or one or both are directly involved and would be unable to serve on such a committee impartially and a Chief Resident from a program other than the program of the appealing resident.

The Executive Director shall serve as chairman of the Appeals Committee. The chairman shall notify the resident of the time, place, and date of the hearing at least thirty (30) days prior thereto. The notice should also include a description of the allegations against the resident and a list of witnesses, if any, expected to testify on AMEP's behalf. The resident may retain legal counsel for consultation and advice outside of the proceeding before the committee, but the resident may be represented at the hearing only by himself/herself or a member in good standing of the housestaff unless the resident and Executive Director mutually agree to counsel representation. The resident may call, examine, and cross-examine witnesses and present such evidence, including a written statement, he/she deems appropriate in his/her defense. The resident's program director shall present such statements and documents, and call such witnesses, as he/she deems appropriate in support of the said director's recommendation for a qualified disciplinary action. The resident's right to a hearing may be forfeited if the resident fails, without good cause, to appear at the hearing.

The Appeals Committee shall make a final determination as to disciplinary action and shall notify the resident in writing, within seven (7) days after the date of the hearing of such determination. The notice to the resident will include a statement of the basis for the decision.

The resident may appeal the decision of the Appeals Committee to the AMEP Board of Trustees (the "Board") by delivering to the Executive Director a written request and petition for appeal. The AMEP Board will hear the appeal at its next regularly scheduled meeting. The proceeding before the AMEP Board shall be as follows:

1. Any AMEP Board member who has participated in the disciplinary procedure prior to the appeal to the AMEP Board meeting shall not participate in the decision making process by the Board, but shall be excused from such proceedings;
2. At least five (5) days prior to the Board meeting, the resident and the Executive Director, as Chairman of the Appeals Committee, shall each present a written summary of the testimony and evidence presented to the Appeals Committee, but no witnesses shall be heard at the appeal, except as provided below;
3. The resident and the program director or Executive Director may present oral argument of equal time in duration as established by the Board, such time not to exceed thirty (30) minutes
4. At the conclusions of the oral statements or arguments, the Board shall consider in executive session the appeal and shall issue a decision in writing within ten (10) days of the appeal hearing;
5. The AMEP Board's decision may affirm the decision of the Appeals Committee, reverse the decision of the Appeals Committee, modify the decision of the Appeals Committee, or remand the matter back to the Appeals Committee for further hearing and decision. In any event, the decision of the AMEP Board is final and may not be further appealed. If the matter is remanded to the Appeals Committee by the Board, the resident may seek reconsideration from the Board following the decision of the Appeals Committee on remand.

During the entire appeals process, the resident may be suspended from all activities in the residency program or may be allowed to fully or partially participate in the program until a final decision is made, provided, however, that the decision for complete suspension from or partial or full participation in the program during the appeals process shall be the decision of the Executive Director, which decision shall not be subject to appeal. The timelines set forth above for the hearing may be shortened upon mutual agreement of the parties.

PROBLEM RESOLUTION

SETON and the AMEP program strives to give objective consideration to resident concerns and to ensure fair resolution of resident problems through a formal problem resolution procedure. Formal complaints occurring with respect to administrative, professional, educational, or personal issues may be resolved in accordance with this procedure.

This procedure specifically excludes any action taken relating to sexual harassment, a positive drug test, inplacement or outplacement, severance agreements or employment at will terminations. Special consideration will be taken if timelines outlined below cannot be met.

Step One:

A resident wishing to file a grievance or register a complaint must first bring the problem to the attention of his or her chief resident within five (5) working days of the awareness of the incident giving rise to the problem. The resident shall meet and explain verbally his or her concern to the chief resident who will attempt to assist the resident in resolving the situation. The decision of the chief resident shall be verbally provided to the resident within three (3) working days of their meeting.

Step Two:

If the resident is not satisfied with the decision and/or outcome of Step One, the resident must schedule a meeting to discuss the issue with the Program Director of the rotation or designee. If the Program Director of the rotation is not the Home Program Director of the resident then the Home Program Director of the resident will be notified (by the resident filing the complaint) at this time of the situation. This meeting must occur within five (5) working days from receipt of the decision of Step One. At least 24 hours prior to the meeting a written document outlining the concern as well as the requested resolution must be submitted to the Program Director or designee. The employee may contact the Human Resources Director or designee who will assist the resident in presenting his or her complaint in writing. The Program Director or designee shall notify the resident of the results of his or her decision in writing, within ten (10) working days of the meeting.

Step Three:

If the resident and the Program Director or designee cannot resolve the problem, the Program Director or designee will arrange for a convening of the Graduate Medical Education Problem Resolution Committee (the "Problem Resolution Committee") within 5 days which will be appointed by the AMEP Designated Institutional Official (DIO) or designee.

1. At this point, the Program Director or designee will appropriately document the unresolved issues that will be the focus of the Problem Resolution Committee's attention.
2. The Problem Resolution Committee will be a sub-committee of the Graduate Medical Education Committee and will be composed of one faculty member, one hospital administrator, and two residents. Neither the faculty member nor the residents shall be from the resident's program.
3. The Problem Resolution committee will investigate the complaint completely to include interviewing appropriate members of the resident's department.
4. The Problem Resolution Committee will issue an initial response within 10 working days of the appointment of the Committee regarding the issue presented to it. Should the Problem Resolution Committee be unable to resolve an issue, the matter will be referred to the Board of Trustees of AMEP. The decision of the Board will be final.

Additionally:

- A Transitional resident will take his or her complaint to the chief resident of the service to which he/she has been assigned. If resolution does not occur, the Transitional complainant will present the issue to the Transitional Program Director who will bring the issue to the Problem Resolution Committee if solution cannot be resolved by the Transitional Program Director.
- A resident who presents an issue or complaint to his or her mentor or faculty advisor should be apprised by that mentor or advisor of the Problem Resolution Policy.
- A Program Director or designee, or a chief resident presented with an issue or complaint of a global or pervasive nature (that is, of interest or concern to all AMEP residents) may take the issue to the GMEC Problem Resolution Committee directly.
- A resident with an issue or complaint involving any or all members of the appropriate chain-of-command may petition directly to the AMEP DIO for the convening of the Problem Resolution Committee.
- This Problem Resolution Policy does not apply to a resident response or reaction to a disciplinary action including, but not limited to, academic probation, promotion, suspension, dismissal, board eligibility, or non-renewal of contract. Such issues are more appropriately addressed by the policies set above in regard to Resident Evaluation, Feedback and Due Process.

IMPAIRED RESIDENT PHYSICIAN

Austin Medical Education Programs ("AMEP") policy is to provide a procedure for the possible identification, intervention, and referral for treatment of a resident. The objectives of this policy are to strive to assure quality of care for all patients and to maintain a safe environment for patients, employees, faculty and residents of AMEP.

Definitions

Impaired Resident: A physician whose ability to practice medicine is impaired, or reasonably believed to be impaired, by drug or alcohol abuse or mental or physical illness.

Under the Influence: The condition wherein any of the body's sensory, cognitive, or motor functions or capabilities are altered, impaired, diminished, or affected due to alcohol, drugs, or controlled substances. "Under the influence" also means any detectable presence of alcohol or drugs within the body."

I. Investigation

- A. Impaired resident physicians may be identified by behavior and patterns of behavior which include, but are not limited to:
 - 1. Consistent tardiness
 - 2. Unexplained absences (especially after days off)
 - 3. Angry outbursts or unprofessional behavior
 - 4. Unexplained somnolence
 - 5. Legal difficulties
 - 6. Unexplained lack of progression during the training year (reaching a plateau)
 - 7. The smell of alcohol on a resident
 - 8. Poor impulse control
 - 9. Lack of interest - depression
 - 10. Other psychiatric disturbances
 - 11. Other medical illness
- B. AMEP encourages an impaired resident to self report to their program director. Upon receipt of a self report, the Program Director will meet with the resident to determine the severity of the problem and the appropriate course of action.
- C. Upon receipt of a report that a resident may be impaired, the Program Director may request the assistance of the programs Residency Evaluation Committee.
- D. If there is concern that the residents impairment could possibly present a threat of danger to patient care, colleagues or the resident, the case should be referred to the Residency Safety Committee ("RSC") for further investigation.
- E. The RSC shall consist of the AMEP Program Directors of Family Practice, Internal Medicine, Pediatrics, Psychiatry, Transitional as well as the Education Director.
- F. The RSC shall promptly notify the resident that AMEP has received information indicating that the resident may suffer an impairment.
- G. The RSC shall fully investigate the report. Such investigation may include, but is not limited to: (1) interviews of the person making the report and other relevant witnesses; (2) review of patient and hospital records for evidence of impairment; (3) request for drug testing and psychological and/or medical evaluation; (4) conference with the resident to gather information and provide the resident with an opportunity to dispute any allegations.
- H. At the Program Director's sole discretion, the resident may be immediately suspended without pay pending the outcome of an investigation.
- I. If the RSC believes that the resident poses a threat to the health and safety of patients, the resident, faculty and/or other residents, the resident will be referred to the Travis County Medical Society Physician Health and Rehabilitation Committee.
- J. If the resident refuses to cooperate with the investigation, the RSC will interview the resident and consider the evidence presented by the Program Director. If the RSC agrees with the Program Director, the resident will be required to submit to the evaluation in order to remain in residency training. If the RSC does not

support requiring the resident to undergo an evaluation, the issues of discipline or academic failure will be addressed and issues of impairment will continue to be monitored by observation and follow up with the Program Director.

- K. If a resident complaint is identified by an individual outside AMEP, such as a hospital, AMEP will assume the responsibility for investigating the complaint.
- L. If a resident suspects a fellow resident or faculty member or other medical professional, the resident is strongly encouraged to report the suspected impaired professional to the program director or to the Travis County Physician for Health and Rehabilitation Committee.

II. Recommendation and Action

- A. After completing its investigation, the RSC may recommend one of the following options, depending upon the severity of the problem, if any, and prognosis (whether the resident self-reported his or her impairment to AMEP or whether the resident immediately admitted the problem will be a consideration):
 - a. Take no action;
 - b. Continued monitoring of the suspected impaired resident;
 - c. Refer the practitioner to the Travis County Medical Society's Physician Health and Rehabilitation Committee ("PHRC");
 - d. Require the practitioner to enter into a treatment program with or without pay as a condition of continued residency;
 - e. Impose appropriate restrictions on the resident's training and practice;
 - f. Suspend the practitioner from the residency program immediately with or without pay until an appropriate treatment program has been successfully completed to AMEP's satisfaction;
 - g. Terminate the resident;
 - h. Take any other action it deems appropriate;
- B. The RSC will provide the resident with notice of its decision.
- C. If the resident refuses to accept a determination by the RSC requiring treatment, the resident may be terminated immediately and may exercise his or her rights under the AMEP Due Process Policy.

III. Rehabilitation and Reinstatement

- A. If the resident is referred to the PHRC, the resident will then work with the PHRC and, if applicable, the Texas State Board of Medical Examiners ("TSBME") to establish a treatment program. The Program Director may meet with the chairman or members of the PHRC, and the resident, to establish terms of treatment.
- B. Treatment time which requires an absence from work will be considered a medical leave. If the leave exceeds a month of training time, the residency must be extended to meet the training requirements for promotion or board eligibility.
- C. The impaired resident is fully responsible for any out-of-pocket expenses related to the resident's treatment that extends beyond the resident's insurance coverage.
- D. AMEP may, at its sole discretion, reinstate the resident if it has been established that he or she has successfully completed a suitable treatment program.
- E. If reinstatement is granted, AMEP may place the resident on probation for a specified amount of time with conditions including, but not limited to any of the following:
 - 1. Resident's continuation of treatment/therapy approved by AMEP;
 - 2. Ongoing monitoring and periodic evaluations by AMEP;
 - 3. Drug testing upon the request of PHRC;
 - 4. Maintenance of individual professional liability insurance with limits acceptable to AMEP;
 - 5. Search of resident's person, office, space assigned to practitioner, and any item owned or used by resident which is on AMEP or Seton Healthcare Network premises;
 - 6. Authorization by resident for the release of practitioner's drug and alcohol abuse records;
 - 7. Written updates from the physician or therapist treating resident for his or her impairment.
- F. Failure by the resident to comply with drug rehabilitation, the recommendations of the RSC, and/or the terms of any reinstatement may result in disciplinary action up to and including termination.

G. Subsequent relapse by the resident may result in action up to and including discharge.

IV. Report to Texas Board of Medical Examiners

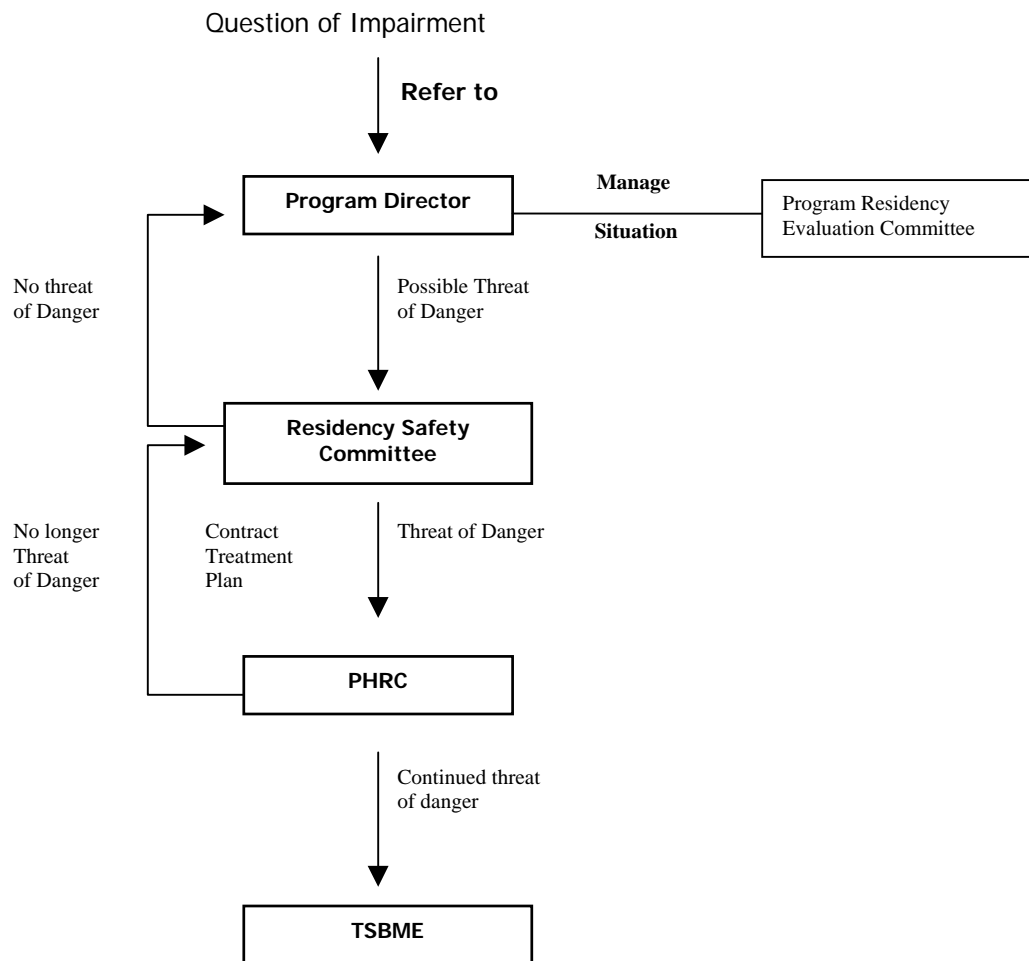
Any action taken by AMEP which meets the requirements for reporting under the Texas Medical Practice Act including, but not limited to, a determination that the physician poses a continuing threat to the public welfare through the practice of medicine, will be reported to the Texas Board of Medical Examiners as required by law.

V. Confidentiality

AMEP records, files, or other medical, psychiatric, and chemical dependency information including the results of drug tests are maintained by AMEP as confidential. In addition, confidentiality protection is afforded to all resident and peer review committee discussions, investigations, deliberations, and documentation pursuant to the Texas Medical Practice Act.

VI. Savings Clause

If any part of this policy and procedure is held invalid by a competent authority, the remainder of the policy shall continue in full force and effect.



Anti-Harassment and Non-Discrimination Policy

SETON is committed to a work environment in which all individuals (including employees, patients, physicians, contractors, temporary agency workers, vendors, and visitors) are treated with respect and dignity. SETON will not tolerate harassment or discrimination of any employee or applicant based upon race, color, religion, national origin, sex, age, sexual orientation, disability, veteran status or any other legally protected category. SETON prohibits harassment or discrimination of any of its employees, officers, representatives, physicians, applicants, patients, volunteers, guests, or vendors on SETON premises, SETON-sponsored events or at other designated work areas regardless of the physical location.

Harassment is defined as any conduct including verbal, physical or visual in nature that is intimidating, hostile or offensive to others in the work environment. Harassment or discrimination of any kind will be grounds for disciplinary action up to and including immediate termination of employment.

Definitions of Harassment

Sexual Harassment: constitutes discrimination and is illegal under federal, state and local laws. For the purposes of this policy, sexual harassment is defined, as stated in the Equal Employment Opportunity Commission Guidelines, as unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment; (2) submission to, or rejection of, such conduct by an individual is used as the basis of employment decisions affecting such individual; or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance, or creating an intimidating, hostile or offensive work environment.

Sexual harassment may include a range of subtle and not so subtle behaviors and may involve individuals of the same or different gender. Some examples of sexual harassment include, but are not limited to: unwanted sexual advances or requests for sexual favors; sexual jokes and innuendo; verbal abuse of a sexual nature; comments about an individual's body; leering, catcalls, touching, pinching or brushing against another's body; insulting or obscene comments or gestures; sexually oriented pictures, calendars, screensavers, e-mails; and other physical, verbal or visual conduct of a sexual nature.

Other: Harassment on the basis of any other protected characteristic (i.e., race, gender, religion, national origin, age, disability, or any other characteristic protected by federal, state and local laws) is also strictly prohibited. Under this policy, harassment is verbal or physical conduct that denigrates or shows hostility or aversion toward an individual because of the protected characteristics stated above and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive work environment; (2) has the purpose or effect of unreasonably interfering with an individual's work performance; or (3) otherwise adversely affects an individual's employment opportunities.

Harassing conduct includes, but is not limited to: epithets, slurs, or negative stereotyping; threatening, intimidating or hostile acts, including physical threats or conduct; denigrating jokes and display or circulation in the workplace of written or graphic material that denigrates or shows hostility or aversion toward an individual or group (including via e-mail).

Retaliation is Prohibited: SETON will not retaliate against any individual who reports or files a bona fide discrimination or harassment complaint or participates in an investigation of such reports or complaints. Retaliation against an individual for reporting harassment or discrimination, for participating in an investigation of a claim of harassment or discrimination is a serious violation of this policy and, like harassment or discrimination itself, will be subject to disciplinary action up to and including termination of employment.

Reporting an Incident of Harassment, Discrimination or Retaliation: SETON strongly urges the reporting of all incidents of discrimination, harassment or retaliation, regardless of the offender's identity or position. Individuals should immediately report any type of harassment or retaliation to their immediate manager, Human Resources or a member of the leadership team.

Investigation and Responsive Action: SETON will promptly investigate all complaints with the greatest degree of confidentiality possible under the circumstances. At the completion of the investigation, SETON will inform the individuals involved of the conclusion of the investigation and take any necessary corrective action, which will include all forms of disciplinary action up to and including termination of employment. Refer to SETON HR Procedures 300.13 and 400.07 for additional information.

Supervision of Resident Physicians at SETON Healthcare Network

This policy is intended to guide the activities of attending physicians, residents, nursing staff, and medical records personnel in insuring that in-hospital patient care activities in which residents participate are appropriately supervised and documented during the course of their training based in the hospital. This supervision should begin with the resident's initial patient contact and continues through the daily care the resident provides to the patient.

EXCEPTIONS

1. It is the hospital and programs responsibility to ensure that residents level of training and educational needs are understood and are not secondary to the services needs of the hospital.
2. Residents may write patient care orders as delegated by the attending physician. No member of the medical staff can be prohibited writing orders on patients cared for in part by residents.
3. Medical Staff members who choose not to participate in residency training or who choose not to supervise residents are not subject to denial or limitation of hospital privileges.

REFERENCES

1. JCAHO Accreditation Manual
2. ACGME Institutional and Specific Program Requirements
3. SETON Medical Staff Bylaws

BACKGROUND

This is a general policy encompassing residents from multiple specialties training in SETON Healthcare Network facilities. It is recognized that each specialty has specific program requirements which guide the residency training and resident duties in those respective specialties. This policy statement will give general guidance to resident supervision in all network facilities. Ultimately all patient care activities are supervised by a credentialed attending physician. It is also recognized that residents will vary in level of training, ability, and previous experiences. It is the responsibility of each attending and program director to assess the abilities of each resident in training and provide the appropriate supervision for that level of training. In addition, residents and supervising attending physicians are guided by specific roles and responsibilities delineated for residents at certain levels of training. The care of the patient, and the risk to patients takes primary precedence over the decisions made by supervising attending physicians. Residents should never be expected to perform patient care activities for which they are not qualified. In addition, resident patient care activities are guided by specific rotational curriculum provided by the residency programs. All residents must act within the policies outlined in the Austin Medical Education Programs Policy.

PROCEDURE

Residents are expected to interact with patients in the SETON Healthcare Network with the permission, and under the director of attending physicians who delegate to residents medical care responsibility. Medical care begins with admission of the patient, continues through the daily progress of the hospitalization, and concludes with discharge of that patient from the hospital with completion of the permanent medical record on that patient.

Specific resident responsibilities are addressed in the Resident Job Description. Key, specific responsibilities of the supervising attending physician and of the resident are listed below:

- The attending physician shall evaluate the patient in person and be in a position to confirm the findings of the resident and discuss the care plan.
- The supervising attending physician confirms the subjective and objective findings of the resident, reviews the differential diagnosis, and discusses patient care management with the resident.
- For an obstetrical admission, after consulting the prenatal record available on the labor floor, and after examining the patient, the resident will contact the attending physician with obstetric privileges to describe findings and discuss the plan of care.
- At least on a daily basis (more often as the needs of the individual patients may dictate), the resident and the attending physician will review progress of the patient, make the necessary modification in the care plan, plan family conferences as needed, and agree on the type and scope of documentation for the medical record.

- When either a medical patient or an obstetrical patient develops a condition that the resident feels is potentially dangerous for that patient, the resident will contact the attending physician and report these developments.
- As the level of skill and knowledge increases for individual residents, attending physicians may delegate increasing levels of responsibility and allow increasing level of participation in patient care, including the performance of procedures.
- The attending physician should insure the completeness of the medical record by offering suggestions to the resident or by making additional comments in the progress notes.

POSITION SUMMARY OF RESIDENT PHYSICIANS

In general, a resident physician or fellow is a physician in training for a specific specialty or subspecialty who has completed medical school. Training occurs in AOA or ACGME accredited programs according to specific standards. Residents assume progressive clinical responsibility and autonomy under the supervision of licensed, privileged attending staff who function as faculty within the graduate medical education programs.

Major Responsibilities:

1. Residents assume clinical responsibilities according to their year of training as directed by each program. Responsibilities include:
 - Participating in providing safe, compassionate and ethical care.
 - Developing an understanding of how to provide cost-efficient care in an environment that seeks to minimize errors, while delivering evidence-based care.
 - Developing an understanding of the medicolegal and ethical principles of care.
 - Understanding the socio-economic aspects of medicine and the delivery of care within the various systems of care.
 - Understanding the role of the resident within the health care team.
 - Participating in the various committees and councils, if invited or elected, to assure effective communication, improve care, and monitor the care provided to the patients within the facility.
 - Participating in research programs and educational presentations, as required by the individual programs.
 - Adhering to the guidelines and regulations of the medical staff as well as the policies of the graduate medical education program.
2. Residents will assume progressive clinical responsibility as training progresses. Each program will assess the competency of the resident to assume these responsibilities.
3. The resident, in turn will evaluate the program's effectiveness in teaching and in providing the necessary supervision.
4. The resident will provide supervision to medical students and more junior resident staff. The resident will provide feedback and evaluation to these individuals.
5. The resident will maintain an accurate log of procedures performed in accordance with specific program requirements.
6. The resident will provide accurate and necessary documentation within the medical record of the care provided to patients.
7. Residents will write orders for patients under their care with the supervision of privileged attending staff.
8. Residents are responsible for the timely completion of medical records as per the policies of the Medical Staff, under the guidance and supervision of the attending staff.
9. Residents will understand the value of quality improvement and will participate in quality improvement activities.

Program Specific job descriptions are attached to this policy as follows:

Appendix 1	Family Practice
Appendix 2	Internal Medicine
Appendix 3	OB/GYN Fellows
Appendix 4	OB/GYN Residents – St. Joseph's
Appendix 5	Pediatrics
Appendix 6	Psychiatry
Appendix 7	Surgery
Appendix 8	Transitional

APPENDIX 1

Austin Medical Education Programs Family Practice Residency Program

TEACHING MEDICINE SERVICE

The overall purpose of the Family Practice Inpatient Service is to provide resident physicians with in-hospital clinical opportunities to develop the knowledge, skills, and attitudes necessary to care for persons with medical problems severe enough to require hospitalization. The rotation is structured to maximize the resident's ability to develop independent decision-making skills while still providing adequate supervision and role-modeling by attending family physicians.

Hospital Sites	Eligible Patient Admissions
St. David's Hospital (SDH)	Blackstock Family Health Center (BFHC) patients
	Unassigned Emergency Department patients
	David Powell Clinic patients
	Patients referred by private family physicians with hospital privileges
	MAP/City Clinic Card patients receive care from the AMEP Internal Medicine service
Children's Hospital of Austin (CHOA)	BFHC pediatric patients
	Unassigned Emergency Department patients on Mondays
	MAP/City Clinic Card patients receive care from the AMEP Pediatric Medicine service
Brackenridge Hospital	BFHC Continuity Obstetric patients
	MAP/City Clinic Card patients receive care from the AMEP Internal Medicine service

CALL RESPONSIBILITIES

The residents assigned to the Family Practice Inpatient Service are responsible for all the patients on this service for the 28-day term to which they are assigned. Call during this period will be shared amongst the first, second, and third year residents. The resident on call must be available and accessible at all times. Holiday call assignment is handled on a rotating basis among second year residents.

Residents on the Family Practice Inpatient Service have unique responsibilities in addition to the general responsibilities of residents as outlined by AMEP policy and procedures:

- hospitalized patients at St. David's Medical Center
- admissions from BFHC, David Powell Clinic (DPC) or the emergency room to St. David's
- admissions from private family physicians who choose to refer their patients requiring hospitalization to the AMEP FP Inpatient Service at St. David's
- admissions of BFHC patients from clinic or the emergency room to CHOA
- continuity obstetric patients less than 36 weeks gestational age who present to Labor and Delivery (L&D) at Brackenridge
- initial evaluation of obstetric patients at L&D when deemed appropriate for referral to BFHC and when family practice resident is not already on call for the OB department
- after-hours telephone triage for BFHC and Hospice patients

Duties and Responsibilities

Resident physicians on the AMEP FP Inpatient Service must follow the same general expectations as outlined by AMEP Policy and Procedures including the following specific responsibilities:

- Attendance of all conferences and scheduled didactics
- Initial and ongoing assessment of the medical, physical and psychosocial status of patients assigned to the resident
- Active participation during daily teaching rounds, writing progress notes, and discharge planning
- Dictation of initial history and physical, discharge summary, and death summary
- Call consulting physicians to obtain specialty consults
- Daily reading and literature review of medical conditions relevant to patients on the service
- Provide continuity between weekly resident team and attending covering the service by active participation during rounds, assist with weekend progress notes and discharges.
- Assist in codes, but may not run codes.
- Attend/assist in surgery of their patients with the consent of the surgeon and patient.
- Each resident will usually have one day off per week

Further details of the AMEP FP Inpatient Service, including the resident responsibilities by PGY level, can be found in the AMEP FP Residency Handbook and St. David's Medical Center Policies and Procedures.

PRECEPTORSHIP ROTATIONS

The Family Practice Residency curriculum involves a number of required and elective preceptorship rotations that, to varying degrees, require residents' participation in providing care in the hospital setting. It is beyond the scope of this job description to

delineate specific resident responsibilities for each of these rotations. A listing of the types of electives and a general overview of responsibilities is contained herein, with the entire curriculum available in the AMEP FP Residency Handbook.

In general, preceptorship rotations involve the traditional one-to-one relationship between a resident physician and community attending role model/teacher. The degree of time spent in the care of hospitalized patients varies depending on the specialty, with more teaching occurring in the hospital, surgical, and procedural-oriented specialties such as surgery, orthopedics, and cardiology.

As with other hospital patient care provided by residents, supervision is required by the privileged attending physician, in this case the rotation preceptor, in accordance with the guidelines of each hospital's medical staff policy. Responsibilities of the residents in the hospital are similar to those outlined elsewhere in the job description.

Available required and elective rotations include, but are not limited to:

Additional Emergency Medicine	Additional Obstetrics/Perinatology
Additional Surgery	Ambulatory Pediatrics
Cardiology	Dermatology
Emergency Medicine	Endocrinology
ENT	Family & Community Medicine
Gastroenterology	General Surgery
Geriatric Medicine	Gynecology
Intensive Care/Critical Care Medicine	Internal Medicine
Neonatology	Neurology
Obstetric Medicine	Occupational Medicine
Ophthalmology	Orthopedic Medicine
Pediatric Medicine	Psychiatry
Pulmonology	Radiology
Rheumatology	Rural Medicine
Sports Medicine	Urology

Appendix 2

Austin Medical Education Programs

Internal Medicine Resident Position Description

Program Specific Requirements:

Residents at the First Year of Training

Internal Medicine Residency Program responsibilities and competencies to be demonstrated in the first year of training:

1. Residents will perform accurate histories and physicals of hospitalized and ambulatory patients in various settings. Residents will compile data, identify problems, prioritize problems and develop a differential diagnosis. These tasks will be performed under the supervision of more senior residents and faculty attendings.
2. Residents will assess patients and perform focused histories and physicals on patients in the Emergency Department under the supervision of an Emergency Medicine Attending Staff while rotating in the Emergency Department.
3. Residents will write admitting orders and daily orders for care under the supervision of more senior residents and the attending faculty. Residents may write orders in the ED, on the various nursing units and within the ICU.
4. Residents will be "on-call" for the Emergency Department and will assess patients for admission under the supervision of the more senior resident and their attending physicians.
5. Residents will respond to pages or calls from nursing units about assigned or cross-cover patient problems. Residents will assess the problem and will seek advice from more senior residents or from attending staff, if the problem is beyond the experience and competency of the resident.
6. Residents will legibly document the care provided and the assessments of the treating team using the appropriate format or form. Resident documentation will be reviewed by attending staff and he or she will make the appropriate additions and or amendments to the medical record.
7. Residents will perform procedures under the supervision of either a procedure-credentialed resident, nurse, or attending. These procedures include:
 - Lumbar punctures
 - Paracentesis
 - Central Line placement by the subclavian, femoral, or internal jugular approach
 - Thoracentesis
 - Arthrocentesis
 - Bone marrow aspirates and biopsies
 - Arterial puncture and line placement
 - Venous puncture and line placement
 - Exercise Treadmill Testing
 - Pharmacologic stress testing
 - NG tube placement
 - Urinary bladder catheterization
 - Endotracheal intubation

In addition, residents may complete requirements for credentialing in conscious sedation as specified by network policy.

8. Residents will carry a "code" pager and will respond to all emergencies as designated by the page.
9. Resident will be or become BLS and ACLS certified.
10. Residents will verbally present cases to faculty attending physicians in accordance with the accepted format. Presentations will be used to facilitate the supervision of patient care and assess the knowledge and clinical skills of the resident.
11. Residents will communicate with and teach patients and families about the disease process or care problem.
12. Residents will negotiate with patients and families the plan of care as determined by the team and the supervising attending.

13. Resident will develop competency in the care of common medical conditions, understanding and initiating the appropriate diagnostic work-ups and management plans.
14. Residents will understand their gaps in knowledge and seek to acquire the knowledge necessary for the care of patients by consulting more experienced or subspecialty physicians and the medical literature.
15. Residents will seek to enhance their acquisition of knowledge by attending required teaching conferences.
16. Residents will supervise and teach medical students.
17. Residents will understand the role of consulting physicians
18. Residents will care for patients in the clinic setting, acquiring a continuity panel of patients. Residents will gain skill (under the supervision of the faculty attending) in the care of acute and chronic medical conditions. Residents will participate in health maintenance and the prevention of disease. Residents will participate in the post hospitalization care of patients.
19. Residents will participate in the care of subspecialty patients in the clinic setting. Subspecialty faculty will supervise the care provided and will determine the diagnostic and treatment plan of these patients. Residents will compile data, communicate with the patient and the family, and with the primary care provider.
20. Residents will gain experience in the care of critically ill patients in the ICU under the direct supervision of the critical care faculty and more senior residents.
21. Residents will gain competency in communication skills and the recognition and management of psychiatric disease during the Behavioral Medicine and Psychiatric Liaison Service rotation. Residents will facilitate the transfer of patients to the appropriate mental health facility when necessary.

Residents at the Second Year of Training

1. Residents at the second year of training will be competent to recognize, diagnose and treat, most common internal medicine problems. Residents will assess patients from the emergency department for possible admission to the hospital. Residents will recognize gaps of knowledge or inexperience with medical problems and will seek emergency consultation from the attending physician or the appropriate subspecialty physician to insure the proper and timely care of the patient.
2. Residents will supervise the first year resident and will model the appropriate clinical behaviors in performing the history and physical and in the gathering of laboratory data.
3. Residents will supervise the first year resident in the documentation of care and in the writing of admission and daily orders.
4. Residents will document the initial history and physical, assessment and plan in the expected format, modifying or amending the findings and data as presented by the first year resident as necessary. Resident history and physical will emphasize the important findings, summarizing and explaining the rationale for treatment.
5. Residents will insure that the patient has a daily progress note and that the rationale of care is communicated within the medical record.
6. Resident will insure that the appropriate discharge orders are written and that the discharge plan of care is understood by the first year resident. The supervising attending will supervise the plans for discharge during the daily rounds.
7. Resident, if not credentialed in the above list of procedures will seek to acquire competency in the performance of common internal medicine procedures by the supervision of a credentialed resident or attending physician.
8. If the resident is credentialed by the process set forth in the department and as stated in the program manual, the resident may perform indicated procedures independently.
9. Credentialed residents may supervise a non-credentialed resident in the performance of a procedure.
10. Residents will provide back-up coverage for the admission of patients out of the Emergency Department when the long call team has capped or the team is overwhelmed with patient care responsibilities.
11. Residents will rotate on subspecialty electives and provide subspecialty consultation to ward and ICU teams or hospitalist physicians in cardiology, infectious disease, pulmonary medicine, hematology-oncology, gastroenterology, rheumatology, endocrinology, nephrology, and neurology. Resident consultations will be supervised by the

subspecialty faculty. Residents will provide supporting literature to the consulting teams, if appropriate and will participate in subspecialty conferences.

12. Residents will gain progressive responsibility within the ICU setting and with the care of critically ill patients under the supervision of the critical care attendings. Residents will be competent in the care of common emergency conditions and will assess and treat the common medical emergencies appropriately. At all times, residents will have access to the supervising attending for consultation, supervision and direct care of patient urgencies and emergencies.
13. Residents will supervise the work and care of patients by first year transitional and medicine residents in the Clinic Rotation. Residents will organize the subspecialty clinic work flow and patient flow and will provide the necessary follow-up responses to data gathered by the physicians in the outpatient setting. The resident assigned to clinic will review all outpatient Internal Medicine laboratory data and will respond urgently to critical lab values. Residents will participate in Emergency Room follow-up and all specialty clinics assigned to Medicine. All patient care by subspecialty clinics will be supervised by the subspecialty faculty. Residents will facilitate the care of subspecialty patients with urgent or emergent problems requiring immediate attention.
14. Residents will gain progressive responsibility in the outpatient setting, acquiring a larger panel of continuity patients and managing their chronic and acute problems. Residents will be competent in the health maintenance of patients. Continuity attendings will supervise the care provided, reviewing documentation and care plans with the resident.

Residents at the Third Year of Training

1. Third year residents act as “night float”, independently admitting patients with the supervision of the hospitalist service and the long-call attending. Night Float supervises the first year resident assigned to ward call and the ICU first year resident.
2. Third year residents gain competency in the outpatient department during the ambulatory care block. Residents learn efficiency and focused care on patients with complex medical problems, geriatric problems, and primary care problems. Residents are supervised by clinic attending physicians and multiple specialty, subspecialty and surgical attending staff.
3. Third year residents continue to gain competency with the Internal Medicine procedures, supervising residents when credentialed in a procedure.
4. Third year residents require less direct supervision by attending staff in all departments. Residents at this level of training are able to determine the clinical questions to be addressed to attending staff and are able to direct the care of patients with most medical problems.
5. Residents at the third year of training have competency in assessing their gaps of knowledge and in consulting the medical literature or other sources to insure the acquisition of knowledge.
6. Residents at the third year of training will participate in hospital and departmental committees and councils when invited.

Residents at the third year of training will help evaluate and mentor:

Appendix 3

Austin Medical Education Programs Obstetric Fellowship

- 1) The overall purpose of the Obstetric Fellowship is to provide physicians who have completed a Family Practice program with in-hospital clinical opportunities to develop the knowledge, skills, and attitudes necessary to care for obstetric and gynecologic patients in a rural, unsupervised community. The rotation is structured to maximize the fellow's ability to develop independent decision-making skills while still providing adequate supervision and role-modeling by attending obstetrician/gynecologist.
- 2) Participation in teaching conferences and educational activities, especially those directed to the fellow level.
- 3) Participation in teaching of medical students assigned to clinics and to the Labor and Delivery area with the faculty and OB/Gyn resident staff.
- 4) Participation or performance of procedures, with direct faculty supervision, such as caesarian sections, operative vaginal deliveries, obstetric ultrasound, puerperal sterilization and colposcopy with biopsy. Fellows and attendings will be jointly responsible for ensuring appropriate explanation and acquisition of informed consent, as well as for detailed documentation.
- 5) Attendance at routine and high risk prenatal clinics, colposcopy clinics, gynecology clinics and ultrasound clinics as assigned by the administrative chief ob/gyn resident and/or faculty.
- 6) Responsibility for coordination of discharge management, after receiving approval of the attending physician includes:
 - a) Performing a pertinent discharge exam;
 - b) Arranging for discharge medications, follow-up visit, studies and plans, providing orders for home health services, coordinating with the hospital discharge planner;
 - c) Discussion of medications and treatments and follow-up precautions with the patient;
 - d) Arranging for family planning, as appropriate;
 - e) Discharge dictations are the responsibility of the fellow, unless otherwise arranged with the attending physician. These should be dictated at the time of discharge, or prior to if the summary needs to accompany the patient to another care setting such as a nursing home or another hospital. A brief discharge summary note should be written on the chart to provide information otherwise not available until the discharge summary has been transcribed. Contents of a brief note should include: discharge diagnoses, medications and treatments, and follow-up plans.
- 7) Other, specific on-call hospital responsibilities are as follows:
 - a) The management of patients in labor and delivery, including triage of patients and prioritization of patient care will be the responsibility of the fellow.
 - b) Overall management with deployment of appropriate housestaff in the labor and delivery area, with faculty supervision.
 - c) Supervision of lower level family practice housestaff, in conjunction with attending faculty, is the responsibility of the fellow while in the labor and delivery and postpartum areas.
 - d) Other: Residents on the ob/gyn service may be called when housestaff and fellows are having difficulties with individual patient management or volume of patients becomes too intense.

Appendix 4

Austin Medical Education Programs
CHRISTUS ST. JOSEPH OB/GYN RESIDENCY – Position Description
 Integrated Program

PROCEDURE	PGY4	PGY3	PGY2	PGY1
Normal ante/post partum care	1	1	2	2
Management of Labor	1	1	1	2
Administration of local anesthesia/pudendal block	1	1	1	1
Maternal/fetal monitoring	1	1	1	1
Induction/augmentation of labor	1	1	1	1
Manual removal of placenta	1	1	2	2
Post-partum uterine exploration	1	1	2	2
Episiotomy/repair	1	1	1	1
Post-partum D&C	4	4	4	4
All vaginal deliveries	4	4	4	4
Assist in gyn. Surgery	1	1	1	1
Amniotomy	1	1	1	1
Amniocentesis	4	4	4	4
All high-risk pregnancies	4	4	4	4
Major medical disease complications of pregnancy, except those in Category III	4	4	4	4
Operative deliveries	4	4	4	4
All Cesarean deliveries	4	4	4	4
All gynecological procedures, except those in Category III	4	4	4	4
Conscious Sedation	4	4	4	4
Intrauterine transfusions	A	A	A	A
Radical hysterectomy	4	4	4	4
Pelvic radiation therapy	A	A	A	A
Laser surgery	4	4	4	4
Amnioscopy	A	A	A	A
Radical vulvectomy	4	4	4	4
Microsurgery	4	4	4	4
Genetic amniocentesis	4	4	4	4
Operative laparoscopy (Pelviscopy)	4	4	4	4
Operative hysteroscopy and resectoscopy	4	4	4	4
LEEP (loop electrosurgical excision)	4	4	4	4
LAVH (laparoscopic assisted vaginal hysterectomy)	4	4	4	4
Diagnostic hysteroscopy	4	4	4	4
External versions	4	4	4	4

A = ASSIST;

4 = UNDER DIRECT SUPERVISION ONLY OF ATTENDING WHO IS PRESENT;

3 = DIRECT SUPERVISION OF PGY 3 OR 4, INDIRECT SUPERVISION OF ATTENDING

2 = DIRECT SUPERVISION OF PGY 2 OR HIGHER, INDIRECT SUPERVISION OF ATTENDING

1 = MAY PERFORM WITHOUT DIRECT SUPERVISION, BUT INDIRECT SUPERVISION OF ATTENDING

TYPE III Privileges

PROCEDURE	PGY4	PGY3	PGY2	PGY1
Repair of surgical defects of bowel or bladder	4	4	4	4
Ureteral repair (emergency requires urological consultation)	4	4	4	4
Vulvectomy – radical with groin dissection	4	4	4	4
Ureteral transplant	4	4	4	4
Radium insertion – cervix	A	A	A	A
Radium insertion – uterus (Heyman's)	A	A	A	A
Plastic construction of vagina with skin grafts	4	4	4	4
Radical hysterectomy	4	4	4	4
Colostomy (including closure)	4	4	4	4
Anterior exenteration	4	4	4	4
Posterior exenteration	4	4	4	4
Complete exenteration	4	4	4	4
Urinary diversion	4	4	4	4
Cystoscopy & Biopsy & insertion of ureteral catheter	4	4	4	4
Diagnostic Cystoscopy	4	4	4	4
Insertion of intraperitoneal access (IP port-a-cath, Tinchoff catheter)	4	4	4	4
Epidural/Saddle block anesthesia	A	A	A	A
Para aortic lymphadenectomy	4	4	4	4
Small and large bowel resection with reanastomosis	4	4	4	4
Pelvic lymphadenectomy	4	4	4	4
Insertion of permanent central venous access (port-a-cath, Hickman)	4	4	4	4
Pelvic exenteration	4	4	4	4
Liver biopsy	A	A	A	A

A = ASSIST;

4 = UNDER DIRECT SUPERVISION ONLY OF ATTENDING WHO IS PRESENT;

3 = DIRECT SUPERVISION OF PGY 3 OR 4, INDIRECT SUPERVISION OF ATTENDING

2 = DIRECT SUPERVISION OF PGY 2 OR HIGHER, INDIRECT SUPERVISION OF ATTENDING

1 = MAY PERFORM WITHOUT DIRECT SUPERVISION, BUT INDIRECT SUPERVISION OF ATTENDING

Appendix 5

Austin Medical Education Programs

Position Description: Pediatric Residents

Program Specific Requirements:

Junior Residents (PL-1, FP-1 and FP-2, and Transitional)

Responsibilities and competencies to be achieved in the first year of training:

1. Junior residents will perform accurate histories and physical examination of hospitalized and ambulatory patients in various settings. Residents will compile data, identify problems, prioritize problems, and develop differential diagnoses. These tasks will be performed under the supervision of pediatric faculty attendings. Senior residents may assist attendings supervise junior residents.
2. Junior residents will assess patients and perform focused histories and physicals on patients in the Emergency Department under the supervision of an Emergency Medicine Attending Staff while rotating in the Emergency Department.
3. Junior residents will write admitting orders and daily orders for care of hospitalized patients under the supervision of senior residents and the attending faculty. Residents may write orders in the ED, on the various nursing units, in the Specialty Care Center, and in the NICU and PICU.
4. Junior residents will respond to pages or calls from nursing units about assigned or cross-cover patient problems. Junior residents will assess the problem and will seek advice from senior residents or from attending staff, if the problem is beyond the experience and competency of the resident or if the junior resident has questions.
5. Junior residents will write at least daily progress notes on hospitalized patients. Resident progress notes will be reviewed by attending staff and (s)he will make appropriate additions and/or amendments to progress notes as indicated.

Senior Residents (PL-2 and PL-3)

1. Senior residents will document the initial history and physical, assessment and plan in the expected format, modifying or amending the findings and data as presented by the first year resident as necessary. Senior residents' assessment and plan will emphasize relevant findings and explain the rationale for treatment.
2. Senior residents will supervise the junior residents and will model the appropriate skills in performing the history and physical and in formulating an assessment and plan.
3. Senior residents will supervise junior residents in the documentation of care and in the writing of admission and daily orders.
4. Senior residents will assure that the patient has a daily progress note and that the rationale of care is documented in the medical record.
5. Senior residents will assure that appropriate discharge orders are written and that the discharge plan of care is understood by junior residents.
6. Residents will gain experience in the care of critically ill patients in the PICU and NICU under the direct supervision of the pediatric critical care and neonatology faculty.

All Pediatric Residents (PL-1, PL-2, and PL-3)

Skills and competencies to be acquired over the three years of pediatric training or responsibilities during all three years:

1. Residents will perform procedures and acquire procedural skills under the supervision of either a resident with demonstrated skills, nurse, or attending. These procedures include:
 - Basic and advanced life support
 - Endotracheal intubation
 - Placement of intraosseous and intravenous lines
 - Arterial puncture
 - Venipuncture
 - Umbilical artery and vein catheter placement
 - Lumbar puncture

- Bladder catheterization
- Thoracentesis
- Chest tube placement
- Gynecologic evaluation of prepubertal and postpubertal females
- Wound care and suturing of lacerations
- Subcutaneous, intradermal, and intramuscular injections
- Developmental screening test

2. All residents will carry a "code" pager and will respond to all emergencies as designated by the page.
3. All residents will be certified in PALS and NRP.
4. All residents will verbally present cases to faculty attending physicians in a format appropriate to the situation. Presentations will be used to facilitate the supervision of patient care and assess the knowledge and clinical skills of the resident.
5. All residents will communicate with and teach patients and families about the disease process, care problem, and plan of care.
6. All residents will develop competency in the care of common pediatric problems, with understanding of appropriate diagnostic work-ups and management plans.
7. Residents will understand their gaps in knowledge and seek to acquire the knowledge necessary for the care of patients by consulting more experienced or subspecialty physicians and the medical literature.
8. All residents will attend required teaching conferences.
9. All residents will supervise and teach medical students.
10. All residents will understand the role of consulting physicians
11. All residents will acquire a panel of continuity patients. Residents will gain skill (under the supervision of the attending physicians) in the care of acute and chronic medical conditions. Residents will participate in health maintenance and the prevention of disease.
12. All residents will participate in the care of subspecialty patients. Subspecialty faculty will supervise the care provided and will determine the diagnostic and treatment plan of these patients.
13. All residents will participate in hospital and departmental committees and councils when invited and/or appointed.

Austin Medical Education Programs

Psychiatry Resident Program – Position Description

GENERAL DESCRIPTION

The psychiatry residents spend 4 years and the child psychiatry residents spend 5 years acquiring the skills, knowledge, and attitudes required to become board eligible in psychiatry and child psychiatry. After meeting requirements for training in each year, the resident signs a contract for the following year until training is complete.

EDUCATION/TRAINING/EXPERIENCE

Each resident has graduated from a school of medicine and has a valid Texas license to practice medicine or an institutional permit issued by the Texas State Board of Medical Examiners.

KNOWLEDGE/SKILLS/ATTITUDES

Each rotation and class has required competencies written for resident acquisition of knowledge, skills, and attitudes. The resident is expected to read the rotation description before he/she starts the rotation. The core competencies are incorporated in the position evaluations.

PSYCHIATRY TRAINING

The following goals and skills are in accordance with those required by the Accreditation Council for Graduate Medical Education special requirements for psychiatry:

I. Specific Goals

A. Diagnostic Goals and Skills; sites where implemented

1. Complete initial evaluation of a patient for medical and surgical disorders, provide basic care for these illnesses, and appropriately request consultation for patient care. Communicate clearly and effectively. Brackenridge Hospital (BH); Shoal Creek Hospital (SCH), Austin State Hospital (ASH)
2. Diagnose, treat and appropriately refer neurologic disorders. BH; ASH
3. Demonstrate skill in understanding of medical disorders displaying symptoms likely to be regarded as psychiatric, as well as psychiatric disorders likely to be noted with apparent organic manifestations. All locations.
4. Perform a thorough psychiatric interview with sensitivity to the patient's background, and develop differential diagnosis and treatment plan based on the findings. All locations.
5. Appropriately request psychological testing, and incorporate results into discussions. All locations
6. Utilize research results in psychiatric practice. All locations.

B. Acquisition of Knowledge and Goals; sites where implemented

1. Use the current standard Diagnostic and Statistical Manual of Mental Disorders. All locations.
2. Describe the multiple influences on psychological and physical development throughout the life cycle. All locations.
3. Discuss the major theories and schools of thought in psychiatry, historically as well as the current concepts. SCH
4. Outline the role of ethics in the practice of psychiatry. All locations.
5. Describe the interrelationships of psychiatry and the law. Bastrop; SCH

C. Therapeutic Goals and Skills; sites where implemented

1. Perform thorough evaluations of patients, including the psychiatric interview with mental status exam, physical and neurological exams; record this capably; develop a differential diagnosis, provisional diagnosis, formulation, and a biopsychosocial treatment plan. All locations.
2. Utilize group and family therapy. ASH; UT Mental Health Service.
3. Utilize pharmacological and other somatic therapies (including ECT) and drug and alcohol detoxification and treatment with or without psychotherapy. Shoal Creek Hospital.
4. Assume leadership roles; for example, chair a multidisciplinary treatment team. Maintain professional demeanor and boundaries. SCH; ASH
5. Provide psychiatric consultation in a variety of medical, surgical and other settings. Utilize system-based information. ATCMHMR; BH.; Bastrop
6. Achieve specific therapy competencies in the following years:
PGY-2: brief psychotherapy and supportive psychotherapy
PGY-3: cognitive behavioral therapy
PGY-4: psychoanalytic psychotherapy and psychotherapy plus psychopharmacology

II. Clinical Experiences

A. PGY I

1. Family Practice or Internal Medicine: 2 month rotation on inpatient services at Brackenridge or St. David's Hospitals
2. Pediatrics: 2 month rotation on inpatient services at Brackenridge Children's Hospital
3. Neurology: 2 month rotation including inpatient consultation at ASH, outpatient clinic at Seton Brackenridge, and neuroradiology rounds at Seton Brackenridge Hospital.
4. Inpatient Adult Psychiatry: 6 month rotation at Shoal Creek Hospital

B. PGY II

1. Inpatient/Outpatient Geriatric Psychiatry: 3 month rotation at St. David's Hospital.
2. Consultation Liaison: 3 month rotation at Seton Brackenridge Hospital
3. Outpatient Adult Psychotherapy and Supervision: 3 hours per week for 12 months.
4. Inpatient Child and Adolescent Psychiatry: 3 months on the Child and Adolescent Psychiatric Service at ASH.
5. Inpatient/Outpatient Substance Abuse: 3 month rotation at Shoal Creek Hospital.

C. PGY III

1. Outpatient Psychiatry: 12 month ½-time rotation at the University of Texas Counseling and Mental Health Center (young adults), or
2. Veteran's Outpatient clinic: 12 month ½-time (veterans/their families),
3. Forensic Psychiatry: 12 hours per week for 3 months at Bastrop.
4. Cognitive Therapy: 12 hours per week for 3 months at Seton Shoal Creek Hospital.
5. Outpatient adult psychotherapy – 5 hours/week for 12 months.

D. PGY IV

1. Adult Outpatient Community Psychiatry: 12 month ½-time rotation at Austin-Travis County MHMR.
2. Outpatient Adult Psychotherapy and Supervision: 8 hours per week for 12 months.
3. Psychiatric Emergency Service: 4 months half-time at ATCMHMR. (For residents going into the child psychiatry training program, this may be taken in the PGY-2 in place of the child and adolescent psychiatry rotation.)
4. Elective: 12 hours per week for 10-12 months
 - Administration: at TDMHMR and/or ASH.
 - Austin-Travis County MHMR (a variety of experiences are available).
 - Center for the Deaf: inpatient services at ASH.
 - Trinity Treatment Center: inpatient adult developmental disability service at ASH.
 - Forensic Psychiatry: an extension of the PGY-3 rotation.
 - Neuroscience Institute: The University of Texas multidisciplinary study at graduate and postdoctoral levels in behavioral neuroscience, cellular and molecular neuroscience, neurobiology and neuropharmacology.
 - Community Services: outpatient psychiatry in small outlying communities.
 - Psychotherapy Service: intake evaluations and assessment of applicants for long-term psychotherapy.
 - Pediatric consultation liaison or pediatric neurology may be taken for one month.

III. Seminars

A copy of the seminar schedule for the year may be obtained from the departmental administrative assistant. The seminars include the history of major schools of theory in psychiatry, review of psychiatric disorders, growth and development, psychopharmacology, alcohol and substance abuse, interviewing techniques, psychodynamic psychiatry, brief psychotherapy, cognitive-behavioral therapy, supportive psychotherapy, family therapy, psychological testing, forensics, and research methods as well as other topics required by ACGME.

IV. Additional Experiences

- A. Miniboard oral exam annually after the PGY-1
- B. Psychiatry Resident In-Training Exam (P.R.I.T.E.) annually
- C. Review of all evaluations every six months or more frequently with the director or assistant director
- D. Journal Club monthly
- E. Resident retreat annually to evaluate the training program
- F. Core Lectures by AMEP Faculty and Invited Speakers

CHILD AND ADOLESCENT PSYCHIATRY TRAINING

Special requirements for Child and Adolescent Psychiatry by the Accreditation Council for Graduate Medical Education are met by the following:

I. Specific Goals

A. Diagnostic Goals; sites where implemented

1. Be able to diagnose the spectrum of disorders as listed in DSM-IV. All sites
2. Assess family/group function. ASH; Austin Child Guidance; Children's Shelter (CS); Children's Hospital (CH)
3. Diagnose genetic or acquired physical conditions contributing to psychiatric disorders. All sites.
4. Perform physical examinations and neurological examinations; follow up with indicated diagnostic procedures. CH; ASH

B. Therapeutic Goals; sites where implemented

1. Be able to establish and maintain effective therapeutic relationships for individuals and groups; complete required therapy experiences. All sites.
2. Acquire an integrated personal theory of therapy and be practiced in application of knowledge. ASH.
3. Be able to monitor patient-child psychiatrist relationship boundaries. All sites.
4. Understand how the patient's function in other areas impacts on therapy in progress; be able to develop an individualized treatment plan based on the diagnostic formulation. All sites.
5. Understand and be competent in using a variety of therapeutic modalities, including somatic therapies. ASH; ATCMHMR; CS; ACGC

C. Administrative Goals; sites where implemented

1. Understand and develop the skills necessary for leadership. ASH
2. Assist in in-service training. ASH; CH
3. Be able to establish and supervise a variety of therapeutic modalities. ASH
4. Maintain and audit documentation following accreditation guidelines. All sites.
5. Serve on hospital committees. ASH; SCH
6. Be familiar with legal issues and practiced in maintaining ethical standards. All sites

D. Teaching/Research Goals; sites where implemented

1. Supervise at least two trainees. ASH; CS; CH
2. Team teach one of the resident seminars. SCH
3. Carry out approved study/research project. Sites to be announced

E. Liaison Goals; sites where implemented

1. Serve as liaison for support groups. ASH; CS; CH
2. Provide consultation to community agencies/schools/court. ACGC; CS; CH
3. Give seminars on request to community groups. SCH
4. Become effective communicators with mental health professionals and physicians in other specialties sharing systems-based information. All sites

II. Clinical Experience - specific duties and experience noted in the Child Psychiatry Rotation Folder in Room 605.

A. First Year

1. Pediatric Neurology.
2. Austin State Hospital Child and Adolescent (Inpatient) Psychiatric Service.
3. Children's Hospital at Brackenridge - Consultation Liaison

B. Second Year

1. Austin Child Guidance Center - (Outpatient)
2. Austin Travis County Mental Health Mental Retardation Center - (Outpatient)
3. Children's Shelter - consultation at a residential facility for abused and neglected children.
4. Research
5. Elective time
 - Drug and Alcohol Treatment
 - Juvenile Justice System
 - Learning Abilities Center
 - Speech and Hearing Center
 - Administrative Psychiatry
 - Preschool Program
 - Developmental Disabilities Program

III. Seminars

The seminars cover literature, normal and abnormal growth and development, cultural variation, psychopathology, schools of theory and application of therapeutic modalities, pediatric psychopharmacology, neurology, developmental disabilities,

psychological testing, legal issues, research methodology, as well as other topics. A copy of the seminar schedule for the year may be obtained from the departmental secretary.

IV. Other Required Experiences

- Oral examination in child psychiatry annually
- PRITE and CPRITE annually
- On site supervised consultation
- Weekly meetings with supervisors and training faculty
- Individual evaluation and feedback
- Experiential Group every two weeks
- Journal Club and Grand Rounds or Emergency Medicine classes monthly
- Resident retreat attended by residents and fellows annually to evaluate classes, rotations, and supervisors; written evaluation given to the training director.

Appendix 7

Austin Medical Education Programs General Surgery Residency Position Description Integrated Program – Christus St. Joseph's, Houston, TX

As the surgical residency program is seen primarily as an educational endeavor, certain educational objectives have been set for residents at each level of training. A brief description follows:

CHIEF RESIDENT: (PL V)

1. Provide supervision of the junior resident in carrying out patient care responsibilities for the patient chosen by the chief resident for care (patients with complex surgical problems).
2. Communicates the details of patient progress or complications to attending surgeon in a timely way.
3. Understands with sophistication the patho(physio)logy of the patient's disease processes.
4. Perfects the elements of pre-operative preparation of the surgical patient, especially in consideration of existing co-morbid factors.
5. Understands, in depth, the principles of the operative procedure including pertinent anatomy and technical consideration and decision making process.
6. Develops, with the attending surgeon, a postoperative plan of care considering co-morbid factors, basic disease process, and conduct of the procedure.
7. Masters the interpersonal skills in dealing with patients, staff, fellow residents, and attendings.
8. Masters the surgical technique (under the supervision of attendings) specific to those patients with complex surgical problems.
9. Functions as consultant to junior and senior residents as needed.
10. Functions as educator of surgical house staff and medical students.
11. Functions as administrator of the junior and senior resident staff.
12. Supervises the junior resident (PL1) training at the Surgical Training Center

SENIOR RESIDENT :(PL III & IV)

1. Provide supervision of the junior resident in carrying out patient care responsibility to include:
 - a. Confirm and review pertinent history and physical findings with the junior resident.
 - b. Review subjective and objective evidence of patient progress or complications with the junior resident.
 - c. Review pertinent laboratory and imaging data with the junior resident.
 - d. Modify (as needed) patient care plan developed by the junior resident.
2. Communicate the details of patient progress or complications to the Chief Resident and to attending surgeon in a timely way.
3. Master the sophistication of the patho(physio)logy of the patients disease process.
4. Master the element of preoperative preparation of the surgical patient, especially in consideration of existing co-morbid factors.
5. Understand the principles of the operative procedure including pertinent anatomy and technical considerations as well as decision-making processes.
6. Develop, with attending surgeon, a postoperative plan of care considering co-morbid factors, basic disease process and conduct of operative procedure.
7. Supervise the junior resident in the day-to-day execution of the care plan.

8. Refine interpersonal skills in dealing with patients, staff, fellow residents, and attendings.
9. Learn surgical techniques (under supervision of attending surgeon) specific to the rotation.
10. Become conversant with the periodical and surgical literature.

JUNIOR RESIDENT : (PL I & II)

1. Perform comprehensive history and physical assessment and share information with senior resident/attending.
2. Use available information, in combination with the interpretation of basic laboratory and radiographic data to develop a plan for the preoperative preparation of the patient and discuss with the senior resident/attending.
3. Understand the basic patho(physio)logic disease process and its surgical implications.
4. Understand the decision-making process required of the surgeon and the principles on which the decisions are based.
5. Understand the basics of the surgical procedure performed, including tubes placed, drains placed, lines placed, etc.
6. Develop with the aid of senior resident and attending surgeon a postoperative plan of care and surveillance.
7. Provide for the day-to-day care of the patients on his or her service – write admission orders, organizes tasks, obtains data, etc.
8. Serve as instructor to senior medical students on elective rotation and supervises their assigned tasks along with the senior resident.
9. Develop interpersonal skills necessary for dealing with patients, nursing staff, fellow residents and attending staff.
10. Master the principles of basic surgical biology as they impact on the basic care of the surgical patient.
11. Accomplish the course objectives stated for each rotation.
12. Learn basic surgical skills – sterile technique, OR conduct, dressing changes, wound care, basic surgical procedures under supervision.
13. Complete the training course at Surgical Training Center.
14. Complete ATLS and ACLS programs.

ALL RESIDENTS

1. Spend at least two half –days per week in an ambulatory setting appropriate for the rotation. This experience will focus on providing pre and post-operative care to the patient.
2. Maintain and turn in your operative procedures. This can be done on through the ReSOLution diskette provided and cases either emailed or hand delivered to the office. This operative log must be keep current (within a week).
3. Maintain a list of your ICU experiences in a manner acceptable to the RRC and ABS.
4. Maintain a log of your invasive procedures that will lead to credentialing.
5. Attend all didactic and educational meetings conducted by the residency unless on vacation or have specific approval by either the Chief Resident or Program Director.
6. Complete evaluation forms on a timely basis

Appendix 8

Austin Medical Education Programs Transitional Resident Program

Objective: The objective of the Transitional Year is to provide a well-balanced program of graduate medical education in multiple clinical disciplines designed to facilitate the choice of and/or preparation for a specific specialty.

13 Block Rotations of 4 weeks each: Internal Medicine 16 (12 weeks wards, 4 weeks clinic), Pediatrics 8 (8 weeks wards), Surgery 8 weeks, ER 4 weeks, electives 16 (4 blocks). Electives offered include anesthesia, cardiology, dermatology, endocrinology, ophthalmology, PM&R, psychiatry, radiology and sports medicine.

Skills: During each required rotation, the Transitional resident develops the skills and knowledge to perform a medical history, complete a physical exam, identifies patient problems, outlines a diagnostic plan and implements therapy appropriate for the patient's condition.

Supervision: There is direct supervised patient care by the attending physician and senior residents. For each rotation the attending physician evaluates the resident's ability to obtain a medical history, complete a physical exam, identify patient problems, outline a diagnostic plan and implement therapy appropriate for the patient's condition. Transitional residents develop skills in the supervision of medical students.

Job Responsibilities:

Internal Medicine Wards. The team consists of the attending physician, a senior resident and one or two first-year residents. While on call the Transitional resident admits patients to the service by completing the initial work up and admission, presenting the patient to the senior resident on call, and then presenting the case to the attending physician. The Transitional resident is responsible for the daily care of the patients he/she admits up to and including discharge.

Internal Medicine Clinics. The Transitional resident attends clinic Monday-Friday, 8:30 AM-5:30 PM. Responsibilities include evaluating patients with a thorough, well-directed history and physical, interpreting cumulative lab data, presenting the patient to the attending, and formulating a treatment plan. Clinics include Allergy, Cardiology, Dermatology, General Medicine, GI, Neurology, Pulmonology, Renal, Rheumatology and Emergency Room follow up.

Pediatrics Wards. The team consists of one attending, a senior pediatric resident and one or two first year residents (Pediatrics, Family Practice, Transitional). On call the first year resident admits patients with a senior resident's supervision and assumes care until discharge.

Emergency Medicine. There is a total of 19 10-hour shifts. Responsibilities include initial assessment, formulation of a plan, and either provide treatment or refer the patient to specialty care services. Procedural experiences include suturing, incision and drainage, removal of foreign bodies and rust rings from the cornea, aspirating/injecting joints, doing digital blocs. Supervision is by the ER attending physicians.

Surgery. The team consists of a chief resident, two upper level surgery residents and two first-year residents (surgery and/or family practice, transitional). The first year resident is responsible for admitting patients from the Emergency Room, managing the patients after they are on the wards, and discharging all patients. They must attend Surgery Clinics held four times a week.

Electives. On elective, the resident is expected to report for duty with the same responsibility and attendance as that required of all the other rotations.