DEPARTMENT OF PEDIATRICS

RESIDENT MANUAL
2012-2013

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UNIVERSITY OF UTAH HEALTHCARE

MISSION
The University of Utah Health Sciences Center serves the people of Utah and beyond by continually improving individual and community health and quality of life. This is achieved through excellence in patient care, education, and research; each is vital to our mission and each makes the others stronger.

- We provide compassionate care without compromise.
- We educate scientists and health care professionals for the future.
- We engage in research to advance knowledge and well-being.

VISION
A patient-focused Health Sciences Center distinguished by collaboration, excellence, leadership, and respect.

VALUES
Compassion
Collaboration
Innovation
Responsibility
Diversity
Integrity
Quality
Trust

UNIVERSITY OF UTAH, DEPARTMENT OF PEDIATRICS

MISSION
Improving the lives of children through excellence in advocacy, education, research and clinical care.

VISION
Caring for children, caring for their future.

PRIMARY CHILDREN’S MEDICAL CENTER
“The Child First and Always”

MISSION
Attain the highest levels of excellence in the provision of healthcare for children in an atmosphere of love and concern.

VISION
Primary Children's vision is to provide the highest value for outstanding pediatric care, medical education, child advocacy, and research, in the United States.

VALUES
Mutual respect
Accountability
Trust
Excellence
GENERAL INFORMATION
AMERICAN BOARD OF PEDIATRICS CERTIFICATION - It is the responsibility of each resident to make sure their Board applications are complete and submitted on time. The department does not pay the application fee for this exam.

PEDIATRICS IN-TRAINING EXAM - The ITE is mandatory for all residents who are in training to meet the eligibility requirements for pediatric Board certification. Each pediatric, medicine-pediatric and triple board resident (PGY-1 to PGY-4) will be expected to take the pediatric in-training exam. PGY-5’s and Chief Residents may also take the exam if desired. The department pays the fees for this exam and it will be administered on July 11-17, 2012.

PALS/BLS/NRP CERTIFICATION - Initial certification and manuals are paid for by the Department. ALL pediatric, medicine-pediatric and triple board residents are expected to keep current certifications in Pediatric Advanced Life Support (PALS), Basic Life Support (BLS) and Neonatal Resuscitation (NRP). The residents are responsible for scheduling and attending renewal courses and paying all associated costs.

Medicine-Pediatric & Triple Board residents are also required to maintain current certification in ACLS.

PAGERS - You will be issued a pager from the Primary Children’s Medical Center Security office and will be expected to return it to the Residency office or PCMC Security on the last day of your training.

CELL PHONES - Cell phones are available during ward rotations. These are the property of Primary Children’s Medical Center and should not be used for personal calls.

CONTRACTS - Contracts for the next year will be distributed in March of the current year. Residents need to sign their contracts for the coming year by the end of April and submit them to the Program Coordinator.

EMPLOYEE ASSISTANCE PROGRAM - The EAP is a confidential service that offers assistance with a variety of personal concerns. Some of the areas in which the EAP can help include: depression, anxiety, grief, alcohol/drugs, stress, parenting, marital issues, workplace, management consultation, etc. Services are available to all benefit eligible employees and their immediate family members. You will have up to 3 visits at no cost. Call (801) 587-9319 for more information. http://uuhsc.utah.edu/eap/

RESIDENT APPLICANTS - Residents are encouraged to play an active role in the interviewing and recruitment of resident applicants. Sign-up sheets for resident/applicant dinners and applicant lunch tours will be posted in the resident lounge during recruitment months (November-February). All applicants interview with faculty and residents at Primary Children’s Hospital. Resident applicant files are available in the Program Coordinator’s office. Evaluation forms on all resident applicants with whom you have contact should be
completed and turned in to the Program Coordinators on the day of the interview. This is your opportunity for input into the selection of applicants who will become your colleagues.

**JOB BOARD/FUTURE PLANS** - We often receive advertisements for pediatricians and pediatric specialists. These are posted on a bulletin board outside of the resident lounge or sent to the residents via email.

**EDUCATIONAL FUNDS** - All residents are given an educational fund in the amount of $1,100 (beginning July 1, 2012) to be used over three years for meeting registrations, books, journals, software, and other educational materials. If a resident is not in the program for 3 years, the amount received will be divided as so: $300/$400/$400. Purchases other than educational text materials or software must have prior approval from the Program Director, in order to receive reimbursement. Original receipts must be submitted to the Program Coordinator.

**TEACHING** - Chief residents and supervising residents should set aside time twice weekly to meet with the students on the service to discuss didactic subjects. In addition, work rounds should also be used as teaching rounds for the students.

Each year at the Pediatric Awards Banquet, an award is presented to the resident(s) voted to be the best teacher(s) by the medical students.

**MEALS - UNIVERSITY HOSPITAL** - The University of Utah GME office will issue call money to you for University Hospital call. This will be added to your University of Utah ID card (like a debit card) on the first of each month. Meal cards are accepted at the University Hospital Cafeteria, The Point (HCI) and The Bistro (HCI). You will only receive money for overnight shifts/call.

**MEALS - PRIMARY CHILDREN’S** - Primary Children’s Medical Center will issue call money to you for Primary Children’s call. This will be added to your PCMC white card (like a debit card) on the first of each month. Meal cards are only accepted at the Primary Children’s Hospital Cafeteria and Park Station Café. You will receive $10-$14.00 for each overnight call night/shift.

**LIBRARY FACILITIES** - The Primary Children’s Medical Center Library is located on the 1st floor of the medical center, across from the cafeteria. You have full access to everything the library has to offer including: journals, internet access, copy services, etc.

The Eccles Health Science Library is adjacent to the hospital and school of medicine. Hours of operation are:

- 7:00am-11:00pm Monday-Thursday
- 9:00am-8:00pm Saturday
- 7:00am-8:00pm Friday
- 11:00am-11:00pm Sunday
CONFERENCES - Residents are required by the RRC to attend conferences during their training. These conferences include, but are not limited to: (Resident Morning Report, Intern Conference (if applicable), Morbidity and Mortality Conference, and Resident Noon Conference). Conference schedules and reminders are emailed and posted on E-Value.

*Morning Report*: Mondays, Wednesdays and Fridays (8:15-8:45-9am)
Morning report is an outstanding learning opportunity. General as well as subspecialty cases are discussed by the residents and faculty. Breakfast is provided.

*Intern Conference*: Fridays (11am-12pm)
Held during the first year of training, this lecture series provides basic skills as well as opportunities for group interaction.

*Morbidity and Mortality*: 3rd or 4th Monday of Each Month (12-1pm)
This conference involves subspecialty, pathology and radiology consultants. Cases are prepared, discussed and reviewed by the Chief Pediatric Residents with presentations by junior residents relating to the cases of the day. Lunch is provided.

*Noon Conference*: Everyday (12-1pm)
Topics in general pediatrics, subspecialty issues as well as pediatric surgical subspecialties are presented by faculty. Interesting case conferences presented by junior and senior residents, as well as journal club occur at this time. Lunch is provided.

Research in Progress: Tuesdays (September through May) (8-9am)
Research in Progress enables faculty, fellows, and residents to present ongoing clinical and basic science research projects. Breakfast is provided.

Grand Rounds: Thursdays (September through May) (8-9am)
Held in the PCMC auditorium, Pediatric Grand Rounds features a variety of local, national and international speakers. Breakfast is provided.

*Residents are required by the Program to attend at least 50% of these conferences during their training. Conference attendance will be monitored by the Program and will be discussed during your semi-annual and annual reviews with the Program Director. Residents are responsible for logging their conference attendance on E-Value.*
**RESIDENT RESEARCH** - Residents are encouraged to participate in research projects and attend meetings. Up to one week of educational leave may be taken with Program Director Approval. If abstracts are accepted at regional and national meetings, all expenses associated with presentations, will be paid by the Program and Division sponsoring the research. All travel expenses should be submitted to the Program Coordinator within 30 days of return travel date. Original receipts must be submitted. Meals are reimbursed at actual cost and not at the per diem rate.

Resident research associated with continuity clinic should be arranged through the Continuity Clinic Director and approved by the Program Director.

**ELECTIVE ROTATIONS** - Because the faculty supports a diverse educational experience and because we have been approved for an adequate number of resident positions, we are fortunate to be able to maintain electives for the 2nd and 3rd year residents. For this to happen, the department and the GME office must have sufficient advanced notice for proper arrangements. Residents are responsible for coordinating their elective months. A list of approved rotations is available in the residency office and on E-Value. All electives must be pre-approved by the program director and an elective rotation documentation form must be submitted to the Program Coordinator. Off-site electives must be pre-approved by the Program Director and the GME office (see Off-Site Training Agreement Form).

**IF YOUR ELECTIVE TAKES YOU OUT OF STATE, YOU WILL BE RESPONSIBLE FOR YOUR OWN PROFESSIONAL MALPRACTICE/LIABILITY INSURANCE.**
ELECTIVE ROTATION DOCUMENTATION
Pediatric Residency Program

NAME OF RESIDENT
__________________________________________________________

PROPOSED ROTATION
__________________________________________________________

START DATE OF ROTATION
____________________________

LENGTH OF ROTATION
2-week  4-week  other _________

PRECEPTOR
_______________________________________________
(Faculty responsible for supervising rotation)
Preceptor Email: ________________________________ Phone #:_________________

EDUCATIONAL GOALS AND OBJECTIVES

☐ The goals and objectives for this rotation are published on the CANVAS curriculum site.

☐ The educational goals and objectives for my elective experience are...

1. ____________________________________________________________________________________
   ____________________________________________________________________________________

2. ____________________________________________________________________________________
   ____________________________________________________________________________________

3. ____________________________________________________________________________________
   ____________________________________________________________________________________

4. ____________________________________________________________________________________
   ____________________________________________________________________________________

5. ____________________________________________________________________________________
   ____________________________________________________________________________________

_________________________________________  _____________________________
Signature, Houseofficer  (Date)  Signature, Preceptor  (Date)
OFF-SITE TRAINING AGREEMENT

This Off-Site Training Agreement is to be completed for all houseofficers doing rotations in any location that is not approved by the Accreditation Council for Graduate Medical Education for the houseofficer’s program, or for which there does not exist an alternative Residency Training Agreement. This form must be completed, in advance, for the houseofficer to receive liability coverage while on this rotation. **We regret that we cannot provide liability coverage for any out-of-state rotations.**

**NAME OF HOUSEOFFICER** ________________________________________________________________

**ROTATION** _______________________________ **UTAH MEDICAL LICENSE NO.** _____________________

**DATES OF OFF-SITE TRAINING** ____________________________________________________________

**NAME OF OFF-SITE FACILITY** ____________________________________________________________

**ADDRESS OF OFF-SITE FACILITY**

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

(______) (______) (______)

**PRECEPTOR**

(Faculty person responsible for supervising rotation and brief description preceptor responsibilities)

**EDUCATIONAL GOALS AND OBJECTIVES** (brief statement, or attach document to this agreement)

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

1. The off-site facility and preceptor have been granted approval by the University of Utah Graduate Medical Education Committee to train housestaff.

2. The preceptor must be a member of the University of Utah School of Medicine Clinical Faculty.
3. The preceptor has been given a description of his/her responsibilities during this rotation and agrees to provide supervision of houseofficer’s training. An evaluation of the houseofficer’s performance will be submitted by the preceptor upon completion of the off-site rotation.

4. The policies and procedures which govern the houseofficer’s off-site training can be found in the University of Utah and Affiliated Hospitals Housestaff Policy Manual, located at http://www.med.utah.edu/som/education/gme. Houseofficers are required to receive training in and to comply with the privacy provisions of HIPAA.

5. If the off-site training location is a “non-hospital” setting, the University of Utah Hospitals and Clinics may report the houseofficer’s time spent training at the off-site location on the University’s CMS cost report. If the off-site training location is a “hospital” setting, the training location may report the houseofficer’s time spent training on its CMS cost report.

6. University of Utah will pay all salary, benefits and other houseofficer compensation. As compensation for preceptor’s supervision of the houseofficer’s training, preceptor shall receive all benefits available to University of Utah School of Medicine volunteer clinical faculty. Preceptor’s eligibility to receive these benefits shall be contingent upon preceptor’s compliance with this agreement and all requirements and policies applicable to his/her faculty appointment.

Any changes in the above will invalidate the approval below. Dated ________________, 200__.

Signature, UUMC Program Director

Signature, Houseofficer

Signature, Director of GME

Signature, Preceptor/ Facility Representative

Copies to: Houseofficer’s File, Houseofficer, Preceptor, Program Director

Revised by Graduate Medical Education Office January 2005
Reviewed January 2007
**ROTATION SCHEDULE** - Rotations schedules are maintained through the Pediatric Chief Residents. Any schedule changes must be cleared in advance. The most current rotation schedules can be accessed online at: [www.amion.com](http://www.amion.com); Login: uupeds

**ONLINE CURRICULUM**

The curriculum for each rotation can be accessed online: (Canvas): [https://learn-uu.uen.org/](https://learn-uu.uen.org/) Here you will find the most updated detailed descriptions of all of the rotations, the rotation contact(s) and schedule (if available).

**CALL DESCRIPTIONS**

**Jeopardy Sick:** This is our back-up call. During this month, you wear your pager and come in for any of your colleagues who are sick or have unexpected emergencies. You can take vacation on this month, but somebody else must cover your call. JS is associated with the Neurology rotation.

**Jeopardy Vacation:** This person is used to cover call when colleagues assigned to CP, JS, cross-cover WBN, or cross-cover ward call are on vacation. JV is associated with the Clinic 6 rotation.

**HOLIDAY SCHEDULE** - There is a holiday schedule. You will either have Thanksgiving, Christmas or New Year’s off. The holiday is determined by the track and is indicated on the online rotation schedule.

**VACATION SCHEDULE** - You have three weeks (or 21 days of vacation, not including the holiday schedule.) All PGY-1’s are given the last week of Block 13 as one of the vacation weeks. Vacation requests or changes should be coordinated directly with the Chief Residents.

**ED SCHEDULE** - The ED schedule is prepared by the Emergency Medicine Coordinator. You will work a defined number of shifts and have protected time for continuity clinic. Requests for schedule changes should be directed to the Emergency Department.
CONTINUITY CLINIC
CONTINUITY CLINIC

DOCUMENTATION - Residents must document the clinical experiences throughout their residency training. Continuity clinic cases and procedures should be entered on the ACGME website: [www.acgme.org](http://www.acgme.org). Besides being required for the residency program, these data will be helpful for your subsequent hospital privilege credentialing.

Continuity Clinic General Expectations

The following is a list of general expectations for continuity clinic. They are based on RRC and ACGME requirements and are tailored to the University of Utah Pediatric Residency program. The overall goal of the continuity clinic program is to provide you with a longitudinal educational experience in child health.

1. **You are scheduled for continuity clinic 2 times a week.** Sometimes it will not be possible for you to make both because of post-call days. But, you are expected to attend at least one continuity clinic a week; this responsibility supersedes other clinical responsibilities. You may only miss a week if you are on vacation or an away elective. If you are a categorical pediatric resident, each year you are expected to attend a minimum of 36 clinic days. If you choose to do research, advocacy or a specialty clinic in your second or third year, you are expected to attend 36 clinic days. These minimums vary for Triple Board and Med/Peds.

2. **Scheduling** of continuity clinics is often challenging and we thank you and our schedulers in advance for helping in this process. A few basic guidelines for scheduling:
   a. You must be in continuity once per week (unless you are on an away rotation, on vacation, or in the PICU)
   b. You may **not** be in continuity clinic on a post-call afternoon.
   c. If you are on the wards, NICU, PICU, GI, or WBN you may not have any clinic on a post-call day, morning or afternoon.
   d. While doing non-ward, WBN and ICU rotations, you may be expected to be in continuity clinic in the mornings. RRC guidelines state that you may conduct am continuity clinics post-call.
   e. While on night float, you will not have clinic for two weeks. You will have clinics during the other two weeks of the rotation.
   f. At the South Main Clinic, Teen Mom Clinic, and Clinic 6, your schedule may be altered to accommodate your peers who are on wards, WBN, GI, PICU or NICU rotations.
   g. Schedules will be made at least 2-3 months in advance, so that your patients can schedule with you. If you have any changes due to call responsibilities, trades or vacations, you must notify the clinic scheduler, chief residents and your preceptor 4 weeks in advance. If it is less than 3 weeks before your clinic and you have patients scheduled, you will be responsible for finding a replacement for yourself or for calling your patients and asking them to reschedule.
   h. Online schedules are located on the Pediatric Department Intranet and on E-Value.

3. **You are expected to be on time** to your continuity clinic, so that your patients are not waiting for you. You are also encouraged to **be sure that all patients will be**
taken care of before you leave and to take advantage of down time (gaps in your schedule, patient no-shows, etc.) for your education or for improving the clinic quality and/or environment. This means that you could help other residents who are behind and would like help, see acute visits, review didactic material with your preceptor, read or do a literature search about a recent patient’s problem, organize clinic files or patient education materials, participate in a clinic quality improvement project, etc.

You should always check with the other doctors, nurses and the front desk before you leave to make sure there is nothing pending for you (late-scheduled patients, incomplete charts or billing forms, phone calls, etc.):

a. Morning clinics typically have patients scheduled between 9 am and 11:30-11:45 am.
b. Noon conference is from 12:00-1:00, so, afternoon clinics begin at 1:20-1:30 pm and end around 5 pm.
c. If you are on call and your patients have all been seen, you may leave early after checking with your preceptor, the nurse, and the front desk.

4. **Number of patients** to be seen: You are expected to see all patients that are scheduled for your clinics, whether or not they are your continuity patient. But, there is a minimum requirement of 4 patients seen in a half day for interns, 5 patients seen for R2s and 6 patients seen for R3s.

5. **Logging your patients:** Patients MUST be logged into the ACGME system. It is easiest to do it the same day as your clinic to keep on top of it. If you haven’t logged it, it hasn’t happened and you will be asked to make up clinic days if they are not recorded. You will need to enter the date of the clinic, the age of the patient and the ICD-9 code for the visit. [https://www.acgme.org/residentdatacollection/](https://www.acgme.org/residentdatacollection/)

6. **Increasing continuity of care and the medical complexity of your patients:** One of the most important parts of your clinic experience is that you see patients grow and develop over a three year time period. The RRC states that “ideally residents should participate in the care of their patients through any hospitalization, assess them during acute illnesses and be available to facilitate other services, such as school-related evaluations and specialty referrals.” You may want to enhance your accessibility to families by making sure they know how to contact you in a given situation and discussing how your schedule in clinic works. A goal of the University of Utah residency program is for each resident to take care of an increasing number of medically complex children over his/her 3 years.

7. The **continuity clinic curriculum** emphasizes “the generalist approach to common office-based pediatric issues, including anticipatory guidance from birth through young adulthood, developmental and behavioral issues, and immunization practices and health promotion, as well as the care of children with chronic conditions. You will learn to serve as the coordinator of comprehensive primary care for children with complex and multiple health-related problems and to function as part of a health care team”:

   a. **Structured learning objectives** for continuity clinic address the curricular issues.
   b. A **weekly topic or case** for all residents will allow a uniform didactic curriculum, despite the variety of clinical sites. These topic synopses will be
emailed to all residents and preceptors weekly, so that you may discuss them in clinic.

8. **Evaluation:** You will be evaluated by your preceptor(s) every 3 months during your intern year and every six months thereafter. The evaluations will be competency based.

9. In your second or third year, you may opt to take a different path for your second continuity clinic day. There are 4 options:

   a. Continuity Clinic  
   b. Mentored Research  
   c. Mentored Advocacy Experience  
   d. Mentored Specialty Continuity Clinic

If you elect b-d, you will be expected to complete an application for such experience, choose a mentor, and have your application accepted by a committee. On weeks when only one half-day is available, you must use it to attend your continuity clinic as opposed to your alternative activity.

While these are general expectations, there will always be exceptions and changes. If you have any questions or concerns about continuity clinic, please feel free to contact me.

Wendy Hobson-Rohrer, MD, MSPH  
Pager: (801) 339-6928  
Office: (801) 585-6585 or (801) 662-5711
POLICIES
&
LICENSES
INFORMATION
I. PURPOSE
To outline the content and procedure for timely completion of incomplete medical records by housestaff.

II. POLICY
All medical records shall be completed by the housestaff within seven (7) days of patient discharge. A complete record is defined as including a history and physical exam within 24 hours of admission, sufficient progress notes and/or diagnostic tests to justify treatments and length of stay; applicable informed consent(s); a dictated/signed report of operation and/or a written preoperative, operative, and postoperative note immediately prior to or following surgery; a dictated/signed discharge summary, and orders to justify treatments and length of stay. Medical records will be considered delinquent if they have one or more of the following deficiencies not completed within 21 days post discharge.

III. INPATIENT MEDICAL RECORD REQUIREMENTS:
A. Admit History and Physical Exam
   1. Must document the provisional or admitting diagnosis, chief complaint, present illness, planned treatment and impression.
   2. Complete history (include past history, family history, social history, review of systems) must be completed within 24 hours of admission.
   3. Complete physical examination (includes temperature, pulse, respiration, blood pressure, general appearance of patient, and a detailed description of the negative or positive findings of the examination) must be written within 24 hours of admission. The physical examination should be pertinent to the scope of the service provided.
B. Tentative clinical diagnosis; recommendations for additional studies and/or treatments; and consultation notes (if applicable)
C. Complete meaningful progress notes, the frequency of which is determined by the condition of the patient
D. Treatment procedures; medical and surgical
E. Appropriate informed consents
F. Laboratory reports, x-rays (and all diagnostic reports and appropriate flow sheets)
G. Nurses notes
H. Doctors’ orders with each order dated and signed.
   1. Admit Order, specifying attending physician, location, and patient status.
   2. Verbal Orders must be signed as soon as possible after issuance, not to exceed 30 days.
3. Recertification order signed and dated on or before 60\textsuperscript{th} day of admission.
4. Final discharge order completed and signed on prior to discharge of patient.
The discharge order must include:
   a. Date of discharge
   b. Principal diagnosis
   c. Secondary diagnosis
   d. All operations, treatment and procedures
   e. Discharge medications
   f. Adverse drug reactions or other complications
   g. Specific follow-up plans and discharge education and/or instructions
   h. Complete signature of discharging physician

I. Operative Reports
   1. An OP note must be written in the progress notes by the intern or resident on the day of operation. Post-operative notes must be written immediately after surgery. The operative procedures must be dictated immediately following the surgery.
   2. Housestaff who fail to dictate OP reports within 2 working days of the procedure will receive notice that they have 48 hours to dictate the OP report or it will be assigned to the attending physician for dictation. The attending physician will be recommended for suspension if the OP report is not dictated within 48 hours of re-assignment.

J. A discharge summary should be dictated by the house officer designated by each service within 24 hours post discharge. Discharge summaries will be dictated on all admissions with the following exceptions:
   1. Admissions less than 48 hours
   2. Normal newborn
   3. Normal deliveries

K. In case of death, a hand-written death note must be written in the progress notes, and a death summary dictated within 24 hours.
   1. The handwritten death note should include:
      a. Terminal circumstances
      b. Findings/conclusions
      c. Final diagnosis
      d. Time and date of death
      e. Name of person who pronounced the patient
      f. Consent for autopsy (if appropriate)

IV. INCENTIVE/PENALTY PROCEDURE
A. Incentive Procedure
   1. Housestaff who dictate discharge summary(ies) within 24 hours of patient discharge will receive $5.00 per report.
   2. Housestaff who dictate inpatient operative report(s) within 24 hours of surgery will receive $5.00 per report. (Ambulatory surgery does not qualify for incentive program.)
   3. The $5.00 credits will be accumulated and will be issued by the Health Information Department as scheduled.
B. Penalty Procedure:
Housestaff who fail to dictate discharge and/or operative report(s) within seven (7) days post discharge or seven (7) days post operative day will be subject to a penalty.

1. Fines per non-dictated discharge summary may be assessed at $10.00 per chart for each seven (7) day period post discharge. (First seven (7) days are business days; days thereafter are calendar days.)

2. Fines per non-dictated operative reports may be assessed at $10.00 per chart at 48 hours or 2 business days from date of surgery. (First seven (7) days are business days; days thereafter are calendar days.)

3. Fines will be subtracted first from any accrued credits.

4. Fines not covered by credits may be deducted from housestaff paychecks.

5. Fines will be limited to $100 or less per pay period.

6. Housestaff will leave an accrual of $100 in credits in their account in order to avoid actual fines.

C. Suspension day(s) may be assessed for each week a discharge summary and/or operative report exceeds seven (7) days post discharge or post operative day.

1. Suspension day(s) will be tracked and added to the required time at the end of the program.

2. Suspension day(s) will only be assessed in lieu of fines at the discretion of the Program Director.

3. Suspension day(s) will be assessed at one (1) day per week when the non-dictated discharge and/or operative report exceeds the 7th post discharge or postoperative day.

D. Fines or suspension days will not be assessed if deficiency(ies) are due to circumstances beyond the physician’s control (i.e., lost record, illness, or vacations). It is the obligation of the houseoffice to notify the Health Information Department when circumstances merit this consideration.

E. Notification of delinquencies will be sent the housestaff and/or attending staff weekly. Fines or suspension days will not be assessed without housestaff receiving prior personal notification.

F. All signature deficiencies will be classified as minor deficiencies and sent to attending physician for signature if not completed within 14 days by housestaff. (See completion policy for definition of major and minor deficiencies.)

V. ALL ENTRIES IN THE MEDICAL RECORD MUST BE DATED AND SIGNED.

Reviewed: January 2012
PRIMARY CHILDREN’S MEDICAL CENTER (MEDICAL RECORDS POLICY)

Each houseofficer is expected to complete all discharge dictations on patients they have discharged. Also, each houseofficer is required to dictate or write and off-service note on any patients remaining in the hospital. **Please note:** These must be completed before the conclusion of each rotation.

Each houseofficer is responsible for contacting Medical Records about delinquent charts and making arrangements to complete them:

**Lois Smith**  
Medical Records Office  
Primary Children’s Medical Center  
(801) 662-3821 or (801) 662-3841

**Medical Records Documentation:**

**Policy Statement**

A. The medical record contains sufficient information, recorded in both electronic and paper format, to identify the patient; support the diagnosis; justify the treatment; document the patient’s hospital course; and facilitate continuity of care among health care providers. The record is accessible to authorized persons, authenticated, confidential, secure, current, and complete.

B. The medical record includes: identification data; a medical history; findings from relevant physical examinations/assessments; diagnostic and therapeutic orders; evidence of appropriate informed consent; clinical observations, conclusions during the course of, and the termination of hospitalization.

**Scope**

All persons authorized by licensure, scope of practice, granted privileges and/or PCMC job description to document in and/or access patient’s medical records.

**Definitions**

A. Authentications: The process of identifying the author of entry.

B. Physician or Dentist: An individual with and M.D., D.O., or D.D.S. degree who is currently licensed to practice medicine in Utah.

C. Licensed Independent Practitioner (LIP): A health professional (such as MD, NP, PA, etc.) whose license allows treatment and prescribing practices within the scope of their license, privileges, and established protocols.

D. Medical Staff: The formal organization of all licensed physicians And dentists who are granted authority by the Governing Board to provide patient care at PCMC.

E. HouseOfficer/Housestaff/Resident: An individual who participates in an approved graduate medical education (GME) program or a physician who is not an approved GME program, but is authorized to practice only in a hospital setting.
Provisions

IMPORTANT NOTICE: Failure to comply with specified charting requirements outlined below may result in disciplinary action against the physician (see Description of Procedural Steps below):

A. Authorization of Entries: Those authorized to make entries in the medical record are members of the medical staff; members of the housestaff; medical students; students of all disciplines; and, within the scope of their practice, and all other health care providers who are consulting or involved in the patient’s care. Additional authorized individuals include; social services representatives, case managers/utilization review representatives or insurance companies, and home care, skilled care, clergy, and inpatient psychiatry patients along with their parents.

B. Authentication:
   1. Authors may authenticate entries in the medical record by one or more of the following:
      a. A signature which, at least, includes first initial, last name, and discipline. Certain forms provide a designated space for initials and signature so that initials may be used for entries elsewhere on the form. See individual form guidelines for specific instructions.
      b. A computer identification process unique to the author.
      c. A system by which the author reviews, acknowledges and authenticates with a single signature all unsigned entries in the record. The list of entries covered by that single signature is permanently retained in the medical record.

C. Legibility:
   1. All entries in the medical record must be legible and written in black/blue ink or typed.
   2. A physician whose handwriting is judged to be consistently illegible by the Medical Records Clinical Pertinence Committee may be required to dictate all entries.

D. Abbreviations and Symbols: Symbols and abbreviations may be used in the medical records as defined in Medical Abbreviations: “14,000 Conveniences at the Expense of Communications and Safety” by Neil M. Davis, with the following exceptions listed in the Prohibited Abbreviation and Entries list below:
### Prohibited Abbreviations and Entries

<table>
<thead>
<tr>
<th><strong>DO NOT USE</strong></th>
<th><strong>Acceptable Usage</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCT, HCTZ</td>
<td>Write out “hydrocortisone” or “hydrochlorothiazide”</td>
</tr>
<tr>
<td>HS (for half-strength)</td>
<td>Write out the desired concentration (using HS to mean “at bedtime” is acceptable)</td>
</tr>
<tr>
<td>IU</td>
<td>Write “mcg” or “micrograms”</td>
</tr>
<tr>
<td>MS, MSO₄, MgSO₄</td>
<td>Write out “morphine sulfate” or “magnesium sulfate”</td>
</tr>
<tr>
<td>µg</td>
<td>Write “daily” or Q24H</td>
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<tr>
<td>Q.D.</td>
<td>Write “every other day” of Q48H</td>
</tr>
<tr>
<td>Q.O.D.</td>
<td>Write “three times weekly”</td>
</tr>
<tr>
<td>T.I.W.</td>
<td>Write out &quot;unit&quot;</td>
</tr>
<tr>
<td>Trailing zero (e.g. 5.0 mg)</td>
<td>Never write a zero after a decimal point (write 5 mg)</td>
</tr>
<tr>
<td>Omitted leading zero (e.g. .1 mg)</td>
<td>Always use a zero before a decimal point (Write 0.1 mg)</td>
</tr>
<tr>
<td>Slashes (e.g. / or )</td>
<td>Never use slashes in any orders involving quantities (Write “per”)</td>
</tr>
</tbody>
</table>

On the Interdisciplinary Discharge Summary form, diagnosis, procedures and complications are not abbreviated (see PCMC Form Guideline).

**E. Corrections:**
1. Corrections in the medical record are indicated by drawing a single line through the entry, writing “error” above the entry, dating and initialing.
2. Obliterating an entry with ink or white-out is unacceptable.

**F. Late Entries:** Late entries may be made in the medical record, but must be written as an “addendum” and reflect the date and time entry is being made.

**G. Confidentiality and Security:**
1. All medical records are property of PCMC, and are not to be taken from PCMC’s control except by a court order or subpoena.
2. Unauthorized removal of charts from PCMC will result in disciplinary action determined by PCMC Administration and/or the Medical Executive Committee (see PCMC Policy: Medical Records Control).
3. It is the responsibility of all members of the medical staff and PCMC personnel to assure the security and safeguarding of the record and its informational content. (see PCMC Medical Records Control Policy and IHC’s Confidentiality Policy.)
4. It is the ethical and legal obligation of all members of the medical staff and hospital personnel having access to patient record information; protect the privacy of patients; and to comply with IHC’s confidentiality policy.
5. Medical Records are current and complete as per Patient Administration procedures.

**H. Retiring of Incomplete Medical Records:** Medical staff members are not permitted to complete the medical record on a patient unfamiliar to him/her in order to retire a record that was the responsibility of another staff member who is deceased or, for other reasons, permanently unavailable. Exceptions may be granted only by the Clinical Pertinence Committee.
I. Concurrent Assembly: Documentation contained in the medical record will be completed and assembled for each patient concurrently throughout the hospitalization.

J. Integration: The outpatient medical record shall be integrated with the patient’s hospital record or record indemnification system by utilization of a unit medical record number.

K. Medical Record Content Requirements:
   1. History and Physical (H&P)
      a. A comprehensive H&P includes a chief complaint, history of present illness, past medical history, medications, medication allergies and drug reactions, social history, family history, review of systems, vital signs, physical examination, pertinent laboratory and radiographic studies, assessment, and plan.
      b. The H&P is completed within 24 hours of admission and prior to surgery. NOTE: For cases that require emergency surgery, and admission note including significant findings and diagnosis may be written prior to surgery, with a full H & P being completed within 24 hours.
      c. The Pediatric Pre Procedure Teaching/Instruction/History & Physical Exam form may be used for patients admitted to and discharged from Same Day Surgery.
      d. H&P’s may be performed and authenticated by an attending physician, housestaff member, nurse practitioner, physician assistant or by a medical student. However, H & P’s written or dictated by medical students require co-signature by an attending physician or a member of the housestaff.
      e. For patients who are readmitted within thirty days of a previous admission to PCMC for the same or related problem, and interval H&P reflecting and subsequent changes may be used provided the original information is in the medical record:
         1) An authenticated H&P examination obtained within one week of admission to PCMC may be used providing changes, if any, have been noted at the time of admission.
         2) An H&P is completed by a physician or nurse practitioner for any patient being treated by a dentist.

2. Operative/Procedure Reports
   a. The operative report is dictated or written immediately after surgery describing the findings; technical procedures used; the specimen(s) removed, post-operative diagnosis; and the name of the surgeon and any assistants. The report is authenticated within 30 days of discharge.
   b. Because a significant time delay exists between the immediate dictation of the operative report and its placement in the medical record, a postoperative condition of the patient. However, the complete operative report is dictated or written, thereafter, on the same day of surgery.
   c. A pre-operative diagnosis is recorded before surgery by a licensed practitioner responsible for the patient.
   d. The completed operative report is authenticated by the surgeon.
   e. When an organ or tissue is obtained from a living donor for transplantation, separate medical records are maintained for the donor.
and the recipient. The requirements are the same as any other surgical inpatient record.

3. Discharge Summary: A summary by the responsible practitioner is dictated for all patients hospitalized for longer than 48 hours. The summary includes a restatement of: the reason for hospitalization; the procedures performed; the treatment rendered; and the condition of the patient at time of discharge:
   a. Discharge summaries are dictated before patient discharge for all patients with a hospital stay over 48 hours. The summary is authenticated within 30 days after discharge by the practitioner who dictated it.
   b. Death Summary: A dictated death summary is required for all deaths, regardless of the length of stay. The summary includes the requirements defined in the discharge summary as well as the time of death; the events leading to death; that appropriate consent for autopsy was obtained; and whether the case is within the jurisdiction of the state medical examiner. Note: A death note on the Emergency Department record is sufficient for DOA’s.
   c. Anatomic Diagnosis: When an autopsy is performed, the provisional anatomic diagnosis is completed within two working days of the autopsy. The final autopsy report is completed within 60 days.
   d. Interdisciplinary Discharge Summary: This document acts as the discharge order and is completed by the interdisciplinary health care providers involved in the patient’s care preparatory to discharging the patient. At the time of discharge the attending physician, houseofficer, nurse practitioner, or physician assistant writes the principle and secondary (if appropriate) diagnosis; complications; operation/procedures; and the patient’s condition at time of discharge. Additionally, the summary included: written discharge instructions, prescribed medications, treatment, and therapies, as appropriate, will also be noted. A copy will be given to the patient/family at the time of discharge.
   e. This summary is dated, timed and authenticated by an attending physician or by a member of the housestaff involved in the care of the patient.
   f. This summary serves as the discharge summary for patients whose hospitalization is less than 48 hours.
   g. Diagnosis, procedures and complications are recorded in full without abbreviations and symbols.

4. Progress and Procedure Notes: Progress notes are recorded as needed to provide a documented chronological report of the patient’s hospital course; support the diagnosis; and to reflect any change in condition and the results of treatment:
   a. Results of invasive procedures are specifically noted.
   b. Progress and procedure notes are authenticated by the author of note.
   c. In the event of a death, a death note is made documenting the date and time of death, terminal circumstances, who pronounced the patient dead, and consent for autopsy (if appropriate).
   d. Inpatients requiring a procedure to be done in Medical Imaging; the medical record must accompany the patient to Medical Imaging and the radiologist is required to write a progress note to include,
procedure performed findings, complications and medications if any administered.

5. Medical Orders:
   a. Medical orders may be written by physicians, housestaff, dentists and within the scope of their clinical privileges.
   b. Medical orders include:
      1) Date order written
      2) Intervention/order
      3) Authentication
   c. Verbal and telephone orders may be accepted from a physician, dentist, or LIP and transcribed by qualified personnel as authorized by their scope of practice. RNs may accept all verbal or telephone orders and Respiratory Therapists, Dieticians, and Pharmacists may accept medical orders related to their specialty area (e.g. the RT accepts an order for respiratory treatments, the Pharmacist clarifies a medical order, or the Dietician clarifies the patient’s diet). In addition to the above criteria (J.6.b.), verbal or telephone orders include the following:
      1) See “Telephone or Verbal Order Read-Back Procedure”, below.
      2) Medical Order Transcription: Upon receiving medical orders, they are transcribed onto the applicable forms and computer order/entry programs (see specific form guidelines for direction). The RN verifies that the transcription is complete and accurate. His/her verification is noted by placing his/her signature and the date and time the orders were received on the bottom right of the indicated section of the Medical Order.
      3) Verbal and telephone orders are authenticated within 30 days post discharge by the LIP giving the order and/or responsible for the care of the patient.
      4) Orders written by medical students are co-signed by and attending physician or house officer before carried out.
      5) STAT orders are promptly reported to the responsible RN in addition to being written in the Medical Orders.
      6) See PCMC policy for written criteria required for medication and “Do Not Resuscitate” (DNR) orders.
   d. Dictated Emergency records are exclusively available in the electronic record.
   e. Laboratory Results and Medical Imaging: Reports of pathology, clinical laboratory results and other diagnostic procedures are included in the paper and electronic medical record, while radiology and nuclear medicine examinations or treatments are exclusively available in the electronic record.
   f. Consultations: Requests for a consultation occur between the attending ordering physician and the attending consulting physician through verbal or written communication. A consultation summary contains: an opinion by the consultant; findings; impressions; and recommendations.
   g. Anesthesia Record and Notes:
      1) A pre-anesthesia evaluation will be written in the medical record. The evaluation includes determination of the capacity of the patient to undergo anesthesia and the pre-operative anesthesia plan. The pre-anesthesia evaluation also includes a review of the appropriate diagnostic data; an interview with the patient/parent
to discuss the patient’s medical anesthetic, and drug history; and a review of the patient’s physical status.

2) A post-anesthesia evaluation made early in the post-operative period is written. The post-anesthesia evaluation includes the status of the patient in relation to the procedure and anesthesia administered.

3) The Anesthesia Record records all pertinent events during the induction of, maintenance of, and emergence from anesthesia, including dosage and duration of anesthetic agents; intravenous fluids and blood or blood components; all drugs administered; and treatment rendered.

4) Re-evaluation, pre-induction evaluation: Vital signs are taken by the anesthesiologist in the OR on children who are cooperative and recorded as the first set of VS on the Pediatric Anesthesia Record. If the anesthesiologist is unable to obtain VS, the patient’s color, breathing and activity will be assessed and determined to be adequate, unless otherwise noted.

5) The Anesthesia Record and Notes are authenticated by the anesthesiologist.

6. Acknowledgement of Consent: This formal record kept by PCMC certifies that the patient (of legal age) or parent/guardian has given consent to the physician or dentist, after having been informed of the noted perimeters per policy. “Acknowledgment of Consent” should be secured by the appropriate hospital employee of the physician caring for the patient.

7. Certification of Need for Psychiatric Services: Certification of need for inpatient psychiatric services requires the signatures of a physician and another member of the care team;
   a. The certification of need is signed and dated, at the time of and not more than 30 days prior to admission, for all patients under the age of 21 years.
   b. Re-certification is done every 30 days for continued stay.

8. Patient Transfers between In-patient Units:
   a. Intensive Care Units (PICU, NBICU): When patients are transferred into intensive care areas because of the severity of their illness, all orders are rewritten. This normally done by the receiving service. Then patients are transferred out of intensive care areas, all orders are rewritten. This normally done by the receiving service, but may be done by the sending service if necessary to expedite bed availability. When patients are placed in intensive care areas because of bed shortages on other inpatient units, orders do not need to be rewritten when the child is transferred out of the intensive care unit if the medical or surgical service does not change.
   b. Non-Intensive Care Units (Infant, Children’s Med/Surg): When patients are transferred between non-intensive care units without change of medical or surgical service, orders do not need to be rewritten. If the patient changes services, all orders must be rewritten, usually by the receiving service.
   c. Education: Staff receives education regarding this policy upon hire and as needed with policy changes, form revisions and quality data.

Description of Procedural Steps
Suspension: Medical records are completed in a timely manner according to the
schedules outlined in the “Provisions” section. Records not completed within specified time frames are considered delinquent, which may result in suspension of, or disciplinary action taken against the physician until the deficiencies are corrected.

A. Suspension Procedures:

1. Physicians: Suspension from hospital privileges may include but are not limited to one or all of the following disciplinary actions being taken against the physician:
   a. Loss of admitting privileges.
   b. Inability to perform surgery or to schedule new surgery cases on the PCMC campus.
   c. Inability to perform any diagnostic procedures at PCMC.

2. Once suspended from hospital privileges, an attending physician must correct deficiencies before reinstatement may occur.

3. Habitual Offenders: The deficiency histories of habitual offenders are reviewed by the Medical Executive Committee to determine whether additional disciplinary measures are necessary and appropriate.

4. Houseofficers/Residents/Medical Students: Attending physicians are accountable for assigned housestaff, however, house officers, residents, and medical students are also held accountable for medical record completion as outlined in this policy. Non-compliance may be reported to the individual’s GME program. Penalties include but are not limited to:
   a. Suspension from rotation. Lost rotation time is made up at the end of residency or fellowship.
   b. Documentation of non-compliance in the houseofficer’s permanent record.
   c. Future rotations are not allowed until the resident or fellow has eliminated all delinquencies and has received a signed release from PCMC Patient Administration verifying completion.

5. Additional Information:
   a. Patient Administration submits a detailed suspension list to the medical staff president and the medical director on a weekly basis.
   b. A report is submitted by Patient Administration to the medical staff office of all physician suspensions and will be used in the reappointment process.
   c. Except in the case of H&P and Operative Report delinquencies, a medical staff member will not be placed on suspension for delinquencies while on vacation, provided that notification has been given to Patient Administration prior to the vacation period.

Exceptions

A. Medical Records that are the property of an individual physician rather than of PCMC are not subject to this policy. An example of such a medical record is one created by a physician during an office visit with a patient that the physician retains in his or her office are a hospital or a non-hospital operated clinic located at PCMC.

B. Physicians employed by the University of Utah who provide services at PCMC are subject to the Government Records Access and Management Act, Section 63-201-1 et seq., Utah Code Ann. (1993 and Supp. 1996) (GRAMA).

C. Subject to compliance with GRAMA, PCMC may have a right of access to the foregoing described medical records.

Telephone or Verbal Order Read-Back Procedure Addendum
Purpose
To describe the correct procedure for accepting and documenting a verbal or telephone order

Supportive Data
A. Objectives: To safely document orders that are given verbally in person or by telephone.
B. Indications: Whenever a verbal or telephone order is received from an LIP.

Content
A. Accept the order from the prescriber (verbally in person, or by telephone).
B. Verify that the transcription is complete and accurate.
C. Write the following on the order sheet:
   1. The order, as given to you
   2. Indicate that it is a verbal (V.O.) or telephone (T.O.) order
   3. Name and title of LIP giving order
   4. Date and time the order was received
D. After you write the order, read back the exact information that has been written on the order sheet to the prescriber placing the order.
E. Confirm that the written information is correct
F. Note your Read back on the order:
   1. Sign your name.
   2. Placing “RB” (for read back) by your signature. (e.g.: T.O. Dr Smith/R.B. Cassy Weeks RN)

Operative Report Guidelines
- Patient Name (spelled out in full)
- Date and Time of Surgery
- Pre-operative Diagnosis
- Post-operative Diagnosis
- Name of Surgeon
- Name of Assistant
- Description of Procedures/Findings
- Description of Specimen(s) Removed
- Indication/Clinical Summary
- Complication(s), if any
- Blood Loss
- Patient Disposition and Condition

Discharge Summary Guidelines
- Patient Name (spelled out in full)
- Admission/Discharge Date (expiration date and time)
- Attending Physician
- Consultants
- Discharge Diagnosis/Secondary Diagnosis
- Procedures Performed
- History of Present Illness/Past Medical History
- Social History/Family History
- Immunizations
- Review of Systems/Physical Examination
- Pertinent Laboratory Data
- Hospital Course
- Discharge Instructions/Discharge Disposition
  a. Medication
  b. Diet
  c. Physical Activity
  d. Follow-up Care

**PCMC Telephone Dictation Instructions**

1. Dial #66101 from inside the hospital or 1-877-649-0832 (outside)  
   (YOU DO NOT NEED TO LISTEN TO ALL THE MESSAGES!!)

2. Enter your PHYSICIAN ID, followed by the # key.  
   You do not need to enter preceding “0’s” (zeros)

3. ENTER WORK TYPE, followed by the # key.

   1 History & Physical  
   2 Consultation  
   3 Operative Reports / General Surgery  
   4 Discharge Summary  
   5 Endoscopy  
   6 Procedure Report  
   7 **STAT** / Preoperative History & Physical  
   8 Trauma Admit Report  
   9 Letter  
   13 EEG Report  
   14 Long-term Video EEG Monitoring

4. Enter PATIENT ACCOUNT NUMBER, followed by the # key.

5. Press 2 to start recording. The tone should go away. If the tone does not go away,  
   you are not being recorded.  
   *Please dictate patient’s name.

**KEYPAD CONTROLS** (Dictation Only)

   2 Start / Stop recording  
   3 Short Review / Play, press 2 to start dictating  
   44 Fast Forward  
   5 **Disconnect** / Job Verification Number  
   77 Rewind to Beginning  
   8 **End Report** / Job Verification Number / Start New Report  
   9 To mark impression
PURPOSE

To assure a work environment that is comparable with safe patient care and resident education. The Department of Pediatrics duty hours policy has been developed to comply with policies of the Accreditation Council on Graduate Medical Education (ACGME) and the Joint Commission on Accreditation of Healthcare Organizations concerning resident duty hours.

POLICY

I. Duty Hours:

(a) Duty hours are defined as all clinical and academic activities related to the residency program. This includes patient care, administrative duties related to patient care, provision for transfer of patient care, time spent in-house during call or shift activities, moonlighting, and all scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the work site or travel to and from work.

(b) Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all activities as defined above.

(c) The four-week period averaged must be within the same rotation.

(d) Residents must be provided with 1 day in 7 free from all educational and clinical responsibilities, averaged over a four-week period, inclusive of call. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.

(e) A 8-hour time period for rest and personal activities must be provided between all daily work periods. (10-hours is desirable.) PGY-2 level residents and above must have 14-hours free of duty after 24-hours of in-house duty.

(f) Residents are required to record attendance at Morning Report, Morbidity and Mortality Conference and Noon Conference. PGY-1’s are also required to record their attendance at Intern Conference.

(g) Duty hours are monitored by the Program.

II. On-Call Activities:

(a) In-house call is defined as duty hours, beyond the normal workday, when residents are required to be immediately available in the assigned institution.

(1) Duty hours for PGY-1 residents must not exceed 16-hours in duration

(2) Continuous on-site duty hours, including in-house call for PGY-2 level residents and above, must not exceed 24 consecutive hours. Residents may remain on
duty for up to 4 additional hours to participate in educational activities, maintain continuity of care, transfer care of patients, or conduct outpatient continuity clinics. Strategic mapping between the hours of 10:00 p.m. and 8:00 a.m. is recommended.

(3) In-house call must occur no more frequently than every third night, averaged over a four-week period.

(4) Call is every fourth night on Hem/Onc (Lahey), Glasgow, Family Medicine, and PNICU.

(5) PGY-2 level and above residents must not be assigned additional clinical responsibilities after 24-hours of continuous in-house duty.

(6) In unusual circumstances, residents on their own initiative may remain beyond their scheduled period of duty to provide care to a single patient.

(b) At-home call (pager call) is defined as call taken from outside the assigned institution. Home call can apply to various subspecialty rotations.

(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 four-week period.

(2) When residents are called into the hospital from home, the time spent in-house is counted toward the 80-hour limit.

(3) The Department monitors at-home call to minimize excessive service and/or fatigue.

III. Resident Learning and Working Environment

(a) Programs must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

(b) The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

(c) The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

(d) The learning objectives of the program must:

(1) Be accomplished through and appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events, and

(2) Not be compromised by excessive reliance on residents to fulfill non-physician service obligations.
(e) The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

(1) Assurance of the safety and welfare of patients entrusted to their care;

(2) Assurance of their fitness for duty;

(3) Management of their time before, during and after clinical assignments;
(4) Recognition of impairment, including illness and fatigue, in themselves and in their peers;

(5) Attention to lifelong learning;

(6) The monitoring of patient care performance improvement indicators; and,

(7) Honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

(f) All residents and faculty must demonstrate responsiveness to patient needs that supersedes self-interest. Residents must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient’s care to another qualified and rested provider.
### PGY-1 Sample Rotation Schedule

<table>
<thead>
<tr>
<th>Rotation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBN</td>
<td>Wards</td>
<td>Cardiology</td>
<td>Wards</td>
<td>ED</td>
<td>UNICU</td>
<td>Selective</td>
<td>ID</td>
<td>Wards</td>
<td>PICU/Wards</td>
<td>NF/SHF</td>
<td>Adolescent</td>
<td>NF/Advocacy</td>
<td></td>
</tr>
</tbody>
</table>

*PGY-1’s will complete 4 months of Wards or 3 months of Wards and 1 month of PICU.

### PGY-2 Sample Rotation Schedule

<table>
<thead>
<tr>
<th>Rotation</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastroenterology</td>
<td>Hem/Onc</td>
<td>NF/Elective</td>
<td>PICU</td>
<td>Elective</td>
<td>PNICU</td>
<td>B &amp; D</td>
<td>NF/Elective</td>
<td>Renal</td>
<td>Wards</td>
<td>ED</td>
<td>WBN</td>
<td>Elective</td>
<td></td>
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</table>

### PGY-3 Sample Rotation Schedule

<table>
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<tr>
<th>Rotation</th>
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<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective</td>
<td>Wards</td>
<td>Elective</td>
<td>PICU</td>
<td>Specialty</td>
<td>ED</td>
<td>Urgent Care</td>
<td>UNICU</td>
<td>Elective/NF</td>
<td>Elective</td>
<td>Wards</td>
<td>Endo/Pulm</td>
<td>Neuro/Psych</td>
<td></td>
</tr>
</tbody>
</table>

### ROTATION KEY:

- Adolescent
- B&D - Behavior and Development
- Cardiology
- ED - Emergency Department
- Elective
- Endo/Pulm - Endocrine/Pulmonary (2 weeks / 2 weeks)
- Gastroenterology
- Hem/Onc - Hematology/Oncology
- ID - Infectious Disease
- NF/Advocacy - Night Float/Advocacy (2 weeks / 2 weeks)
- NF/Elective - Night Float/Elective (2 weeks / 2 weeks)
- NF/SHF - Night Float/Safe and Healthy Families (2 weeks / 2 weeks)
- Neuro/Psych - Neurology/Psychiatry Consult Liaison (2 weeks / 2 weeks)
- PICU - Pediatric Intensive Care Unit
- PNICU - Newborn Intensive Care Unit (Primary Children’s Medical Center)
- Renal - Nephrology
- Selective
- Specialty
- UNICU - Newborn Intensive Care Unit (University Hospital)
- Urgent Care - Kids Care
- Wards - Inpatient Wards
- WBN - Well Baby Nursery

Reviewed: January 2012
General Competencies for Pediatric Residents

The residency program requires its residents to obtain competencies in the 6 areas below to the level expected of a new practitioner.

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

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

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

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

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

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

**Performance Standards**

1. The resident will demonstrate honesty, integrity, and respect in his/her interpersonal interactions.

2. The resident will attempt to resolve interpersonal conflicts in the medical setting as they arise.

3. The resident will recognize and respect the individual differences in people, such as those associated with age, religion, ethnic background, sex, and socioeconomic status. He or she will not engage in discriminatory practices or behaviors.

4. The resident must be free of the effects of alcohol and any unprescribed psychotropic drugs during work hours.

5. The resident's behavior during normal duty hours and publicly during off hours, as a representative of the University of Utah School of Medicine, will uphold the moral and ethical standards expected of members of the medical profession.

6. The resident will treat information gained from parents, patients and families as confidential, except where legal statues take precedence (e.g., child abuse reporting).
7. The resident will seek professional help for emotional or physical problems that interfere with his/her ability to function as an effective houseofficer.

8. The resident will demonstrate the intellectual, technical, organizational and judgment skills appropriate for a houseofficer at his/her level of training.

9. The resident will be present at his/her assigned rotation during normal work hours. All absences must be approved by his/her senior resident, chief resident, attending physician or program director.

10. The resident will successfully accomplish the goals outlined in the department's resident handbook for each of the clinical rotations required for promotion to the next clinical year and for eventual board certification.

11. The resident will report to his/her supervisor (senior resident, chief resident, attending physician or sub specialty/elective mentor) any medical practice by any member of the health care team that may violate acceptable medical practice or ethical standards.

12. The resident will participate in the evaluation component of the program, including the evaluation of rotations, faculty (attendings), and residents (including him or herself and others), meetings with the program director to discuss progress and performance, and overall program evaluation.

**PERFORMANCE STANDARDS**

**RESIDENT LEVEL I (PL-1)**

1. The PL-1 resident will adhere to the general guidelines for resident performance for all houseofficers in the pediatric training program at the University of Utah School of Medicine.

2. The PL-1 will adhere to the medical records requirements as outlined in the bylaws of each facility in which the resident receives training. These are outlined in the University's resident handbook.

3. The PL-1 will successfully acquire a Utah State medical license, controlled substance, and a DEA license at the completion of his/her first year of training.

4. The PL-1 will demonstrate improvement in his/her knowledge base, as measured by consistent improvement in his/her score on the in-training examinations at consecutive levels of training, through attendance at didactic conferences, and rounds as well as independent reading and study.

5. The PL-1 will continue to demonstrate improvement in his/her ability to take thorough histories and perform comprehensive physical examinations throughout the year. Improvement will be defined by the results of rotational evaluations by faculty and senior residents, and faculty in inpatient and ambulatory rotations, and continuity clinics.

6. The PL-1 will demonstrate consistent improvement in his/her ability to integrate medical facts and clinical data, weighing alternatives, considering risks and benefits, and integrating cost effectiveness and individual, family and social considerations into his/her decision making processes. These abilities will be assessed by his/her senior residents,
faculty mentors, and attending physicians on ambulatory and inpatient rotations and continuity clinics.

7. The PL-1 will develop and expand interpersonal skills as he/she learns to relate to patients, families, referring physicians and other health care professionals. He/she will consistently improve his/her ability to communicate effectively and educate these individuals around their health care issues as assessed by his/her senior residents, faculty mentors, and attending physicians on ambulatory and inpatient rotations and continuity clinics.

8. The PL-1 will demonstrate continued improvement in his/her ability to take on increasing patient care responsibilities. He/she will write and maintain clear, timely, legible, and comprehensive patient care notes daily for patients for whom he/she is responsible.

9. The PL-1 will demonstrate integrity, respect, and compassion in the care of patients and families. He/she will demonstrate an increasing ability to be responsive to patients’ wishes, be respectful of the patient’s needs for information, earn and maintain the patient and family’s trust, provide empathy, and maintain credibility and rapport as assessed by his/her senior residents, faculty mentors, and attending physicians on ambulatory and inpatient rotations and continuity clinics.

10. The PL-1 will begin to effectively utilize appropriate laboratory tests, diagnostic studies, consultative services and therapeutic modalities in the evaluation and management of patients under his/her care.

11. The PL-1 will develop skill in identifying the appropriate and efficient utilization and coordination of patient care, both in the hospital and the community, including the appropriate utilization of consultants and non-physician providers of services. He/she will begin to assume a patient advocacy position, choosing the optimal use of limited resources to maintain or enhance his/her patient's quality of care.

12. The PL-1 will successfully pass the Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP) and maintain certification.

13. The PL-1 will demonstrate increasing proficiency in those pediatric technical procedures outlined by the committee as appropriate for the PL-1 level of training.

14. The PL-1, through independent study, elective selection, participation in rounds and conferences, and in some cases, research experiences will continue to demonstrate a commitment to scholarship and continuing medical education.

15. The PL-1, with the assistance of the Program Director, will make steady progress toward correcting deficiencies identified during the biannual resident review. If the biannual review ended with a decision to place the resident on probation, all deficiencies must be corrected before promotion to the PL-2 year will be permitted.

16. The PL-1 will participate and contribute effectively to medical student education during his/her assignment to inpatient and ambulatory rotations.

17. The PL-1 will effectively complete the objectives for each of his/her clinical rotations.
18. The PL-1 will be evaluated biannually. Input will be received from the faculty attendings, supervisory residents, chief residents, patients or patients, nursing staff, continuity clinic preceptor, and as appropriate, fellow supervisors. Based upon the standards listed above, as well as those outlined for each specific rotation, the Program Director may recommend:
* continuation in the program
* probation
* suspension
* remediation of all or part of the PL-1 year
* release from the program/non-renewal of the resident’s contract

19. Any decision by the Program Director is advisory to the Department Chairperson. The resident has the right to appeal any negative action to the University of Utah Graduate Medical Education office. The procedures for such appeals are outlined in the Academic Action, Dispute Resolution, and Hearing Procedures Policy of the University’s Office of Graduate Medical Education.

**PERFORMANCE STANDARDS**

**RESIDENT LEVEL II (PL-2)**

1. The PL-2 resident will adhere to the general guidelines which outline resident performance for all houseofficers in the pediatric training program at the University of Utah School of Medicine.

2. The PL-2 will adhere to the medical records requirements as outlined in the bylaws of each facility in which the resident receives training.

3. The PL-2 will obtain and maintain an active Utah State medical license, controlled substance and a DEA license in good standing.

4. The PL-2 will continue to demonstrate improvement in his/her knowledge base from that identified during his/her PL-1 year through continued attendance at didactic lectures, rounds, and independent reading and study as reflected by consistent improvement in his/her total score during the yearly in-training examination.

5. The PL-2 will continue to demonstrate improvement and maturation in his/her ability to take thorough histories and conduct comprehensive physical examinations. Improvement will be defined by the results of rotational evaluations by faculty and senior residents, and mentors in inpatient and ambulatory rotations, and continuity clinic sites.

6. The PL-2 will demonstrate a more sophisticated ability to integrate medical facts and clinical data, weigh alternatives, consider risks and benefits, and integrate cost effectiveness and individual, family, and social considerations into his/her decision making processes. These abilities will be assessed by his/her senior residents, mentors, and attending physicians on ambulatory and inpatient rotations and continuity clinic sites.

7. The PL-2 will continue to develop and expand his/her interpersonal skills in his/her relationships with patients, families, referring physicians and other health care professionals. He/she will demonstrate improvement from the PL-1 year in his/her ability
to communicate effectively and educate these individuals around health care issues as assessed by his/her senior residents, mentors, and attending physicians on ambulatory and inpatient rotations, and continuity clinic sites.

8. The PL-2 will demonstrate continued improvement in his/her ability to take on more independent patient care responsibility. He/she will write and maintain clear, timely, legible and comprehensive patient care notes daily for patients for whom he/she is responsible. He/she will require less direct supervision from senior residents, mentors and faculty as the year progresses. He/she will demonstrate good judgment in determining when to independently seek such help and consultation.

9. The PL-2 will demonstrate integrity, respect, and compassion in the care of patients and families. He/she will demonstrate maturity in his/her ability to be responsive to patient's wishes, be respectful of the patient's needs for information, earn and maintain the patient and family's trust, provide empathy, and maintain credibility and rapport as assessed by his/her senior residents, mentors, and attending physicians on ambulatory and inpatient rotations and continuity clinic sites.

10. The PL-2 will demonstrate, through experience and education, an improved ability to utilize appropriate laboratory tests, diagnostic studies, consultative services and therapeutic modalities in the evaluation and management of patients under his/her care.

11. The PL-2 will, through experience and learning acquired in the PL-1 year, demonstrate increasing skill in identifying the appropriate and efficient utilization and coordination of patient care, both in the hospital and the community, including the utilization of consultants and non-physician providers of services. He/she will demonstrate a maturing patient advocacy position, choosing the optimal use of limited resources to maintain or enhance the quality of care of patients under his/her care and supervision.

12. The PL-2 resident will successfully pass the Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP) and maintain certification.

13. The PL-2 will demonstrate increasing proficiency in those technical pediatric procedures outlined by the Education Committee as appropriate for the PL-2 level of training. The PL-2 will be expected to begin teaching and supervising students and PL-1’s in those procedures appropriate for their level of training.

14. The PL-2, through independent study, personal elective selection, participation in rounds and conferences, the teaching of students and interns, and, in some cases research endeavors, will demonstrate an increasing commitment to scholarship and continuing medical education.

15. The PL-2, with assistance of the Program Director, will make steady progress toward correcting deficiencies identified during the biannual resident review. If the biannual review ended with a decision to place the resident on probation, all deficiencies must be corrected before promotion to the PL-3 year will be permitted.

16. The PL-2 will participate and contribute to medical student education during his/her assignment to ward, emergency room, subspecialty and ambulatory rotations on which medical students are serving.
17. The PL-2 will effectively complete the objectives for each of his/her clinical rotations.

18. The PL-2 will be evaluated biannually by the Program Director. Input will be received from the faculty attendings, supervisory residents, chief residents, patients or patients, nursing staff, continuity clinic preceptor, and as appropriate fellow supervisors. Based upon the standards listed above, as well as those outlined for each specific rotation, the Program Director may recommend:
   * continuation in the program
   * probation
   * suspension
   * remediation of all or part of the PL-1 year
   * release from the program/non-renewal of the resident’s contract

19. Any decision by the Program Director is advisory to the Department Chairperson. The resident has the right to appeal any negative action to the University of Utah Graduate Medical Education office. The procedures for such appeals are outlined in the Academic Action, Dispute Resolution, and Hearing Procedures Policy of the University’s Office of Graduate Medical Education.

PERFORMANCE STANDARDS
RESIDENT LEVEL III (PL-3)

1. The PL-3 resident will continue to adhere to the general guidelines outlining expected resident performance for all houseofficers in the pediatric training program at the University of Utah School of Medicine.

2. The PL-3 will adhere to the medical records requirements as outlined in the bylaws of each facility in which the resident receives training. He/she will guide the PL-1, PL-2, and medical students in the maintenance of accurate records and help to assure timely completion of his/her team's charts.

3. The PL-3 will maintain an active Utah State medical license, controlled substance and DEA license in good standing.

4. The PL-3 will demonstrate a level of competence in performing physical examinations consistent with a third year pediatric resident.

5. The PL-3 will continue to demonstrate improvement in his/her knowledge base through independent reading and study as reflected by consistent improvement in his/her total score during the yearly in-training examination.

6. The PL-3 will demonstrate a highly refined and matured ability to take a thorough history and complete a comprehensive physical examination. These skills will be defined by the results of rotational evaluations by faculty and chief residents, and mentors in both inpatient, ambulatory and continuity clinic sites. In addition to demonstrating skillful performance of these tasks the PL-3 will show an ability to teach these skills to students and interns working under him/her on clinical rotations.

7. The PL-3 will demonstrate a highly sophisticated ability to integrate medical facts and clinical data, weigh alternatives, consider risks and benefits, and integrate cost
effectiveness and individual, family and social considerations into his/her decision making processes. These abilities will be assessed by his/her chief residents, mentors, and attending physicians on both ambulatory and inpatient rotations. The PL-3, by his/her organization of teaching rounds on both inpatient and outpatient services, will teach and reinforce these concepts to students and interns working on his/her clinical service.

8. The PL-3 will demonstrate highly refined interpersonal skills in his/her relationships with patients, families, referring physicians and other health care professionals. He/she will teach these skills by example to those students, interns and junior residents working on inpatient and ambulatory rotations.

9. The PL-3 will demonstrate an ability to take on increasingly independent patient care responsibility. Working in conjunction with consultants and when appropriate, ward attending physicians, he/she will demonstrate an ability to manage all aspects of a patient's inpatient or ambulatory care. He/she will be able to master, by the completion of the PL-3 year, all the supervisory skills necessary to organize the activities of inpatient and abulatory teams and the care of the patients they serve. He/she will assure that his/her team members write and maintain clear, timely, legible, and comprehensive patient care notes. He/she will require little direct supervision from senior chief residents, mentors and faculty. He/she will demonstrate excellent judgment in determining when to independently seek such help and consultation.

10. The PL-3 will demonstrate, and require of his/her team, integrity, respect, and compassion in the care of patients and families. He/she will demonstrate maturity and teach his/her team members the importance of being responsive to patient's wishes, being respectful of the patient's needs for information, earning and maintaining the patient and family's trust, providing empathy, and maintaining credibility and rapport.

11. The PL-3 will demonstrate and teach his/her students, interns and junior residents, by example and education, the appropriate utilization of laboratory tests, diagnostic studies, consultative services and therapeutic modalities in the evaluation and management of patients under his/her care.

12. The PL-3 will, through his/her organization and leadership on inpatient and outpatient teaching services and teams, develop skill in more junior residents in identifying the appropriate and efficient utilization and coordination of patient care, both in the hospital and the community, including the appropriate utilization of consultants and non-physician providers of services. He/she will facilitate the development in his/her team members of a maturing patient advocacy position, choosing the optimal use of limited resources to maintain or enhance the quality of care.

13. The PL-3 resident will successfully pass the Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP) and maintain certification.

14. The PL-3 will demonstrate personal proficiency in those pediatric procedures outlined by the program as appropriate for the PL-3 level of training and necessary for all graduating residents to allow eventual certification by the American Board of Pediatrics through successful completion of the board examination. In addition, the PL-3 will be expected to demonstrate competence in teaching and supervising students and junior residents in
those procedures appropriate for his/her level of training.

15. The PL-3, through independent study, personal elective selection, participation in rounds and conferences, the teaching of students and interns, and in some cases, research endeavors, will demonstrate a commitment to scholarship and continuing medical education. This quality will be encouraged, by example and teaching style, in the students and junior residents for whom the PL-3 is responsible on his/her teaching services.

16. The PL-3, with the assistance of the Program Director, will, by the end of the third year, have corrected all deficiencies identified during the biannual resident review. If the biannual review ended with a decision to place the resident on probation, all deficiencies must be corrected before successful graduation from the program will be certified and approval to sit for the pediatric boards will be granted.

17. The PL-3 will take a leadership role in medical student education during his/her assignment to ward, emergency room, subspecialty and ambulatory rotations.

18. The PL-3 will effectively complete the objectives for each of his/her clinical rotations.

19. The PL-3 will be evaluated biannually by the Program Director. Input will be received from the faculty attendings, supervisory residents, chief residents, patients or patients, nursing staff, continuity clinic preceptor, and as appropriate fellow supervisors. Based upon the standards listed above, as well as those outlined for each specific rotation, the Program Director may recommend:
   * graduation with board qualifications
   * probation
   * suspension
   * remediation of all or part of the PL-I year
   * release from the program/non-renewal of the resident’s contract

20. Any decision by the Program Director is advisory to the Department Chairperson. The resident has the right to appeal any negative action to the University of Utah Graduate Medical Education office. The procedures for such appeals are outlined in the Academic Action, Dispute Resolution, and Hearing Procedures Policy of the University’s Office of Graduate Medical Education.

Reviewed: January 2012
The Grievance Committee of the Department of Pediatrics is composed of the chief residents, a community pediatrician, members from the full time general pediatric faculty and pediatric subspecialists, and a resident representative from each year of training. The Committee is chaired by the Residency Program Director.

In December and June of each year the Director of the Residency Program will review each resident’s performance and reach one of the following conclusions:

1. The resident is progressing according to performance standards, competencies and expectations for the level of training -or-
2. The resident has failed to meet performance standards, competencies and expectations for the level of training. The following actions will then be considered:

   a. The deficiencies are perceived as serious and will require the repetition of a designated number of rotations to attain promotion to the second or third year or preclude program certification for the resident to sit for the pediatric Boards.
   b. The deficiencies are potentially serious and may affect future promotion or certification. The Program Director will develop a corrective action plan; present it for approval to the resident. A written copy will be provided to the resident. The resident will be re-evaluated by the Program Director at intervals determined by the Grievance Committee until the deficiencies are rectified or further committee action (e.g., probation or dismissal) is suggested.
   c. The deficiency is minor and will be discussed between the resident and the Program Director. A formal committee re-review will not be necessary.

All performance evaluation decisions by the Committee are advisory to the Chairman. The Chairman must approve all negative actions upon which the Committee plans to act.

The resident may appeal any negative actions suggested by the Committee. The resident will be informed that an appeal to the School of Medicine Grievance Committee could be considered.

Reviewed: January 2012
Necessary leave will be provided during training. The Department leave policy reflects the policy of the University of Utah Office of Graduate Medical Education as adapted to meet the requirements of the American Board of Pediatrics. Each year, routine available leave with pay includes vacation time (21 days), sick leave (12 days) subject to the Payback policy, and education leave (5 days) contingent upon scheduling. The American Board of Pediatrics requires residents to spend 33 of 36 calendar months in approved rotations in order to be certified to sit for the Pediatric Boards. Vacation counts as time away from the program, leaving only 2-3 weeks of time available for other absences in order to complete the required 33 months.

Pediatric residents in the second and third year of training will be permitted a total of five working days over the two year period to utilize for fellowship interviews and/or job interviews. These days are not available for other uses. All days must be approved by the Program Director. It is assumed that these days will be taken during elective rotations and that if call responsibilities fall during this interval, residents will be responsible for providing their own coverage.

Pregnant houseofficers and adoptive mothers may be paid maternity-related time off for up to the unused paid leave time, which is available. This leave may include the time allotted for vacation, sick leave, and educational leave (in this order). They may also request additional unpaid leave time.

Residents are eligible for up to 12 weeks per year of unpaid family leave. However, leave time (paid or unpaid), over three months total in three years, must be made up at the completion of residency training in order to qualify to sit for the Boards. Under most circumstances make-up time will be without pay. During the paid leave time the University and the houseofficer will pay benefit premiums according to the usual split. Any benefits extended during unpaid make-up time will be paid for by the department.

New fathers or other houseofficers who experience a serious family emergency or are eligible for similar leave time under the guidelines outlines above.

Any requests for leave of more than the routine time available must receive Department approval. The resident will be granted leave only if it is possible to do so without significant impact on the rest of the housestaff in terms of night call and service/unit coverage. Since the houseofficer who requests more than three months leave will be required to make up some rotations, the request will only be granted if the rotations that will need to be made up are not significantly impacted by “doubling” up. To prevent overloading a rotation and diluting the experience for other residents, we cannot guarantee that a specific rotation that needs to be made up can be provided at the time the resident requests. The delay in fulfilling a rotation can be up to several months after all the other rotations have been completed.

Reviewed: January 2012
# Request for Leave Under the Family and Medical Leave Act of 1993 (“FMLA”)

## Employee Information

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## Employee Certification

I hereby certify the following:

- I have a need for leave for a reason that may qualify under the FMLA.
- I understand that I must provide advance notice of my need for leave (at least 30 days if my need is foreseeable and as soon as possible and practical if my need is not foreseeable); and that I must comply with my department’s usual and customary notice requirements if I will be unable to work, absent unusual circumstances.
- I understand that I must schedule appointments outside working hours, if available; otherwise, I must make a reasonable effort to schedule them at a time that does not unduly disrupt the business operations of my department.
- In the event I need leave for a Serious Health Condition, I understand I must submit a completed Certification of Health Care Provider prior to approval of my request for leave. I understand that my request for leave may be delayed or denied if the Certification is not complete or does not provide sufficient information.
- I authorize a representative of the Division of Human Resources to contact my Health Care Provider for purposes of clarification and/or authentication of my Certificate of Health Care Provider.

Signature of Employee: __________________________ Date: ____________

## Supervisor Acknowledgement

I have reviewed this Request and discussed the proposed leave with the employee. If possible, the requested leave has been scheduled for a time that will not unduly disrupt the business operations. My signature confirms my knowledge of the employee’s request for leave, but does not approve the employee’s request for leave.

Signature: __________________________ Date: ____________

## Reason for FMLA Request

- □ Maternity, Paternity, Adoption, or Foster Care Placement □ Serious Health Condition (a completed Certification of Health Care Provider is required) □ Employee □ Employee’s Spouse □ Employee’s Parent □ Employee’s Child (must be under the age of 18 or disabled)

## Use of Vacation Accruals

In accordance with University of Utah Policy, an employee must substitute any accrued paid leave, (e.g., sick and vacation) for any unpaid Family and Medical Leave time, except that an employee may retain up to ten (10) days of vacation leave. Upon exhaustion of any accrued leave, the remainder of any Family and Medical Leave will be unpaid.

- □ I wish to use all available vacation accruals □ I wish to retain _____________ hours/days (circle one) of vacation

Begin Date: ____________________ End Date Of Leave: If Known: ____________________ If leave is for a Serious Health Condition, the dates stated by the Health Care Provider will be used.
All resident houseofficers will receive 21 paid vacation days (18 working days) each academic year. Vacation will be taken in one-week blocks unless specific permission has been obtained for longer blocks from both the Chief Resident and the Program Director.

Since some rotations are designated as essential to resident training by the American Board of Pediatrics, vacation cannot be taken on these rotations. All vacations must be taken in the first or last week of a rotation, unless prior approval is obtained from the Chief Residents, Program Director and Chief of Teaching Service.

Two residents will not be permitted vacation on the same rotation or the same team. All resident vacation requests must be received by May 31 of each academic year. If not received by that date vacation times will be assigned by the Chief Resident.

When duplicate requests are received priority will be given to the PGY-3, PGY-2 and the PGY-1 in that order. Conflicts within the same year will be resolved by 1) resident agreement, or 2) lottery conducted by the Chief Resident. Requests for special consideration will be honored whenever possible.

Reviewed: January 2012

CHANGE OF VACATION TIME - Should a change of vacation time be necessary, you must obtain prior approval from the Chief Residents, Program Director and Chief of Teaching Service.

Vacation time is reported monthly to the GME office for hospital billing purposes. It is the responsibility of the residents to notify the Program Coordinator of any changes.
TRAVEL POLICIES

Department of Pediatrics Travel Policy - Residents are encouraged to attend high quality conferences/meetings such as the annual PAS and WSPR, which are approved by the Department. Any resident presenting a poster at an approved meeting will be financially supported by the Department and/or Division supporting the research, and reimbursed for expenses associated to these conferences in accordance with the pediatric residency program’s travel guidelines. All expenses which are expected to be reimbursed must be in accordance with the travel guidelines and coordinated through the Program Coordinator.

University of Utah Travel Policy - All travel using University funds (including those obtained through research contracts and grants) must be approved in advance of the trip. Foreign travel, supported by University funds, must be approved in advance by the Dean of the School of Medicine. When departmental personnel are authorized to travel on university business, the university will pay (out of department funds) reasonable incurred transportation, lodging, and meal expenses. Travel must be coordinated through the Program Coordinator at least one month prior to travel and travel reimbursements must be submitted to the Program Coordinator immediately following the conclusion of travel. Original, itemized receipts must be submitted for reimbursement of lodging, meals, car rental and related expenses, registration fees, parking, and airline tickets/fees.

The University will pay reasonable transportation costs based on applicable scheduled rates other than first class. Travel insurance costs purchased for the benefit of the traveler, or the beneficiary designated by the traveler, are not reimbursable costs.

Authorized travel status does not include interim periods of time used for the convenience of the traveler including side trips, layovers and late returns, which are not necessary to the conduct of university business. When travel expenses are to be paid in part from non-university sources, only the university will reimburse those expenses not paid from non-university sources.

All airline reservations must be made through the University-approved agencies. It is recommended to coordinate these arrangements through the Program Coordinator.
Department of Pediatrics
Policy on Professional Attire
2012-2013

PURPOSE

To present a professional appearance to patients, staff, and the public at all training sites, and comply with Joint Commission standards where applicable.

POLICY

Resident appearance and conduct should at all times reflect the dignity and standards of the medical profession. Dress guidelines for residents assist in achieving this goal while also acknowledging individual desires for diversity and self-expression. Following are guidelines for professional attire. It is recognized that each department or specialty may have requirements which are more specific or less rigorous than the guidelines outlined herein. It is the purpose of this policy to provide general guidelines to assist each department or specialty in developing its own dress code policy to meet its specific needs. These guidelines apply to each work day, including days with no patient care responsibilities. Maternity clothes are not exempt from these guidelines.

SPECIFIC STANDARDS

Name Tags: Proper identification as required by each training site must be worn and clearly displayed at all times while on duty.

White coats: White coats are not required. If worn, must be clean and neat. If wearing scrubs outside the operating area, a clean white coat be worn over the scrubs.

Scrubs: Scrubs should not be worn outside of the hospital premises. Scrubs are expected to be clean and pressed. Scrubs may be worn in the operating room, delivery areas, or on the following rotations only unless otherwise delineated by departmental policy: Emergency room, AO, and all ICUs. It is recommended that a coat with name tag be worn over the scrubs.

Shoes: Footwear must be clean, in good condition, and appropriate. Open-toed shoes and sandals are not allowed in patient care areas for safety reasons.

Style: No tank or halter tops, midriffs or tube tops. No sweatshirts or shirts with messages, lettering or logos (except UUMC, PCMC, IMC or VAMC). No shorts. Jeans and capris are discouraged. A tie is recommended for men on weekdays and suggested on weekends.

Fragrance: No strong colognes or perfumes as patients may be sensitive to strong fragrances.

Hands: Fingernails must be clean and short to allow for proper hand hygiene, use of instruments, prevent glove puncture and injury to the patient. Artificial nails do not allow for proper hand hygiene.
Hair: Mustaches, hair longer than chin length, and beards must be clean and well trimmed. Residents with long hair who render patient care should wear hair tied back to avoid interfering with performance of procedures or coming into contact with the patient.

Jewelry: Should not be functionally restrictive or excessive.

Piercings/Tattoos: There should be no visible body piercings, with the exception of ears. Nose piercings which have religious significance are acceptable. There should be no visible tattoos.

Violation: If a resident is in violation of his/her department’s guidelines, he/she may be asked to return home to change into more appropriate attire. Repeat violations will result in a letter being placed in the resident’s permanent file, describing deficiencies in the professionalism.

Reviewed: January 2012
1. **POLICY:**

   a. In a health care system where patient care and the training of health care professionals occur together, there must be clear delineation of responsibilities to ensure that qualified practitioners provide patient care, whether they are trainees or full-time staff. It is recognized that as resident trainees acquire the knowledge and judgment that accrue with experience, they will be allowed the privilege of increased authority for patient care.

   b. The intent of this policy is to ensure that patients will be cared for by clinicians who are qualified to deliver that care and that this care will be documented appropriately and accurately in the patient record. This is fundamental, both for the provision of excellent patient care and for the provision of excellent education and training for future health care professionals.

   c. The quality of patient care, patient safety, and the success of the educational experience are inexorably linked and mutually enhancing. Incumbent on the clinician educator is the appropriate supervision of the residents as they acquire the skills to practice independently.

   d. The principles of good training and educational supervision are not likely to change radically over time. Rules governing billing and documentation, however, will inevitably evolve. This policy focuses on resident supervision from the educational perspective.

   e. Institutional Requirements of ACGME state that "[medical] residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience." This process is the underlying educational principal for all graduate medical education, regardless of specialty or discipline. Clinician educators involved in this process must understand the implications of this principle and its impact on the patient and the resident.

2. **DEFINITIONS:**

   a. Graduate Medical Education. Postgraduate medical education is the process by which clinical and didactic experiences are provided to residents and fellows to enable them to acquire those skills, knowledge, and attitudes, which are important in the care of patients. The purpose of graduate medical education is to provide an organized and integrated educational program providing guidance and supervision of the resident, facilitate the resident's professional and personal development, and ensure safe and appropriate care for patients. Graduate medical education programs focus on the development of clinical skills, attitudes, professional competencies, and an acquisition of detailed factual knowledge in a clinical specialty.

   b. Program Director. The Program Director of the residency or fellowship program is responsible for the quality of the education and training within the program and for ensuring that the individual programs are in compliance with the policies of the respective accrediting and/or certifying body(ies).
c. Residents and Fellows. The term "residents" and “fellows” refer to individuals who are engaged in a postgraduate training program. The term "resident" for the purposes of this policy includes individuals in their first year of training (typically referred to as "interns") as well as those in the PL-2 and PL-3 years of training – leading to the first level of specialization. Fellows are those individuals who have completed a program leading to the first level of specialization and who are now in advanced training programs.

d. Attending Physician. Attending physician refers to licensed, independent physicians, who have been formally credentialed and privileged at the training site, and who have acquired the related board certification or eligibility to sit for the boards. The Attending physician may provide care and supervision only for those clinical activities for which they are privileged.

e. Supervision. Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident or fellow and to ensure the quality of care delivered to each patient by any resident or fellow. Such control is exercised by observation, consultation and direction. It includes the imparting of the practitioner's knowledge, skills, and attitudes by the practitioner to the resident and assuring that the care is delivered in an appropriate, timely, and effective manner.

3. RESPONSIBILITIES:

a. Program Directors. The Residency and Fellowship Program Directors are responsible for the quality of the overall education and training program in a given program and for ensuring that the program is in compliance with the policies of the respective accrediting or certifying bodies. The Program Director defines the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. They are also responsible for:

   (1) Assessing the attending physician's discharge of supervisory responsibilities. At a minimum, this includes written evaluations by the residents and fellows.

   (2) Structuring training programs consistent with the requirements of the accrediting and certifying bodies.

   (3) Arranging for all residents or fellows entering their first rotation to participate in an orientation to policies, procedures, and the role of residents within the affiliated training program.

   (4) Ensuring that residents and fellows are provided the opportunity to contribute to discussions in committees where decisions being made may affect their activities.

b. Attending physician. The attending physician is responsible for and must be personally involved in the care provided to individual patients in inpatient and outpatient settings as well as long-term care and community settings. When a resident or fellow is involved in the care of patients, the responsible attending physician must continue to maintain a personal involvement in the care of those patients. The procedure through which the attending physician provides and documents appropriate supervision is outlined below in section 4.
c. Residents and Fellows. The residents and fellows, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Each resident or Fellow is responsible for communicating significant patient care issues to the attending physician. Such communication must be documented in the record. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities.

4. PROCEDURES:

   a. Resident or fellow supervision by the attending physician. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of such responsibility requires personal involvement with each patient and each resident who is providing care as part of the training experience. Each patient will be assigned an attending physician whose name will be clearly identified in the patient's record. It is recognized that other attending physicians may, at times, be delegated responsibility for the care of a patient and provide supervision instead of, or in addition to, the assigned practitioner. The attending physician is expected to fulfill this responsibility, at a minimum, in the following manner:

      (1) The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident or fellow being supervised. Care must be rendered under the supervision of the attending physician or be personally furnished by the attending physician.

      (2) Documentation of this supervision will be by progress notes entered into the medical record by the attending physician or reflected within the resident's or fellow’s progress note at a frequency appropriate to the patient's condition. The medical record should reflect the degree of involvement of the attending physician, either by the attending physician’s progress note, or the resident's description of attending involvement. The resident or fellow note shall include the name of the attending physician with whom the case was discussed as well as a summary of that discussion. The attending physician must countersign resident or fellow notes and provide an attestation to the resident or fellow note detailing his/her involvement and supervision.

      (3) For patients admitted to an inpatient team, the attending physician must meet the patient early in the course of care (within 24 hours of admission including weekends and holidays). This supervision must be personally documented in a progress note no later than the day after admission. The attending physician's progress note will include findings and concurrence with the resident's or fellow's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed, dated, and timed. Attending physicians are expected to be personally involved in the ongoing care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the trainee.

      (4) The attending physician, in consultation with the resident or fellow, will ensure that discharge or transfer of the patient from an inpatient team or clinic is appropriate, based on
the specific circumstances of the patient's diagnoses and therapeutic regimen. This may include physical activity, medications, diet, functional status, and follow-up plans. At a minimum, evidence of this assurance will be documented by the attending physician's countersignature of the discharge summary or clinic discharge note.

(5) For outpatients, all new patients to the clinic for which the attending physician is responsible should be supervised by the attending physician. This supervision must be documented in the medical record via a progress note by the attending physician or the resident's note and include the name of the attending physician and the nature of the discussion. New patients should be supervised as dictated by graduated level of responsibility outlined for each level of training. Unless otherwise specified in the graduated levels of responsibility, new patients should be seen and evaluated by the attending physician at the time of the patient visit. Return patients should be seen by or discussed with the attending physician at such a frequency as to ensure that the course of treatment is effective and appropriate. This supervision must be documented in the medical record via a note by the attending physician or the resident's note that indicates the nature of the discussion with the attending physician. The medical record should reflect the degree of involvement of the attending physician, either by the attending physician’s progress note or the resident's or fellow’s description of attending involvement. The attending must countersign all resident and fellow notes and provide an attestation detailing his/her involvement. All notes must be signed, dated, and timed.

(6) The attending physician is responsible for official consultations on each specialty team. When trainees are involved in consultation services, the attending physician will be responsible for supervision of these residents or fellows. The supervision of residents and fellows performing consultation will be determined by the graduated levels of responsibility for the resident or fellow. Unless otherwise stated in the graduated levels of responsibility, the attending physician must meet with each patient who received consultation by a resident and perform his or her evaluation in a timely manner based on the patient's condition. The patients seen in consultation by residents or fellows must be discussed and/or reviewed with the attending physician supervising the consultation within 12 hours of initial consultation by the resident or fellow. The attending physician must document this official consultation supervision by writing a personal progress note or by writing his/her concurrence with the resident's or fellow's consultation note by the close of the next working day. The attending physician must countersign all notes and add an attestation detailing his/her involvement.

(7) Emergency room consultations. Emergency room consultations by residents or fellows may be supervised by a specialty attending physician or the emergency room attending physician. All emergency room consultations by residents or fellows should involve the attending physician supervising the resident's discipline specific specialty consultation activities for which the consultation was requested. After discussion of the case with the discipline specific attending physician, the resident may receive direct supervision in the emergency room from the emergency room attending physician. In such cases where the emergency room attending physician is the principal provider of care for the patient's emergency room visit, the specialty specific attending physician does not need to meet directly with the patient. However, the specialty specific attending physician's supervision of the consultation must be documented in the medical record by co-signature of the consultation note or is reflected in the resident physician consultation note.
(8) Assure all Do Not Resuscitate (DNR) orders are appropriate and assure the supportive documentation for DNR orders are in the patient's medical record. All DNR orders must be signed or countersigned by the attending physician.

b. Assignment and Availability of Attending physicians.

(1) Within the scope of the training program, all residents and fellows, without exception, will function under the supervision of attending physicians. A responsible attending physician must be immediately available to the resident in person or by telephone and able to be present within a reasonable period of time (generally considered to be within 30 minutes of contact), if needed. Each discipline will publish, and make available "call schedules" indicating the responsible attending physician(s) to be contacted.

(2) In order to ensure patient safety and quality patient care while providing the opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged attending physician will be available for supervision during clinic hours. Patients followed in more than one clinic will have an identifiable attending physician for each clinic. Attending physicians are responsible for ensuring the coordination of care that is provided to patients.

c. Graduated Levels of Responsibility.

(1) Each training program within the Department of Pediatrics will be structured to encourage and permit residents to assume increasing levels of responsibility commensurate with their individual progress in experience, skill, knowledge, and judgment.

(2) As part of their training program, residents and fellows should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or to act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.

(3) The Residency or Fellowship Program Directors will define the levels of responsibilities for each year of training by preparing a description of the types of clinical activities residents may perform and those for which residents may act in a teaching capacity. The documentation of the assignment of graduated levels of responsibility will be made available to other staff as appropriate.

d. Supervision of Procedures.

(1) Diagnostic or therapeutic procedures require a high level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may
be performed only by residents with the required knowledge, skill, and judgement
and under an appropriate level of supervision by attending physicians. Attending
physicians will be responsible for authorizing the performance of such procedures,
and such procedures should only be performed with the explicit approval of the
attending physician. NOTE: Excluded from the requirements of this section are
procedures that, although invasive by nature, are considered elements of routine
and standard patient care. Examples are the placing of intravenous lines, lumbar
puncture, routine radiologic studies, wound debridement, and drainage of superficial
abscesses.

(2) During the performance of procedures, an attending physician will provide an
appropriate level of supervision. Determination of this level of supervision is
generally left to the discretion of the attending physician within the context of the
previously described levels of responsibility assigned to the individual resident
involved. This determination is a function of the experience and competence of the
resident and of the complexity of the specific case.

e. Emergency Situation.

(1) An "emergency" is defined as a situation where immediate care is necessary to
preserve the life of, or to prevent serious impairment of the health of a patient. In
such situations, any resident, assisted by other clinical personnel as available, shall
be permitted to do everything possible to save the life of a patient or to save a
patient from serious harm. The appropriate attending physician will be contacted and
apprised of the situation as soon as possible. The resident will document the nature
of that discussion in the patient's record.

f. Evaluation of Residents and Supervisors.

(1) Each resident will be evaluated according to accrediting and certifying body
requirements on the basis of the core competencies; Patient Care, Medical
Knowledge, Professionalism, Systems-Based Practice, Interpersonal Skills and
Communication and Practice-Based Learning and Improvement. Evaluations will
occur at the end of each rotation. Written evaluations will be returned to the resident.
No less often than every six months the program director will meet with the resident
and discuss his or her performance.

(2) If a resident's performance or conduct is judged to be detrimental to the care of a
patient(s) at any time, action will be taken immediately to ensure the safety of the
patient(s).

(3) No less often than annually each resident will be given the opportunity to
complete a confidential written evaluation of attending physicians and of the quality
of the resident's training. Such evaluations will include the adequacy of clinical
supervision by the attending physician. The evaluations will be reviewed by the
program director.

(4) All written evaluations of residents and attending physicians will be kept on file by
the Residency or Fellowship Program Director in an appropriate location and for the
required time frame according to the guidelines established by the respective
ACGME Residency Review Committee or other accrediting and certifying agencies.
5. **RESIDENT SUPERVISION:**

a. In the clinical learning environment, each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner) who is ultimately responsible for that patient’s care.

(1) This information should be available to residents, faculty members, and patients.

(2) Residents and faculty members should inform patients of their respective roles in each patient’s care.

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

c. Levels of Supervision.

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

a. Direct Supervision:

(1) the supervising physician is physically present with the resident and patient.

b. Indirect Supervision:

(1) with direct supervision immediately available - the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

(2) with direct supervision available - the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

d. Oversight - The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
e. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

(1) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

(2) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

(3) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

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

(1) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

(2) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

g. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

6. **CLINICAL RESPONSIBILITIES:**

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

b. Monitoring Procedures.

(1) Monitoring of the compliance with these procedures will be performed by the program director and as part of the scheduled internal program reviews.

Reviewed: January 2012
I. PURPOSE
All house officers are required to obtain a Utah medical license, a Utah controlled
substance license, and a Federal DEA certificate to participate in a training program at the
University of Utah Affiliated Hospitals, in accordance with the policy herein.

II. POLICY
All house officers are required to pass Steps 1, 2, and 3 of the United States Medical
Licensing Exam (USMLE) and to obtain a Utah medical license, Utah controlled substance
license, and Federal DEA certificate (as applicable). The Graduate Medical Education
Committee may grant Administrative Variances of this policy in specific instances. Any
house officer who does not comply with this policy, or who is ineligible for licensure at the
required time, as set forth in this policy, without having been granted an Administrative
Variance, will be subject to disciplinary action and or termination as dictated by the
Graduate Medical Education Committee.

III. PROCEDURE
A. POST-GRADUATE YEAR ONE (PGY-1) RESIDENTS

1. PGY-1 EXAM REQUIREMENTS
   a. All post-graduate year one (PGY-1) residents are required to pass
      Steps 1 and 2 (CK & CS) of the USMLE prior to beginning residency
      training, and must show evidence of that as part of the credentialing
      process. All PGY-1 residents are required to take and pass USMLE
      Step 3, receive scores, and provide evidence of a passing score to the
      Graduate Medical Education Office by the last day of their PGY1 year.

2. PROGRAM DIRECTOR RESPONSIBILITIES
   a. Program Directors are expected to obtain verification from applicants
      to programs that they have passed Steps 1 and 2 (CK & CS) of the
      USMLE prior to the beginning of the residency.
   b. Accepted or matched PGY1 residents who have not taken or passed
      Steps 1 and 2CK will be released from their contract.
   c. Program Directors are expected to obtain verification from all PGY-1
      residents in their programs that they have taken, passed, and received
      scores of Step 3 of the USMLE during the PGY-1 year.
   d. The Program Director, Program Coordinator, or PGY-1 resident must
provide the Graduate Medical Education Office with evidence of passing all required exams before the last day of the resident’s PGY-1 year.

B. POST-GRADUATE YEAR TWO (PGY-2) RESIDENTS

1. PGY-2 APPLICATION REQUIREMENTS
   a. All post-graduate year two (PGY-2) residents and all new incoming residents at level PGY-2 or higher, must be eligible for a Utah medical license, a Utah controlled substance license, and a Federal DEA certificate. All PGY-2 and all PGY-2+ residents must submit their completed application by the time guidelines outlined below and are responsible for all necessary follow up to ensure they obtain their licenses in a timely manner.

2. PROGRAM DIRECTOR RESPONSIBILITIES
   a. Program Directors and/or Program Coordinators will verify that all residents at level PGY-2 or higher are eligible to apply for medical licensure by having taken and passed Steps 1, 2, and 3 of the USMLE.
   b. Incoming Residents at the PGY-2 or above who have not taken and passed USMLE steps 1, 2, and 3 will not be accepted into the program unless there is a justifiable reason for an exception to this policy.
   c. If a resident at level PGY-2 or higher is not eligible to apply for medical licensure, the Program Director must notify the Graduate Medical Education Committee and petition that body for an Administrative Variance for the resident to begin the training program.

3. APPLICATION DEADLINES AND FEES
   a. All PGY-2 and PGY-2+ residents will submit a completed Utah medical license application to the Graduate Medical Education Office by July 31 of the PGY-2 year, or within 30 days of hire.
   b. All Utah medical license applications submitted by the stated deadline will be paid for by the Graduate Medical Education Office.
   c. Failure to submit a completed Utah medical license by July 31 or within 30 days of hire will result in immediate suspension without pay. Suspended residents may be reinstated upon submission of a completed application.
   d. PGY-2 or PGY-2+ residents, who fail to submit a Utah medical license application by July 31 of the PGY-2 year, or within 30 days of hire, must pay the cost of the Utah medical license.
   e. All PGY-2 or PGY-2+ residents will apply for a Federal DEA certificate (as applicable) immediately upon receiving a Utah medical license.

4. LICENSING DEADLINES AND COPY REQUIREMENTS
   a. It is the responsibility of the resident to follow through as needed to ensure proper licensure. This may include contacting FCVS, the Utah Board, previous employers or the Graduate Medical Education Office. Residents who do not
follow through as necessary may be subjected to disciplinary matters, including suspension.
b. Copies of all licenses and certificates must be provided to the Graduate Medical Education Office.

5. PROGRAM EXEMPTIONS FOR DEA LICENSE
a. Some programs are specifically exempted from the Utah controlled substance and Federal DEA certificate requirements for housestaff. In these exempted programs, housestaff are required to apply for and obtain a Utah medical license as outlined in this policy. Exempted programs are as follows: Pathology, Radiology, Anesthesiology, Medical Informatics, Dental Education, Hematopathology, Molecular Genetic Pathology, Medical Microbiology, Nuclear Medicine, Pediatric Critical Care, Physical Medicine & Rehab, Neuroradiology and Neurogenetics.

6. TRAINING UNDER A DISCIPLINARY ACTION
a. The Graduate Medical Education Committee will consider each request from a Program Director to allow a resident who is ineligible for license or who has not met the license requirement to begin training.
b. The Graduate Medical Education Committee will make a decision whether to either allow the resident to begin training under the terms of an Administrative Variance.
c. If the Graduate Medical Education Committee grants an Administrative Variance to this policy the resident may begin training under the terms of the Variance. The resident and the Program Director will be notified in writing regarding the length and terms of the Variance. At the end of the Variance period, the resident must have met all terms of the Variance granted. Administrative Variances will not be reported to other agencies.

7. CONSEQUENCES OF FAILURE TO SATISFY REQUIREMENTS
a. Any PGY-2 or PGY-2+ resident who is training under the terms of an Administrative Variance granted by the Graduate Medical Education Committee, and who does not meet the terms of that Variance, may be dismissed from the training program by the Program Director. If the Program Director does not wish to dismiss the resident, the Program Director must notify the Graduate Medical Education Committee and petition that body for permission to allow the resident continue in the training program. The Graduate Medical Education Committee may grant a second Administrative Variance or dismiss the resident from the training program. The Administrative Variance will include terms and conditions by which the resident must abide and will be provided in writing to the resident and the Program Director.
b. Failure of a resident to meet the terms and conditions of a second Administrative Variance will result in dismissal of the resident from the training program with no option to appeal.
c. Any resident who is dismissed from a training program for failure to meet the licensing requirements may re-apply to that program following successfully completing the requirements. Re-acceptance into a program is at the discretion of the Program Director.

C. FELLOWS

a. All eligible incoming Fellows must obtain a Utah medical license, a Utah controlled substance license, and a Federal DEA certificate (as applicable) prior to beginning his/her fellowship at the University of Utah. The GME Office will send the appropriate Federation Credentials Verification Service (FCVS) application and a Utah licensing packet to each incoming fellow, along with instructions on processing and reimbursement upon receipt of notification of hire by the School of Medicine Department.

b. Fellows who are ineligible to apply for licensure prior to beginning may be granted an Administrative Variance upon request from the Program Director. The same procedures and requirements as above will apply.

D. WAIVERS OF THE LICENSE REQUIREMENT

a. The Graduate Medical Education Committee may grant waivers of the medical license policy in specific instances. If a houseofficer is an international medical graduate with no prior residency training in the United States, or is unable to comply with the licensing policy due to overriding concerns or issues deemed by the Graduate Medical Education Committee to be substantial, the Committee may waive the medical license requirement for one year. The Program Director and the resident will be notified in writing of such a waiver, and the waiver will be documented in the resident's file.

b. Waivers of the medical licensing requirements are at the sole discretion of the Graduate Medical Education Committee and should not be assumed to be automatic under the circumstances stated above.

E. LICENSE RENEWALS

a. All Utah MD licenses expire January 31 of the even year, Utah DO licenses expire May 31 of the even year and Utah Podiatric licenses expire September 30 of the even year. Housestaff are responsible for renewing their licenses prior to the expiration date. The GME office will reimburse for the full cost of the license if the resident is continuing on in the subsequent training year and renews prior to the expiration date. The GME office will reimburse for half the license renewal cost if the resident is completing his/her training in the current training year and renews prior to the expiration date. The GME office will not reimburse for licenses renewed after the expiration date.

Reviewed: January 2012
**LICENSING INFORMATION** - All residents above the PGY-1 level **MUST** be licensed at the University of Utah. Residents must apply for licensure by July 31st of their PGY-2 year. Incoming residents at the PGY-2 level are also expected to apply for licensure by July 31st. Incoming residents at the PGY-3 level and above are also expected to be fully licensed at the time they start their training at the University of Utah.

**UTAH MEDICAL LICENSE** - Interns must obtain a Utah Medical License by July 31, immediately following their first year of clinical training. Housestaff who do not comply will be in violation of their contract and will be suspended* from clinical rotations until compliant. The GME office will pay for the initial state license. State license renewal fees are paid by the GME office on a prorated basis, depending on length of residency training.

*This suspension will remain a part of your permanent record.

**DEA LICENSE FEES** - Residents are required to apply and obtain a Federal DEA license. Residents should apply for a “FEE EXEMPT” license, unless they are planning to perform external moonlighting in which the Resident will be responsible for obtaining and paying all fees associated with a “FEE PAID” license.
GENERAL COMPETENCIES & RESIDENT EVALUATION
GENERAL COMPETENCIES

In February 1999, the ACGME endorsed the concept of general competencies for residents in specific areas including:
- patient care,
- medical knowledge,
- interpersonal and communication skills,
- professionalism,
- practice-based learning and improvement, and
- systems-based practice

Residency programs will be expected to define the specific knowledge, skills and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

1. Patient Care
Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:
- communicate effectively and demonstrate caring and respectful behaviors when interacting with patient and their families
- gather essential and accurate information about their patients
- make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- develop and carry out patient management plans
- counsel and educate patients and their families
- use information technology to support patient care decisions and patient education
- perform competently all medical and invasive procedures considered essential for the area of practice
- provide health care services aimed at preventing health problems or maintaining health.
- work with health care professionals, including those from other disciplines, to provide patient-focused care

2. Medical Knowledge
Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of the knowledge to patient care. Residents are expected to:
- demonstrate an investigatory and analytic thinking approach to clinical situations
- know and apply the basic and clinically supportive sciences which are appropriate to their discipline

3. Interpersonal and Communication Skills
Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patient's families, and professional associates. Residents are expected to:
- create and sustain a therapeutic and ethically sound relationship with patients
- use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and written skills
- work effectively with others as a member or leader of a health care team or other
4. **Professionalism**
Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

- demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

5. **Practice-Based Learning and Improvement**
Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- analyze practice experience and perform practice-based improvement activities using a systematic methodology
- locate, appraise and assimilate evidence from scientific studies related to their patients' health problems
- obtain and use information about their own population of patients and the larger population from which their patients are drawn
- apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- use information technology to manage information, access on-line medical information; and support their own education
- facilitate the learning of students and other health care professionals

6. **Systems-Based Practice**
Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

- understand how their patient care an other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
- know how types of medical practice and delivery systems differ from one and another, including methods of controlling health care costs and allocating resources
- practice cost-effective health care and resource allocation that does not compromise quality of care
- advocate for quality patient care and assist patients in dealing with system complexities know how to partner with health care managers and health care providers to assess, coordinate and improve health care and know how these activities can affect system performance
RESIDENT EVALUATION

EVALUATION AND PERFORMANCE REVIEWS - Resident faculty and peer evaluations will be reviewed by the Program Director biannually, and a summary of your performance will be written by the Chief Residents. These evaluations will be discussed with the Program Director. Performance progress/issues will also be discussed during these meetings.

RESIDENT EVALUATION PROCESS - As you rotate through each block, you will be evaluated by faculty members and your peer residents with whom you have had contact with. You will also be asked to evaluate your evaluators and the rotation. It is highly recommended that you discuss your performance with each faculty member who performs an evaluation at the time the evaluation is submitted.

EVALUATIONS TO INCLUDE:

- Attending Evaluation of Resident (Rotation Specific)
- Pediatric Resident Evaluation of Attending
- Pediatric Resident Evaluation of PGY-1 (Peer Evaluation)
- Pediatric Resident Evaluation of PGY-2 & PGY-3 (Peer Evaluation)
- Pediatric Resident Evaluation of Rotation
- Year-End Program Evaluation
PEDIATRIC RESIDENT LIST

(2012-2013)
Chief Residents
Bailey, Suzanne
O’Connor, Meghan
Stout, Andrea

PGY-1 Residents
Ames, Stefanie
Bennett, Erin
Brown, Laura
Carpenter, Kyleen
Diaz-Ochu, Margarita
Dowse, Benjamin
Ellsworth, Grant
Esty, Brittany
Fuchs, Erin
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Jones, Tyson
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Patterson, Paige
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Wilson, Carey

PGY-2 Residents
Balch, Heather
Bexfield, Nathan
Boucek, Dana
Braski, Katherine
Crowell, Kody
Doll, Elizabeth
Edmundson, Meghan
Elkon, Benjamin
Fisher, Edward
Hayes, Samuel
Johnson, Carrie
Jolliffe, Anna
Khan, Jawaria
Koepf-Shakib, Sabine
Larsen, Chari

PGY-3 Residents
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Follett, Kelly
Garcia, Kathy
Goerl, Danae
Gottlieb, James
Jager, Sara
Kaza, Elisabeth
Kirking, Hannah
Kleschen, Melissa
Meznarich, Jessica
Nelson, Gary
Olarte Carhuaz, Liset
Parsons, Elizabeth
Petersen, Anna
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Shillington, Holly
Stahl, Jessica
Unger, Kortni
Vu, Judy
Ware, Adam
Waterhouse, LuLu
Whipple, Nicholas
Wolford, Mariposa

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Lindsay, Ian
Shea, Patrick
State, Rachel

PGY-5 Residents
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(2012-2013)
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James F. Bale, M.D.  Professor, Associate Chair-Education, Pediatric Residency Program Director
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Carrie L. Byington, M.D.  Professor, Associate Chair-Clinical Research Enterprise
John C. Carey, M.D., M.P.H.  Professor, Associate Chair-Academic Enterprise
J. Michael Dean, M.D., M.B.A.  Professor, Associate Chair-Financial Enterprise
Jacquie Bernard  Administrative Director

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Rajendu Srivastava, M.D., M.P.H.  Associate Professor
Adam T. Stevenson, M.D.  Assistant Professor
Bryan L. Stone, M.D.  Associate Professor
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Jeffrey VanBlarcom, M.D.</td>
<td>Assistant Professor</td>
</tr>
<tr>
<td>Elizabeth S. Vukin, M.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Victoria L. Wilkins, M.D., M.P.H.</td>
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<td>Gabrielle Zimbric, M.D.</td>
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<td>Armand H. Antommaria, M.D., Ph.D.</td>
<td>Associate Professor</td>
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<td>Jeffrey R. Botkin, M.D., M.P.H.</td>
<td>Professor</td>
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<td>Cameron R. Botkin, M.D.</td>
<td>Division Director</td>
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<td>Mariana C. Baserga, M.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Joanna C. Beachy, M.D., Ph.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Ryann Bierer, M.D.</td>
<td>Instructor</td>
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<td>Ronald S. Bloom, M.D.</td>
<td>Professor</td>
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<td>Luca Brunelli, M.D., Ph.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Gary M. Chan, M.D.</td>
<td>Professor</td>
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<td>Robert DiGeronimo, M.D.</td>
<td>Professor</td>
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<td>Jack L. Dolcourt, M.D., M.Ed.</td>
<td>Professor</td>
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<td>Roger G. Faix, M.D.</td>
<td>Professor</td>
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<td>Camille M. Fung, M.D.</td>
<td>Assistant Professor</td>
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<td>Jerald D. King, M.D.</td>
<td>Professor</td>
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<td>Robert H. Lane, M.D.</td>
<td>Professor</td>
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<td>Daniel T. Malleske, M.D.</td>
<td>Instructor</td>
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<td>J. Ross Milley, M.D., Ph.D.</td>
<td>Professor</td>
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<tr>
<td>Lonnie Miner, M.D.</td>
<td>Adjunct Instructor</td>
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<tr>
<td>Donald M. Null, Jr., M.D.</td>
<td>Professor</td>
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<tr>
<td>Elizabeth A. O'Brien, M.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Shrena Patel, M.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Robert M. Ward, M.D.</td>
<td>Professor</td>
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<td>Susan E. Wiedmeier, M.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Bradley A. Yoder, M.D.</td>
<td>Professor</td>
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<tr>
<td>Christian Con Yost, M.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Matthew T. Grinsell, M.D., Ph.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Teri Jo Mauch, M.D., Ph.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Raoul D. Nelson, M.D., Ph.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Joseph R. Sherbotie, M.D.</td>
<td>Associate Professor</td>
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<tr>
<td>James F. Bale, Jr., M.D.</td>
<td>Professor</td>
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<tr>
<td>Helen Barkan, M.D., Ph.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Susan L. Benedict, M.D.</td>
<td>Associate Professor</td>
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<tr>
<td>Joshua L. Bonkowski, M.D., Ph.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Russell J. Butterfield, M.D., Ph.D.</td>
<td>Assistant Professor</td>
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<tr>
<td>Francis M. Filloux, M.D.</td>
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<tr>
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<tr>
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<tr>
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<tr>
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<tr>
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</tbody>
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David L. Corwin, M.D.  Professor  Division Director
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**PCMC Operator**
(801) 662-1000

**Program-Related #’s:**

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(801) 662-5702
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(801) 662-5700

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Kristin Randall, Academic Coordinator
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Resident Lounge
(801) 662-5733 or 25734

PCMC In-Patient #’s:

Admitting Resident Pager
(801) 914-6642

Hospitalist On-Call Pager
(801) 914-8352

Nursing Supervisor Pager
(801) 914-6960

Anderson Team Room
(801) 662-5738 or 25739
Anderson A Pager
(801) 914-8224
Anderson B Pager
(801) 914-9191

Glasgow/Family Medicine Team Room
(801) 662-5757 or 25772
Glasgow/Family Medicine Team Pager
(801) 914-8227

Green Team Room
(801) 662-5790, 25740 or 25741
Green A Pager
(801) 914-8226
Green B Pager
(801) 914-9193

Lahey Team Pager
(801) 914-2059

Osborn Team Room
(801) 662-5757 or 25772
Osborn A Pager
(801) 914-9188
Osborn B Pager
(801) 914-9190

Veasy Team Room
(801) 662-5745 or 25746
Veasy A Pager
(801) 914-8225
Veasy B Pager
(801) 914-9192
Radiology (801) 662-1800

EEG Lab (801) 662-1755

Sleep Lab (801) 662-1780

PCMC Pharmacy Main (801) 662-2600
  PICU/NTU Pharmacist Pager (801) 914-6335
  NICU/IMSU Pharmacist Pager (801) 914-6334
  CMU and CSU Pharmacist Pager (801) 914-6735
  ICS Pharmacist Pager (801) 914-6262
  PCMC Outpatient Pharmacy (801) 662-1680

Laboratory (InPatient) (801) 662-2100

Microbiology Lab (801) 662-2143

Medical Records (Lois) (801) 662-3841 or 662-3821

University Hospital Numbers:

University Operator (801) 581-2121

Well Baby Nursery (801) 587-9099

Concerned Parent Answering Service (801) 595-5244
PROGRAM REQUIREMENTS

Pediatrics
ACGME Program Requirements for Graduate Medical Education
in Pediatrics

Common Program Requirements are in BOLD

Effective: July 1, 2007

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept—graded and progressive responsibility—is one of the core tenets of American graduate medical education.

Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident’s development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

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

Int.C. Duration and Scope of Training

Int.C.1. Programs must provide residents with a broad exposure to the health care of children and substantial experience in the management of diverse pathologic conditions. This must include experience in child health maintenance and those conditions commonly encountered in primary care practice. It must also include experience with a wide range of acute and chronic medical conditions of pediatrics in both the inpatient and ambulatory settings.

Int.C.2. Each program must describe a core curriculum that complies with the Review Committee’s requirements and in which all residents participate. All residents in the program must have a minimum of 18 months of training in common. In addition, programs that utilize multiple hospitals or that offer more than one track must provide evidence of a unified educational experience for each resident.
Int.C.3. The first year should include an introduction to the basic experiences on which the rest of the training will be based. During the last 24 months of training, the program must require residents to supervise the activities of more junior residents within the approved inpatient and outpatient educational settings.

Int.C.4. Throughout the three years of training, the goal should be the achievement of competency in patient care, medical knowledge, professionalism, communication, practice-based learning and improvement, and systems-based practice.

Int.D. Goal of the Residency

Int.D.1. The goal of residency training in pediatrics is to provide educational experiences that prepare residents to be competent general pediatricians able to provide comprehensive and coordinated care to a broad range of pediatric patients. The residents' educational experiences must emphasize the competencies and skills needed to practice general pediatrics of high quality in the community. In addition, residents must become sufficiently familiar with the fields of subspecialty pediatrics to enable them to participate as team members in the care of patients with chronic and complex disorders.

Int.D.2. Residents must be given the opportunity to function with other members of the health care team in both inpatient and ambulatory settings to become competent as leaders in the organization and management of patient care.

I. Institutions

I.A. Sponsoring Institution

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

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

I.B. Participating Sites

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

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents;
I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document;

I.B.1.c) specify the duration and content of the educational experience; and,

I.B.1.d) state the policies and procedures that will govern resident education during the assignment.

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS).

I.B.3. An accredited program may be independent or may occur in two or more sites that develop formal agreements and conjoint responsibilities to provide complementary facilities, teaching staff, and teaching sessions. When participating sites are utilized and a single program director assumes responsibility for the entire residency, including the appointment of all residents, the determination of all rotations, and the assignment of both residents and members of the teaching staff, the participating site may be proposed as integrated. Ordinarily, a hospital may not be an integrated part of more than one pediatric residency, and a program may not propose the primary teaching site of another accredited program as an integrated participant. The Review Committee must approve the designation of a participating hospital as integrated. In making its determination, the Review Committee will consider the proximity of the hospital to the primary teaching site and the duration of rotations planned. Normally, at least three months of required experience should occur at a hospital that is designated as integrated. A significant increase in the time spent at an integrated hospital should receive prior approval from the Review Committee. Within a single program some participating hospitals may qualify as integrated, while others are merely affiliated with the program.

I.B.4. Although no limit is placed on the duration of rotations to sites that are integrated with the primary hospital’s pediatric program (although the duration must have Review Committee approval), rotations to participating sites that are not integrated with the primary hospital may not exceed a total of nine months during the three years of training. No more than three months of these outside rotations may be in sites that do not have their own pediatric residency.

I.B.5. Rotations to other programs should enrich but not replace core experiences. When residents rotate to a site that has its own accredited pediatric residency, the rotating residents must be fully absorbed into the prevailing pattern of instruction and patient care at the same level as the pediatric residents of that host program.
Residency programs that offer training to residents from other pediatric residencies must provide instruction and experience equivalent to that given to their own residents. They should enter into agreements with other programs only if they are prepared to absorb those residents into the prevailing pattern of education and patient care.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution’s GMEC must approve a change in program director. After approval, the program director must submit this change to the ACGME via the ADS.

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

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability.

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee;

II.A.3.b) current certification in the specialty by the American Board of Pediatrics, or specialty qualifications that are acceptable to the Review Committee; and,

II.A.3.b).(1) If Board certification is lacking, the Review Committee will
review active participation in national societies, evidence of ongoing scholarship through contributions to the peer-review literature, and presentations at national meetings.

II.A.3.c) current medical licensure and appropriate medical staff appointment.

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

II.A.4.b) approve a local director at each participating site who is accountable for resident education;

II.A.4.c) approve the selection of program faculty as appropriate;

II.A.4.d) evaluate program faculty and approve the continued participation of program faculty based on evaluation;

II.A.4.e) monitor resident supervision at all participating sites;

II.A.4.f) prepare and submit all information required and requested by the ACGME, including but not limited to the program information forms and annual program resident updates to the ADS, and ensure that the information submitted is accurate and complete;

II.A.4.g) provide each resident with documented semiannual evaluation of performance with feedback;

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution;

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion;

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must:

II.A.4.j.(1) distribute these policies and procedures to the residents and faculty;

II.A.4.j.(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged;

II.A.4.l) comply with the sponsoring institution’s written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents;

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures;

II.A.4.n) obtain review and approval of the sponsoring institution’s GMEC/DIO before submitting to the ACGME information or requests for the following:

II.A.4.n).(1) all applications for ACGME accreditation of new programs;

II.A.4.n).(2) changes in resident complement;

II.A.4.n).(2).(a) A modest change in the resident complement may be made without prior Review Committee approval if the program has the necessary resources to train the additional resident(s) without diluting the experience of those already in the program, and if the change has the approval of the designated institutional official of the sponsoring institution. A program that plans to implement such an increase should review the most recent letter of notification from the Review Committee for any citations pertaining to resources. Any such citation should be addressed prior to implementing an increase in complement. Proposed increases must be reported electronically through ADS.

II.A.4.n).(3) major changes in program structure or length of training;

II.A.4.n).(4) progress reports requested by the Review Committee;

II.A.4.n).(5) responses to all proposed adverse actions;
II.A.4.n).(6) requests for increases or any change to resident duty hours;

II.A.4.n).(7) voluntary withdrawals of ACGME-accredited programs;

II.A.4.n).(8) requests for appeal of an adverse action;

II.A.4.n).(9) appeal presentations to a Board of Appeal or the ACGME; and,

II.A.4.n).(10) proposals to ACGME for approval of innovative educational approaches.

II.A.4.o) obtain DIO review and co-signature on all program information forms, as well as any correspondence or document submitted to the ACGME that addresses:

II.A.4.o).(1) program citations, and/or

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution.

II.B. Faculty

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

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents, and

II.B.1.a).(1) In addition to the key faculty, all programs should have a minimum of one person (e.g., a senior resident, chief resident, or junior faculty) who functions as a liaison between the residents and faculty. Support, based on program size, should be as follows: fewer than 31 residents, one FTE; 31–90 residents, two FTEs and for greater than 90 residents, three full-time equivalents. These numbers reflect minimum support.

II.B.1.a).(2) A measure of the commitment of the teaching staff to the pediatrics program is the degree to which patients under their care are available for resident education.
II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas.

II.B.2. The physician faculty must have current certification in the specialty by the American Board of Pediatrics, or possess qualifications acceptable to the Review Committee.

II.B.2.a) Each time the program is evaluated by the Review Committee, it is the responsibility of the program director to provide evidence of appropriate qualifications for the teaching staff who lack Board certification (e.g. participation in national societies, evidence of ongoing scholarship through contributions to the peer-review literature, and presentations at national meetings).

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment.

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments.

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component.

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences.

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding;

II.B.5.b).(2) publication of original research or review articles in peer-reviewed journals, or chapters in textbooks;

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or,

II.B.5.b).(4) participation in national committees or educational organizations.

II.B.5.c) Faculty should encourage and support residents in scholarly activities.

II.B.6. General Pediatricians

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

II.B.7. Subspecialty Faculty

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

II.B.8. Other Faculty

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

II.B.9. Faculty Development

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

II.C. Other Program Personnel

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

II.C.1. Teaching by other health professionals such as nurses, pharmacists, social workers, child-life specialists, physical and occupational therapists,
speech and hearing pathologists, respiratory therapists, psychologists, and nutritionists is highly desirable.

II.C.2. Each residency should have a minimum of one FTE designated for administrative support. For programs of 31-60 residents, this support should be 1.5 FTE; for programs of 61-90 residents, two FTEs; and for programs of more than 90 residents, three FTEs. These positions should be financially supported by the sponsoring and/or participating sites.

II.D. Resources

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

II.D.1. Inpatient and Outpatient Facilities

II.D.1.a) The inpatient and outpatient facilities must be adequate in size and variety, and must have the appropriate equipment necessary for a broad educational experience in pediatrics.

II.D.1.b) There must be an emergency facility that is appropriately equipped and staffed for the care of pediatric patients. The program must also have an intensive care facility that is appropriately equipped and staffed for the care of a sufficient number of seriously-ill pediatric patients to provide adequate experience for the number of residents in the program.

II.D.2. Patient Population

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

II.E. Medical Information Access

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

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements.
III.B. Number of Residents

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

III.B.1. The Review Committee for Pediatrics does not approve a specific number of resident positions. At the time of program review, the Committee will judge the adequacy of the program’s resources to support the number of resident positions proposed.

III.B.2. Because peer interchange is a very important component of the learning process, each program is expected to recruit and retain a sufficient number of qualified residents to fulfill the need for peer interaction among those training in pediatrics.

III.B.3. Residents at more than one level of training must interact in the care of inpatients, allowing for frequent and meaningful discussion during all phases of the training program (e.g., neonatal, outpatient, inpatient, and emergency services). To achieve this, a program should offer a minimum total of 12 resident positions (i.e., four at each level, exclusive of subspecialty residents). Except for periods of transition, the same number of positions should be offered in each of the three years of training. An inability to recruit the required minimum number of residents and/or a high rate of resident attrition from a program over a period of years will be a cause of concern to the Review Committee. The Review Committee will consider the presence of residents from combined pediatrics programs (e.g., medicine-pediatrics or pediatrics-emergency medicine), when it evaluates the adequacy of the resident complement and of peer interaction. The total number of residents from combined programs should not be so large as to have a negative effect on the education of categorical residents.

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion.

III.D. Appointment of Fellows and Other Learners

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

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

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

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation;

IV.A.3. Regularly scheduled didactic sessions;

IV.A.3.a) Departmental conferences, including regular morbidity and mortality conferences, seminars, teaching rounds, and other structured educational experiences must be conducted on a regular basis and with sufficient frequency to fulfill educational goals.

IV.A.3.b) Reasonable requirements for resident attendance should be established for the various conferences; their attendance should be documented, and there must be appropriate faculty participation.

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and,

IV.A.5. ACGME Competencies

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

IV.A.5.a) Patient Care

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

IV.A.5.a).(1) must be able to provide family-centered patient care that is culturally effective and developmentally and age appropriate;

IV.A.5.a).(2) must be exposed to sufficient numbers of patients ranging in age from infancy through young adulthood, and
representing a diverse population of varying complexity in various clinical settings. The resident must have breadth and depth of inpatient experience in the format determined by the Review Committee. A minimum of 40% of clinical training should be devoted to ambulatory experiences. These experiences include all assignments in the continuity practice, emergency and acute care, and community-based practices, as well as the ambulatory portion of normal/term newborn, developmental/behavioral, adolescent medicine, and other subspecialty experiences;

IV.A.5.a).(3) must be given progressive responsibility under close faculty supervision within a team that fosters peer and supervisory interchange. The availability of consultative resources appropriate to the patient base must be ensured, while allowing residents to participate in the full spectrum of patient care from admission through discharge in the inpatient setting, and from intake through follow-up in the outpatient setting;

IV.A.5.a).(4) must have a satisfactory patient care experience that includes: sufficient numbers of patients, diversity of diagnoses, and acuity/complexity of the patients. Faculty must document the fact that residents possess the necessary knowledge, skills, and attitudes to provide longitudinal primary care to patients;

IV.A.5.a).(5) should demonstrate competence in the following elements of patient care:

IV.A.5.a).(5).(a) gathering essential and accurate information about the patient;

IV.A.5.a).(5).(b) interviewing patients/families about the particulars of the medical condition for which they seek care, with specific attention to behavioral, psychosocial, environmental, and family unit correlates of disease;

IV.A.5.a).(5).(c) performing complete and accurate physical examinations. Residents must be evaluated performing histories and physical examinations. This must be accomplished through direct observation using a structured approach with different evaluators in different settings.

IV.A.5.a).(5).(d) making informed diagnostic and therapeutic decisions;

IV.A.5.a).(5).(e) developing and carrying out management plans;
Residents must have the opportunity for independent evaluation, management, and coordination of care under the guidance of faculty. Residents must demonstrate progressive autonomy over the course of training that affords them the ability to act in a supervisory role under faculty guidance. A minimum of five supervisory months is required during the last 24 months of training.

Supervising residents/faculty must document the residents’ ability to make diagnostic and therapeutic decisions based on best evidence and to develop and carry out management plans. This may be accomplished through direct observation in the clinical setting supplemented by one of the following: chart reviews or chart stimulated recall; faculty review of completed case-based modules; an observed structured clinical encounter; or some combination of these or other methods.

Residents should participate in the following:

- Independent evaluation and development of a differential diagnosis, diagnostic work-up, therapeutic management, coordination of care, and discharge planning under faculty guidance;
- Diagnosis and management of acute episodic medical illness, such as meningitis, sepsis, dehydration, pneumonia, diarrhea, renal failure, seizures, coma, hypotension, hypertension, and respiratory illnesses;
- Diagnosis and management of acute problems associated with chronic diseases, such as diabetic ketoacidosis, status asthmaticus, status epilepticus, oncologic therapy and complications, congenital heart disease, cystic fibrosis, chronic renal disease, gastrointestinal disorders,
hepatic failure, metabolic disorders, neurologic disorders, and rheumatologic disorders;

IV.A.5.a).(5).(e).(iii).(d) pediatric aspects of the management of surgical patients, both preoperatively and postoperatively, including interaction with the surgical team.

IV.A.5.a).(5).(e).(iv) In addition to the above, each resident should demonstrate the following:

IV.A.5.a).(5).(e).(iv).(a) the ability to determine which patients require in-hospital care and why, including medical, psychosocial, and environmental considerations;

IV.A.5.a).(5).(e).(iv).(b) the skills in deciding which patients may be managed on a general inpatient service and which require higher levels of care and expertise in a critical care unit;

IV.A.5.a).(5).(e).(iv).(c) the ability to select and interpret appropriate studies in the evaluation of patients;

IV.A.5.a).(5).(e).(iv).(d) the ability to utilize best evidence to determine therapeutic management; and,

IV.A.5.a).(5).(e).(iv).(e) the appropriate use of consultants.

IV.A.5.a).(5).(f) prescribing and performing all medical procedures;

IV.A.5.a).(5).(f).(i) These educational experiences should be graduated so that residents build and maintain skills throughout the training program. Residents should be supervised until they can demonstrate the necessary skill for independent practice.

IV.A.5.a).(5).(f).(ii) The program must document instruction in the performance of procedures including indications, contraindications, and complications. As part of procedural competence, residents must be able to obtain informed consent and address the pain that is associated with procedures.
Residents must use the on-line log provided by the ACGME to record their procedures. The program director must have documentation showing the competence of each resident for each procedure. The program must also document that residents have completed training in both Pediatric Advanced Life Support and the Neonatal Resuscitation Program.

IV.A.5.a).(5).(f).(iii) Residents must have sufficient training in the following skills:

- basic and advanced life support;
- endotracheal intubation;
- placement of intravenous lines (demonstration in a skills lab or PALS course is sufficient);
- arterial puncture;
- venipuncture;
- umbilical artery and vein catheterization;
- lumbar puncture;
- bladder catheterization;
- gynecologic evaluation of prepubertal and postpubertal females;
- wound care and suturing of lacerations;
- subcutaneous, intradermal, and intramuscular injections;
- developmental screening test;
- procedural sedation;
- pain management; and,
reduction and splinting of simple dislocations/fractures.

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

- circumcision;
- tympanometry and audiometry interpretation;
- vision screening;
- hearing screening;
- simple removal of foreign bodies (e.g., from ears or nose);
- inhalation medications;
- incision and drainage of superficial abscesses;
- chest tube placement; and,
- thoracentesis.

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

providing effective health maintenance and anticipatory guidance;

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

Residents must be able to:

- develop therapeutic relationships with patients and families;
- coordinate the care of children with complex and multiple problems;
- provide child health supervision with an emphasis on age and
provide anticipatory guidance regarding developmental issues and preventive health care;

IV.A.5.a).(5).(h).(ii).(e) implement age-appropriate screening, including oral health;

IV.A.5.a).(5).(h).(ii).(f) manage patients with chronic disease by coordinating the care rendered by other health care providers.

IV.A.5.a).(5).(i) using information technology to optimize patient care.

IV.A.5.b) Medical Knowledge

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

IV.A.5.b).(1) must demonstrate sufficient knowledge of the basic and clinically supportive sciences appropriate to pediatrics.

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

IV.A.5.b).(1).(a).(i) Resident experience on the inpatient service must be for a minimum of five months. A variety of patient experiences will meet this requirement, including general pediatric patients, mixed non-intensive care subspecialty patients, or a single group of non-intensive care subspecialty patients. No more than one of the five required months may be devoted to the care of patients in a single subspecialty. The patient population available for resident education on the inpatient service must be of sufficient number, age distribution, and variety of complex and diverse pathology.

IV.A.5.b).(1).(a).(ii) Residents at more than one level of training must interact in the care of inpatients. A first-year resident should have direct responsibility for an average daily minimum of five inpatients. If the minimum number of patients is not met, resident inpatient logs
will be required to attest to the adequacy of the experience.

IV.A.5.b).(1).(a).(iii) Residents on the inpatient service must be supervised by pediatric faculty who have extensive experience in and knowledge of the care of pediatric patients with illnesses of sufficient severity to warrant hospitalization. The utilization of general pediatricians in this role is encouraged, provided that consultative services from pediatric subspecialists and other specialists appropriate to the patient population are readily available.

IV.A.5.b).(1).(a).(iv) Regularly-scheduled teaching rounds must be conducted by qualified generalists and subspecialists who are directly involved in patient care. These rounds must be held at least three times per week, and may not be replaced by rounds that are primarily work oriented. Rounds should be targeted to the knowledge and skills required of a general pediatrician, and should emphasize the appropriate utilization of subspecialist colleagues. The correlation of the pathophysiologic basis of the disease process should be stressed. During ward rotations, there must be teaching rounds that are patient based, and that address such areas as interpretation of clinical data, pathophysiology, differential diagnosis, cost-effective management of the patient, and the appropriate use of technology and disease prevention.

IV.A.5.b).(1).(a).(v) *In-house call or night call* is defined as those duty hours beyond the normal workday when residents are required to be available on site in the assigned hospital. In addition to providing patient care, the purposes of night call include the following: 1) learning the evolution of disease though continuity of patient care over an extended period of time; 2) cumulative acquisition and maintenance of skills; and 3) fostering progressive independent decision-making. A night-float system may be used. *Night-float* is defined as those duty hours restricted to evening and overnight hours in a block format when residents are required
to be present in the assigned institution. During a night-float rotation, residents do not typically have daytime responsibilities. Structured night-float rotations for which there are formal goals, objectives, and a specific evaluation component, and which provide an educational experience (i.e., both rounds and conferences with faculty), may count for 1 of the 5 required months of non-intensive care inpatient experience.

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

Residents must have a minimum of four months experience in emergency and acute illness. Two of these months should be in emergency medicine, of which the equivalent of one month may be completed longitudinally. At least one of these months must be a block rotation in an emergency department that serves as the receiving point for EMS transport and ambulance traffic and which is the access point for seriously-injured and acutely-ill pediatric patients. This may be either a pediatric emergency department or a combined pediatric/adult emergency department. Assignment to an acute care center or walk-in clinic to which patients are triaged from the emergency department will not fulfill this requirement.

The remaining two months of required experience may be in the emergency department or, if patients are available in sufficient numbers, in another setting where acutely-ill pediatric patients are seen. Optional sites may include walk-in clinics or acute care centers. Preferably, this experience should be a block rotation, but integration into other longitudinal experiences is acceptable if the required duration and the educational goals and objectives can be both met and documented, with appropriate supervision ensured.

The experience must be designed to develop resident competence in managing unselected and unscheduled patients with acute illness and injury of varying degrees.
of severity, from very minor to life-threatening.

IV.A.5.b).(1).(b).(iv) Specific objectives of this experience must include, but not be limited to, the development of skills in the following: resuscitation, stabilization, and triage of patients after initial evaluation; interaction with other professionals involved in emergency care in the emergency department, including the trauma team and emergency physicians; specialists in surgery, anesthesia, radiology, relevant pediatric and surgical subspecialties; dentists and others as appropriate. There must also be interaction with emergency medical personnel in the provision of pre-hospital care for acutely-ill or -injured patients, which includes either preparation of patients for transport or receipt of patients who have been transported via the EMS system.

IV.A.5.b).(1).(b).(v) Residents must have first-contact evaluation of pediatric patients and continuous on-site supervision. It is not an adequate educational experience if the pediatric resident functions only on a consultative basis or deals only with a pre-selected patient population. Residents in these settings must have on-site supervision by board-certified emergency medicine specialists with expertise in the care of pediatric patients, or by members of the pediatric teaching staff who have documented experience in the care of acute pediatric illnesses and injuries.

IV.A.5.b).(1).(b).(vi) Residents should have the opportunity to work on a multidisciplinary clinical team to learn the role of the general pediatrician in such a setting. A system for patient outcome feedback to the resident should be established. A resident’s performance must be evaluated on a regular basis by staff directly involved in the acute and emergency care experience, and appropriate feedback must be provided to the resident and to the program director.
The residents' major responsibility must be for an appropriate range of pediatric patients, although they may be called on to care for some adult patients to ensure adequate volume and diversity. Programs that share the emergency and acutely-ill patient base with other training programs, such as emergency medicine, pediatric emergency medicine, and family medicine, must document that a sufficient and appropriately-diverse pediatric patient population is available to the pediatric residency program.

The comprehensive experience for all residents should include, but not be limited to, the following disorders, and should emphasize the pathophysiologic correlates of the clinical situations:

- **IV.A.5.b).(1).(b).(viii).(a)** acute major and minor medical problems, including but not limited to respiratory infection, respiratory failure, cardiopulmonary arrest, dehydration, coma, seizures, diabetic ketoacidosis, asthma, skin disorders, pyelonephritis, sepsis, shock, fever, and childhood exanthems;

- **IV.A.5.b).(1).(b).(viii).(b)** acute manifestations or exacerbations of chronic diseases;

- **IV.A.5.b).(1).(b).(viii).(c)** acute major and minor surgical problems, including but not limited to appendicitis, bowel obstruction, burns, foreign body inhalation and ingestion, abscess drainage, and head trauma;

- **IV.A.5.b).(1).(b).(viii).(d)** poisonings and ingestion;

- **IV.A.5.b).(1).(b).(viii).(e)** physical and sexual abuse;

- **IV.A.5.b).(1).(b).(viii).(f)** minor trauma (including splinting, casting, and suturing);

- **IV.A.5.b).(1).(b).(viii).(g)** major trauma (including active participation with the trauma team);
participation in pre-hospital management and transport;

acute psychiatric, behavioral, and psychosocial problems; and,

admission or discharge planning, including communication with the personal physician.

Continuity Experience

A program must document one half-day session per week for a minimum of 36 clinic weeks per year throughout the three years of training for each resident. The program must provide adequate continuity experience for all residents to allow them the opportunity to develop an understanding of and appreciation for the longitudinal nature of general pediatric care including: aspects of physical and emotional growth and development; health promotion and disease prevention; management of acute, chronic, and end-of-life medical conditions; family and environmental impacts; coordination of patient-centered care both within the practice and with multidisciplinary providers; and practice management. The scope of each resident's continuity clinic patient population must be documented with a log that includes age, diagnoses, and encounter dates.

Residents must be exposed to a continuity-patient population sufficient in number and of adequate variety to meet the educational objectives. It must include well patients and those with complex and chronic problems. Patients initially managed in the normal newborn nursery, emergency department, inpatient service, intensive care unit (pediatric and neonatal), subspecialty clinics, and other sites may be enrolled in the residents' panels. Inherent in the principle of continuity of care is that patients are seen on a regular and continuing basis. Isolated block experiences alone will not satisfy this requirement. Ideally, residents should participate in the care of their patients through any hospitalization, assess
them during acute illnesses, and be available to facilitate other services, such as school-related evaluations and specialty referrals.

IV.A.5.b).(1).(c).(iii) Residents must see progressive numbers of continuity patients, with a minimum of three patients per session in PGY-1, four in PGY-2, and five in PGY-3. Where residents participate in more than one half-day of continuity clinic per week (i.e., two sessions in same setting or one session in each of two settings), the total number of patients seen per week of clinic may be substituted for the number seen per session.

IV.A.5.b).(1).(c).(iv) The curriculum should emphasize the generalist approach to common office-based pediatric issues, including anticipatory guidance, developmental and behavioral issues, and immunization practices and health promotion, as well as the care of children with chronic conditions. Residents must learn to serve as the coordinator of comprehensive primary care for children with complex and multiple health-related problems, and to function as part of a health-care team. Subspecialty consultants and allied health personnel must be available to residents in the care of their continuity patients.

IV.A.5.b).(1).(c).(v) Residents must assume responsibility for the continuing care of a group of patients throughout their training, either as an individual practitioner or as a team member. In an effort to foster a continuity experience that emulates a pediatric practice setting, the concept of group or team practice will be supported. If a team practice is implemented, there must be a regular and formal mechanism for sharing information among the team members.

IV.A.5.b).(1).(c).(vi) Regardless of the setting, there should be a continuity relationship among the resident(s), preceptor(s), and a group of patients. To enhance the communication that is essential to continuity of experience, team size should not be excessive, and must include a preceptor or a small group of
preceptors to enhance the resident-preceptor relationship. Consistency of preceptors over time is desirable.

IV.A.5.b).(1).(c).(vi).(a) The preceptors’ responsibilities include, but are not limited to, mentoring the residents in communication skills, quality improvement skills, practice management system complexities, and patient advocacy (refer to competencies in Practice-Based Learning and Improvement and Systems-Based Practice).

IV.A.5.b).(1).(c).(vi).(b) The number of teaching staff in the continuity clinic must be sufficient to ensure an appropriate educational experience for all residents present. Teaching staff who serve as attendings in the continuity clinic must have expertise in the area of general pediatrics, and must be able to function as role models in general pediatrics. They must be actively involved in direct patient care to maintain their expertise and credibility.

IV.A.5.b).(1).(d) Normal/Term Newborn Experience

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

IV.A.5.b).(1).(d).(i) recognition and appropriate intervention for high-risk infants;

IV.A.5.b).(1).(d).(ii) distinguishing well from ill infants;
IV.A.5.b).(1).(d).(iii) performance of a physical examination on newborn infants, which includes assessment of gestational age and the appropriateness of intrauterine growth;

IV.A.5.b).(1).(d).(iv) identification of common anomalies, birth defects, and syndromes, including counseling the parents;

IV.A.5.b).(1).(d).(v) provision of routine newborn care;

IV.A.5.b).(1).(d).(vi) recognition and treatment of common physiologic deviations in the newborn;

IV.A.5.b).(1).(d).(vii) identification and management of infants of mothers with substance abuse and/or sexually transmitted diseases (STDs) or other infections;

IV.A.5.b).(1).(d).(viii) routine newborn screening and appropriate follow-up of infants with positive test results;

IV.A.5.b).(1).(d).(ix) preventive measures, including immunization schedules and safety issues, such as counseling parents on the importance of infant safety seats and knowledge of normal infant nutrition, including breast feeding and knowledge of normal newborn growth and development; and,

IV.A.5.b).(1).(d).(x) discharge planning.

IV.A.5.b).(1).(e) Community and Child Advocacy Experiences

IV.A.5.b).(1).(e).(i) Residents must be provided structured educational experiences, with planned didactic and experiential opportunities for learning and methods of evaluation, which prepare them for the role of advocate for the health of children within the community. These experiences should include both didactic and experiential components that may be integrated into other parts of the curriculum (e.g., continuity, adolescent, behavior/development) or they may be designed as distinct longitudinal or block rotations.

IV.A.5.b).(1).(e).(ii) Residents must be supervised by pediatricians and other health professionals
The curriculum should include, but not be limited to, the following subjects:

IV.A.5.b).(1).(e).(ii).(a) community-oriented care with focus on the health needs of all children within a community, particularly underserved populations;

IV.A.5.b).(1).(e).(ii).(b) culturally-effective health care;

IV.A.5.b).(1).(e).(ii).(c) effects on child health of common environmental toxins, such as lead, and also of potential agents used in bioterrorism;

IV.A.5.b).(1).(e).(ii).(d) the role of the pediatrician as a consultant to schools, in early childhood education and in child care settings;

IV.A.5.b).(1).(e).(ii).(e) the role of the pediatrician in child advocacy, including the legislative process;

IV.A.5.b).(1).(e).(ii).(f) the role of the pediatrician in disease and injury prevention; and,

IV.A.5.b).(1).(e).(ii).(g) the role of the pediatricians in the regional emergency medical system for children, as well as their role in handling mass casualties.

These experiences should utilize settings within the community, such as community-based primary care practice settings; community health resources and organizations, including governmental and voluntary agencies (e.g., local and state public health departments, services for children with disabilities and special health care needs, Head Start, schools, including elementary school through college, day care settings, home health services, hospice, facilities
for incarcerated youth, and facilities for treatment and management of substance abuse).

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

**IV.A.5.b).(1).(f).(i)** The curriculum must be designed to teach each resident the knowledge and skills appropriate for a general pediatrician, including the management of psychosocial problems that affect children with complex chronic disorders and their families. The experiences should include appropriate reading assignments, subspecialty conferences, and other activities that familiarize the residents with the techniques and skills used by the subspecialists.

**IV.A.5.b).(1).(f).(ii)** Although it is not possible for each resident to have a formal rotation through every subspecialty, it is required that all residents be exposed to the specialized knowledge and methods of the pediatric subspecialties through longitudinal experiences on the general inpatient and intensive care services and in outpatient settings. Residents should be taught when to seek consultation, when to refer to the subspecialist, and how to manage chronic illness as a team member with the subspecialist and other allied health professionals.

**IV.A.5.b).(1).(f).(iii)** All of the formal subspecialty rotations must involve an adequate number, variety, and complexity of patients to provide each resident with an appropriately broad experience in the subspecialty.

**IV.A.5.b).(1).(f).(iv)** During these rotations, residents must be given appropriate patient care responsibilities with an opportunity to evaluate and formulate management plans for subspecialty patients. In the outpatient subspecialty clinics and with appropriate supervision by a subspecialist, residents should function as the physician of first contact.
IV.A.5.b).(1).(f).(v) Pediatric subspecialty faculty must be directly involved in the supervision of residents, and be readily available for consultation on a continuing basis.

IV.A.5.b).(1).(f).(vi) Intensive Care Experience (NICU and PICU)

IV.A.5.b).(1).(f).(vi).(a) The intensive care experiences must provide the opportunity for residents to deal with the special needs of critically-ill patients and their families. The intensive care experience must be for a minimum of five and a maximum of six months.

IV.A.5.b).(1).(f).(vi).(b) This must include a minimum of three and a maximum of four block months of neonatal intensive care (Level II or III) and two block months of pediatric intensive care. Night and weekend responsibilities when the residents are predominantly responsible for the NICU are included in the allowable maximum intensive care experience, with 200 hours being considered the equivalent of one month. However, when a resident is covering the entire inpatient service, including neonatal intensive care or the delivery room, these hours need not be included in the calculation of time in intensive care. Hours covering the PICU are not included in calculation of time in intensive care.

IV.A.5.b).(1).(f).(vi).(c) To provide additional experience for those who may need it for future practice, one additional elective block month in critical care may be allowed. As is the case with any block month, it may include call. For a program that trains pediatricians to practice in non-urban areas that require the primary care pediatrician to resuscitate critically-ill infants and children, the program may petition the Review Committee for approval to offer additional critical care.
experience, providing appropriate justification.

IV.A.5.b).(1).(f).(vi).(d) The curricula in neonatal and pediatric intensive care must be structured to familiarize residents with the special multidisciplinary and multiorgan implications of fluid, electrolyte, and metabolic disorders; trauma, nutrition, and cardiorespiratory management; infection control; and recognition and management of congenital anomalies in pediatric patients. It also must be designed to teach the following:

IV.A.5.b).(1).(f).(vi).(d).(i) recognition and management of isolated and multi-organ system failure and assessment of its reversibility;

IV.A.5.b).(1).(f).(vi).(d).(ii) understanding of the variations in organ system dysfunction by age of patient;

IV.A.5.b).(1).(f).(vi).(d).(iii) integration of clinical assessment and laboratory data to formulate management and therapeutic plans for critically ill patients;

IV.A.5.b).(1).(f).(vi).(d).(iv) invasive and noninvasive techniques for monitoring and supporting pulmonary, cardiovascular, cerebral, and metabolic functions;

IV.A.5.b).(1).(f).(vi).(d).(v) participation in decision making in the admitting, discharge, and transfer of patients in the intensive care units;

IV.A.5.b).(1).(f).(vi).(d).(vi) resuscitation, stabilization, and transportation of patients to the ICUs and within the hospital;
understanding of the appropriate roles of the generalist pediatrician and the intensivist/ neonatologist in these settings;

participation in preoperative and postoperative management of surgical patients, including understanding the appropriate roles of the general pediatric practitioner and the intensivist in this setting;

participation, during the neonatal intensive care experience, in perinatal diagnostic and management discussions;

resuscitation and care of newborns in the delivery room; and,

evaluation and management, during the pediatric intensive care experience, of patients following traumatic injury.

Adolescent Medicine

Residents must receive an experience in adolescent medicine that will enable them to recognize normal and abnormal growth and development in adolescent patients. The experience must include, as a minimum, a one month block rotation to ensure a focused experience in the area of adolescent medicine. This experience must be supervised by faculty qualified to teach adolescent medicine.

Residents must receive an integrated experience in this area that incorporates adolescent issues into ambulatory and inpatient experiences throughout the three
Residents must receive instruction and experience in the following:

- **Normal pubertal growth and development** and the associated physiologic and anatomic changes.

- **Health promotion, disease prevention, and anticipatory guidance** of adolescents.

- **Common adolescent health problems**, including chronic illness, sports-related issues, motor vehicle safety, and the effects of violence in conflict resolution.

- **Interviewing the adolescent patient** with attention to confidentiality, consent, and cultural background.

- **Psychosocial issues**, such as peer and family relations, depression, eating disorders, substance abuse, suicide, and school performance.

- **Male and female reproductive health**, including sexuality, pregnancy, contraception, and STDs.

Developemental/Behavioral Pediatrics

Residents must have an adequate experience in developmental/behavioral pediatrics to ensure that the resident recognizes normal and abnormal behavior, and understands child development from infancy through young adulthood. The experience must include, as a minimum, a one-
month block rotation that is a focused experience in behavioral/developmental pediatrics. The experience must be supervised by faculty qualified to teach developmental/behavioral pediatrics.

IV.A.5.b).(1).(f).(viii).(b) Residents must receive instruction in the intrinsic and extrinsic factors that influence behavior to enable them to differentiate behavior that can and should be managed by the general pediatrician from behavior that warrants referral to other specialists. Clinical and didactic components of behavioral, psychosocial, and developmental pediatrics should be integrated, when possible, into the general educational program and into each patient encounter.

IV.A.5.b).(1).(f).(viii).(c) Residents must have an integrated experience that incorporates behavioral and developmental issues into ambulatory and inpatient experiences throughout the three years (e.g., inpatient unit, community setting, continuity clinic, and subspecialty rotations).

IV.A.5.b).(1).(f).(viii).(d) The program must include instruction in at least the following components to enable the residents to develop appropriate skills:

IV.A.5.b).(1).(f).(viii).(d).(i) normal and abnormal child behavior and development, including cognitive, language, motor, social, and emotional components;

IV.A.5.b).(1).(f).(viii).(d).(ii) family structure, adoption, and foster care;

IV.A.5.b).(1).(f).(viii).(d).(iii) interviewing parents and children;

IV.A.5.b).(1).(f).(viii).(d).(iv) psychosocial and developmental screening techniques;
behavioral counseling and referral;

management strategies for children with developmental disabilities or special needs, within the context of the medical home;

needs of children at risk (e.g., those in poverty, from fragmented or substance abusing families, or victims of child abuse/neglect);

impact of chronic diseases, terminal conditions, and death on patients and their families; and,

recognition and coordinating care for childhood and adolescent mental health problems that require referral for diagnosis and treatment.

Additional Required Subspecialty Experience

Excluding the adolescent medicine, developmental/behavioral, and intensive care experiences (both NICU and PICU), residents must commit to at least seven months in subspecialty rotations, four of which must be taken at the primary teaching site and/or integrated hospitals.

Within these seven months, each resident must complete a minimum of four different one-month block rotations taken from the following list of pediatric subspecialties or closely allied specialties:

- Allergy/Immunology
- Cardiology
- Endocrinology
- Genetics
- Gastroenterology
For the four required block months in different subspecialties from the above list, the inpatient/outpatient mix should reflect the standard of practice for the subspecialty.

The additional three months may consist of single subspecialties or combinations of specialties from either the list above or the list below. Combinations of subspecialties may be structured as block or longitudinal experiences and, where appropriate, may be combinations of inpatient and outpatient experiences or all outpatient.

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

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

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

IV.A.5.b).(2) must have didactic experiences to critically evaluate and apply current medical information and scientific evidence for patient care.

IV.A.5.b).(2).(a) Faculty must document a resident’s ability to access, appraise, and apply knowledge from the medical literature. Faculty evaluations must address the ability of residents to apply best medical evidence to the care of patients. Evaluation must be based on direct observation and precepting in a clinical setting.

IV.A.5.b).(2).(b) In addition, the program must evaluate the competence of residents in performing an evidence-based exercise. This exercise may include, but is not limited to, a journal club presentation or other structured exercise in which best evidence is applied to a focused clinical question. The evaluation should be based on predetermined criteria.

IV.A.5.c) Practice-based Learning and Improvement

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

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one’s knowledge and expertise;

IV.A.5.c).(2) set learning and improvement goals;

IV.A.5.c).(3) identify and perform appropriate learning activities;

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;

IV.A.5.c).(4).(a) Residents are expected to participate in a quality improvement project.
IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice;

IV.A.5.c).(5).(a) Residents are expected to use evaluations of performance provided by peers, patients, superiors and junior colleagues to improve practice.

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems;

IV.A.5.c).(7) use information technology to optimize learning; and,

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals.

IV.A.5.c).(8).(a) This should be documented by evaluations of residents’ teaching abilities by faculty and/or learners.

IV.A.5.c).(9) take primary responsibility for lifelong learning to improve knowledge, skills, and practice performance through familiarity with general and rotation specific goals and objectives and attendance at conferences;

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

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

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

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.5.d).(1).(a) Residents are also expected to communicate in a developmentally appropriate manner in creating and sustaining such therapeutic relationships.

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies;

IV.A.5.d).(3) work effectively as a member or leader of a health care
team or other professional group;

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and,

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable.

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

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

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

IV.A.5.e) Professionalism

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

IV.A.5.e).(1) compassion, integrity, and respect for others;

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest;

IV.A.5.e).(3) respect for patient privacy and autonomy;

IV.A.5.e).(4) accountability to patients, society and the profession; and,

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

IV.A.5.e).(6) high standards of ethical behavior which includes maintaining appropriate professional boundaries.
The program must document teaching of this competency. This may consist of, but is not limited to, traditional lectures, case-based teaching modules, discussion of vignettes, or role playing exercises that address aspects of ethical and professional behavior.

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

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

IV.A.5.f) Systems-based Practice

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

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

IV.A.5.f).(1).(a) Residents are expected to know how types of medical practice and delivery systems differ from one another, including methods of controlling healthcare cost, assuring quality, and allocating resources.

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems;

IV.A.5.f).(5) work in interprofessional teams to enhance patient safety and improve patient care quality; and,

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions.
IV.A.5.f).(7) know how to advocate for the promotion of health and the prevention of disease and injury in populations;

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

IV.A.5.f).(7).(a) patient advocacy within the system (understanding the epidemiology of major health problems and health literacy awareness in the community);

IV.A.5.f).(7).(b) risk management;

IV.A.5.f).(7).(c) cost effectiveness, balancing cost and quality;

IV.A.5.f).(7).(d) health care organization, financing, and practice management, including the organization and financing of health care services for children at the local, state, and national levels and the role of the pediatrician in the legislative process;

IV.A.5.f).(7).(e) the organization and financing of clinical practice, including personnel and business management, scheduling, billing and coding procedures, telephone and telemedicine management, and maintenance of an appropriate confidential patient record system; and,

IV.A.5.f).(7).(f) systems approach to examining health care delivery practices, system errors and system solutions to error prevention.

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

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

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

IV.B. Residents’ Scholarly Activities
IV.B.1. The curriculum must advance residents’ knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care.

IV.B.2. Residents should participate in scholarly activity.

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.

V. Evaluation

V.A. Resident Evaluation

V.A.1. Formative Evaluation

V.A.1.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment.

V.A.1.b) The program must:

V.A.1.b).(1) provide objective assessments of competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice;

V.A.1.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff);

V.A.1.b).(3) document progressive resident performance improvement appropriate to educational level; and,

V.A.1.b).(4) provide each resident with documented semiannual evaluation of performance with feedback.

V.A.1.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy.

V.A.2. Summative Evaluation

The program director must provide a summative evaluation for each resident upon completion of the program. This evaluation must become part of the resident’s permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy. This evaluation must:

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

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program.

V.B.2. These evaluations should include a review of the faculty’s clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities.

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents.

V.C. Program Evaluation and Improvement

V.C.1. The program must document formal, systematic evaluation of the curriculum at least annually. The program must monitor and track each of the following areas:

V.C.1.a) resident performance;

V.C.1.b) faculty development;

V.C.1.c) graduate performance, including performance of program graduates on the certification examination; and,

V.C.1.d) program quality. Specifically:

V.C.1.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and

V.C.1.d).(2) The program must use the results of residents’ assessments of the program together with other program evaluation results to improve the program.

V.C.2. If deficiencies are found, the program should prepare a written plan of action to document initiatives to improve performance in the areas listed in section V.C.1. The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes.

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

VI. Resident Duty Hours in the Learning and Working Environment

VI.A. Professionalism, Personal Responsibility, and Patient Safety

VI.A.1. Programs and sponsoring institutions must educate residents and faculty members concerning the professional responsibilities of physicians to appear for duty appropriately rested and fit to provide the services required by their patients.

VI.A.2. The program must be committed to and responsible for promoting patient safety and resident well-being in a supportive educational environment.

VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs.

VI.A.4. The learning objectives of the program must:

VI.A.4.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; and,

VI.A.4.b) not be compromised by excessive reliance on residents to fulfill non-physician service obligations.

VI.A.5. The program director and institution must ensure a culture of professionalism that supports patient safety and personal responsibility. Residents and faculty members must demonstrate an understanding and acceptance of their personal role in the following:

VI.A.5.a) assurance of the safety and welfare of patients entrusted to their care;

VI.A.5.b) provision of patient- and family-centered care;

VI.A.5.c) assurance of their fitness for duty;

VI.A.5.d) management of their time before, during, and after clinical assignments;

VI.A.5.e) recognition of impairment, including illness and fatigue, in themselves and in their peers;

VI.A.5.f) attention to lifelong learning;
VI.A.5.g) the monitoring of their patient care performance improvement indicators; and,

VI.A.5.h) honest and accurate reporting of duty hours, patient outcomes, and clinical experience data.

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

VI.B. Transitions of Care

VI.B.1. Programs must design clinical assignments to minimize the number of transitions in patient care.

VI.B.2. Sponsoring institutions and programs must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.

VI.B.3. Programs must ensure that residents are competent in communicating with team members in the hand-over process.

VI.B.4. The sponsoring institution must ensure the availability of schedules that inform all members of the health care team of attending physicians and residents currently responsible for each patient’s care.

VI.C. Alertness Management/Fatigue Mitigation

VI.C.1. The program must:

VI.C.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.C.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.C.1.c) adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back-up call schedules.

VI.C.2. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.

VI.C.3. The sponsoring institution must provide adequate sleep facilities and/or safe transportation options for residents who may be too fatigued to safely return home.
VI.D. Supervision of Residents

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

VI.D.1.a) This information should be available to residents, faculty members, and patients.

VI.D.1.b) Residents and faculty members should inform patients of their respective roles in each patient’s care.

VI.D.2. The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

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

VI.D.3. Levels of Supervision

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

VI.D.3.a) Direct Supervision – the supervising physician is physically present with the resident and patient.

VI.D.3.b) Indirect Supervision:

VI.D.3.b).(1) with direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

VI.D.3.b).(2) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
VI.D.3.c) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

VI.D.4. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

VI.D.4.a) The program director must evaluate each resident’s abilities based on specific criteria. When available, evaluation should be guided by specific national standards-based criteria.

VI.D.4.b) Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

VI.D.4.c) Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.

VI.D.5. Programs must set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

VI.D.5.a) Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

VI.D.5.a).(1) In particular, PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available.

VI.D.5.a).(2) PGY-1 residents must always be supervised either directly or indirectly with direct supervision immediately available.

VI.D.6. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

VI.E. Clinical Responsibilities

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

VI.E.1. The program director must have the authority and responsibility to set
appropriate clinical responsibilities (i.e., patient caps) for each resident based on the PGY-level, patient safety, resident education, severity and complexity of patient illness/condition, and available support services.

VI.E.2. Residents must be responsible for maintaining an appropriate patient load. Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize their educational experience.

VI.F. Teamwork

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

VI.G. Resident Duty Hours

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

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

VI.G.1.a) Duty Hour Exceptions

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

The Review Committee for Pediatrics will not consider requests for exceptions to the 80-hour limit to the residents’ work week.

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

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

VI.G.2. Moonlighting

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

VI.G.2.b) Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
VI.G.2.c) PGY-1 residents are not permitted to moonlight.

VI.G.3. Mandatory Time Free of Duty

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

VI.G.4. Maximum Duty Period Length

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

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

VI.G.4.b).(1) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.

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

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

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

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

VI.G.4.b).(3).(a).(ii) document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
VI.G.4.b).(3).(b) The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

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

VI.G.5.a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.

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

PGY-2 residents are considered to be at the intermediate level.

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

PGY-3 residents are considered to be in the final years of education.

VI.G.5.c).(1) This preparation must occur within the context of the 80-hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

VI.G.5.c).(1).(a) Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

VI.G.5.c).(1).(b) There are no circumstances under which residents may stay on duty without eight hours off.

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

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

VI.G.6.a) Residents should not have more than one consecutive week of night float and not more than four total weeks of night float per year.
VI.G.7. Maximum In-House On-Call Frequency

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

VI.G.8. At-Home Call

VI.G.8.a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

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

VI.G.8.b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

VII. Innovative Projects

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

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