

**DEPARTMENT OF NEUROLOGY RESIDENT MANUAL
ACADEMIC YEAR 2011-2012**

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I PROGRAM GOALS

- to provide a graduate medical education environment with the highest levels of integrity, compassion and intellectual stimulation
- to cultivate professionalism*, humanistic qualities, and interpersonal and communication skills* in trainees
- to ensure that resident physicians acquire the medical knowledge* and learn the skills necessary to provide effective and appropriate patient care*, and develop the habit of thoughtfully and diligently applying their knowledge and skills, so that by graduation they are ready for independent practice as general neurologists
- to provide resident physicians with an understanding of the health care system and the skills for system based practice*, specifically how to optimally utilize the system resources for the care of their patients
- to educate residents in the principles of evidence-based medicine and quality assurance so they develop a habit of practice based learning and improvement*
- to enable the trainees to become board certified in neurology, and
- to promote academic inquisitiveness, leading to a lifelong interest in understanding the nervous system and treating neurologic disorders.

* the underlined items are the 6 core areas for which ACGME requires residents achieve the competence level of a new practitioner.

Core Competencies

As defined by the ACGME and Neurology Residency Review committee (RRC) as follows, are integrated into the curriculum.

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

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.

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

- (1) identify strengths, deficiencies, and limits in one's knowledge and expertise;
- (2) set learning and improvement goals;
- (3) identify and perform appropriate learning activities;
- (4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
- (5) incorporate formative evaluation feedback into daily practice;
- (6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
- (7) use information technology to optimize learning; and,

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

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

- (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
- (2) communicate effectively with physicians, other health professionals, and health related agencies;
- (3) work effectively as a member or leader of a health care team or other professional group;
- (4) act in a consultative role to other physicians and health professionals; and,
- (5) maintain comprehensive, timely, and legible medical records, if applicable.

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

- (1) compassion, integrity, and respect for others;
- (2) responsiveness to patient needs that supersedes self interest;
- (3) respect for patient privacy and autonomy;
- (4) accountability to patients, society and the profession; and,
- (5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

f) Systems-based Practice. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:

- (1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;
- (2) coordinate patient care within the health care system relevant to their clinical specialty;
- (3) incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care as appropriate;
- (4) advocate for quality patient care and optimal patient care systems;
- (5) work in inter-professional teams to enhance patient safety and improve patient care quality; and
- (6) participate in identifying system errors and implementing potential systems solutions.

II RESIDENT PHYSICIAN RESPONSIBILITIES

Resident physicians are expected to:

- Develop a personal program of study and professional growth with guidance from the teaching staff.
- complete a internal medicine internship and 36 months of training in adult and child neurology in inpatient and outpatient settings, practicing medicine with escalating responsibility and competence.
- receive and respond to structured formative evaluations and participate in semi-annual progress reviews
- attend scheduled lectures covering basic and clinical neuroscience, neurophysiology, ethics, pathology, psychiatry, child neurology, medical systems, & professional awareness; and receive credit for at least 70% of courses (didactic program)
- prepare and deliver presentations to the department as scheduled in PGY3 (CPC conference) and PGY4 year (academic/research presentation)
- Participate in annual scheduled structured practical examinations (to fulfill ABPN requirements) and the annual national resident in-service exam (RITE)
- Read and follow the policies and procedures for the residency program (as detailed in this Handbook), especially personal behavior and absence policies.
- meet the service and education goals of each clinical rotations.
- Follow the policies and procedures required for continued employment by Parkland Hospital including required training, medical and security clearance (drug screening and background check) and timely completion of medical records.
- Participate in safe, effective, compassionate and cost-effective patient care under supervision, commensurate with their level of advancement and responsibility.
- Carry an appropriate patient load in both inpatient services and outpatient clinics.
- Attend to clinical duties (patient care, on-call responsibilities and outpatient clinics) as scheduled. When unexpected absences occur, the resident has primary responsibility for notifying the residency coordinator, chief resident, and attending staff responsible for supervising the resident in the clinical duties that will be missed. The resident should also make arrangements to ensure that all clinical responsibilities are adequately covered.
- Comply with ACGME duty hour rules
- Demonstrate a high standard of professionalism and respect at all times in interactions with patients, other physicians, nurses and ancillary health care staff.
- Participate fully in the educational activities of the program and as required, assume responsibility for teaching and supervising other residents and students.
- Take part in scholarly activity and research experiences during residency training.
- Evaluate (by anonymous survey) the program, attending physicians, clinical rotations and peers, and provide regular input and feedback to the program director.

Failure to meet these expectations will lead to remediation as described in section IX of this handbook.

Residents must complete a full year of training in order to receive any credit should they transfer to another program.

III DIDACTIC CURRICULUM

Didactic Supervisor: Dr. Shilpa Chitnis and Dr. Sri Muppidi

The didactic curriculum consists of a series of 19 courses, lasting 4 weeks each.

Introduction to neurology / basic neuroimaging *
 Emergency department neurology *
 Awareness and ethics *
 EMG and NCS *
 EEG *
 Biostatistics and Evidence-based Medicine *
 Neuropathology *
 Basic neuroscience
 Anatomy and physiology of the human nervous system
 Adult clinical neurology I: epilepsy & neuromuscular diseases
 Adult clinical neurology II: behavioral & movement disorders
 Adult clinical neurology III: neuroimmunology & neuroradiology
 Adult clinical neurology IV: vascular and headaches
 Adult clinical neurology V: oncology, sleep, metabolic, inf dis
 Child Neurology: Basic
 Child Neurology: Advanced
 Psychiatry
 Systems and practice of neurology
 Clinical neuropathophysiology

Individual lecture topics are subject to change over time. The didactic curriculum lectures take place at noon on Monday, Tuesday and Thursday (and on Wednesday during the summer. Selected courses (*) are delivered every year, while other courses are delivered twice during every 3 years (approximately once every 18 months).

Residents are expected to receive credit for all 19 courses before graduation. The minimum requirement is completion of 70% (13 courses) which should include the first 7 courses (that are provided annually). Credit and a grade are given for each course based on attendance, participation, and examination. These grades become part of the cumulative transcript of residency training. Each year, the neuroscience award and cash prize is awarded to the resident(s) with the best performance in the didactic program.

The didactic lectures are an integral part of the residency program. Attendance is required (except when on the VA or night float rotations). The attendance expectation is 50%. Urgent responsibilities to provide patient care may on occasion supercede academic activities. However, the clinical service should be organized to render this infrequent. The resident(s) should report to Dr. Vernino or Dr. Chitnis if such conflicts between clinical and academic activities arise. Additional questions about the didactic curriculum should be directed to Dr. Muppidi.

Residents must also participate regularly in departmental grand rounds (Wednesday noon), Friday conferences (Unwin conference and professor rounds). Participation in all other subspecialty conferences is encouraged whenever feasible, and it is mandatory to attend conferences related to current clinical rotations (e.g. neuromuscular conferences during the 2 months on neuromuscular rotation).

IV CLINICAL CURRICULUM

(number of blocks is approximate and will vary depending on scheduling)

<u>PGY2 year</u>	4-week blocks
PMH-ZLUH Stroke Service	4
PMH-ZLUH General Neurology	2-3
PMH Consult Service	2
VA Consult Service*	1
EMU	1
Neuro critical care	1-2
Neuropathology*	1
 <u>PGY3 year</u>	
PMH-ZLUH Stroke Service	1
Child Neurology	3
Psychiatry	1
Neuromuscular service / EMG*	2
Movement Disorders	1
EEG*	1
PMH consult or night float	1
St. Paul Consult Service*	1
Electives* (could include the following) dementia, MS, Sleep, Neuro-oncology	2
 <u>PGY4 year</u>	
PMH-ZLUH Ward senior	4
PMH consult or night float	3
VA Consult*	1
Electives*	4
St. Paul Consult Service	1

* Vacation allowed during this rotation.

If a resident scores below the 15th national percentile for their level of training (on RITE examination), he/she may forfeit a subsequent elective month. Instead, the program director will assign an appropriate rotation and study program for the month. A similar remedial month may be required for a resident who is judged to be academically “at-risk” by the faculty. Notwithstanding this, all residents will always have at least 3 months elective time, as required by the ACGME.

Lines of Responsibility for Patient Care

For the next sections, the designation of junior or senior resident refers to the role that the resident is assigned on the service. The junior resident may be a PGY2 adult neurology resident or a PGY3 child neurology resident. The senior resident may be a PGY3 or PGY4 adult neurology resident or an PGY4-5 child neurology resident. Interns are generally first year psychiatry, child neurology, PM&R or neurosurgery residents but may occasionally be higher level residents serving in the intern role.

Clinical assignments of all residents and the attending assignments are maintained on the master schedule by the chief resident. The official schedule is maintained online (New Innovations) and can be accessed by residents at any time. The program coordinator posts a current schedule on the residency bulletin board across from J3.102. This schedule along with daily call schedules are provided to the hospital for purposes of accounting and identification of call responsibilities. Changes to the schedule must be submitted to the program coordinator and/or chief resident in a timely manner to maintain an accurate current schedule. Unofficial trading of clinical duties is not permitted.

Stroke and general neurology inpatient services:

- ◆ The attending physician has final responsibility for all primary patients on the service, for recommendations made to consult patients, and for supervision of the residents and fellows. The attending is available by phone or pager 24 hours a day each day of the assigned rotation. The attending must always be notified of major changes in patient status including but not limited to death of patient, patient transfer to ICU, or changes in code status.
- ◆ The senior resident (or vascular neurology fellow for the stroke service) is the first assistant and is responsible for day-to-day operation of the service and for oversight of junior residents.
- ◆ Each junior resident assumes the primary care-giving role for their assigned patients, reporting daily to senior resident and attending physician and following their instructions.
- ◆ When an intern is assigned, he or she will have primary responsibility for assigned patients but the junior or senior neurology resident should perform a daily assessment of the patient.
- ◆ Primary and consult patients assigned to each resident and pager numbers of each team member are maintained on the service list which should be updated daily by the senior resident. Service lists contain private patient information and must be kept secure and subsequently discarded only in areas designated for patient material.
- ◆ [see also Zale admission policy, Handbook Section IX, regarding additional responsibilities]

PMH ER consult service:

- ◆ A senior resident performs most consultation evaluations for patients in ER, and can make disposition decisions before discussing the case with the supervising attending.

- ◆ Patients admitted to the inpatient neurology service remain the responsibility of the ER resident until there is a formal communication and transfer of care to the inpatient hospital team.
- ◆ The supervisors for the ER residents are the attending physicians on the stroke and consult services. The attending assumes final responsibility for the recommendations and dispositions of ER consultations performed by the resident.
- ◆ The attending physician should be contacted immediately for difficult decisions or when potentially problematic “political” interservice disagreements arise. At the end of each ER shift, all cases must be discussed with the supervisor for appropriate oversight and billing. To facilitate this supervision, the ER resident should mark all notes for cosignature and be able to discuss the cases with the attending.
- ◆ Typically, the night float ER resident will review cases with the attending on the stroke service (at 7:30 – 8 am) and the daytime ER resident will review cases with the consult attending as arranged during the day.

Neurology intensive care unit:

- ◆ The attending physician has final responsibility for all primary patients on the service, for recommendations made to consult patients, and for supervision of the residents and fellows. The attending is available by phone or pager 24 hours a day each day of the assigned rotation. The attending must always be notified of major changes in patient status including but not limited to death of patient or changes in code status.
- ◆ The neuro critical care fellow serves as first assistant to the attending and also provides supervision and guidance to the resident on service.
- ◆ Each resident assumes the primary care-giving role for their assigned patients, reporting daily to attending physician and following their instructions.

Continuity clinic:

- ◆ The responsibility for the care of each patient becomes that of the supervising attending on the day the clinic visit occurs. Responsibility passes to a different attending when that person supervises clinic on a day the patient returns.
- ◆ The attending is expected to personally evaluate all patients with complex or evolving neurological issues.
- ◆ Because the resident usually has more familiarity with the patient, and may be continuing a care plan initiated under direction of a previous supervising attending, and because the continuity clinic is intended to promote longitudinal management of patients by residents in simulation of the independent management of patients, the attending should acquiesce to the residents plan of care whenever it is reasonable and safe.

VA Service:

- ◆ The attending physician has ultimate responsibility for all patients evaluated by neurology. The attending must always be notified of major changes in patient status.
- ◆ Junior and senior resident each attend to approximately equal numbers of patients, and report to the attending daily.
- ◆ The pager numbers and dates of VA service of attendings and residents are to be distributed to all attendings and residents each month.

- ◆ The resident continuity clinics should be scheduled to minimize the interruption of patient care activities at the VA.

Epilepsy monitoring unit (EMU):

- ◆ The attending has ultimate responsibility for all patients admitted to the EMU service. The junior resident is responsible for delegated duties, and reports daily to the attending. An intern, when present, aids the resident.
- ◆ The attending also has final responsibility for the reports on electroencephalogram, sleep studies and prolonged EEG monitoring studies interpreted by the residents and fellows.

St. Paul Consult service:

- ◆ The attending has final responsibility for all consultation recommendations. The resident is responsible for initial evaluation, daily monitoring and daily reporting to the attending.
- ◆ At night, the resident may perform consultation and provide recommendations but must review all these activities with the attending as soon as possible.

Children's hospital service:

- ◆ The attending has ultimate responsibility for the service's recommendations regarding all patients. Each resident is delegated to take care of a subset of the patients and to report daily to the attending.

Clinical electives, and outpatient services:

- ◆ The faculty member has ultimate responsibility for all patients managed. The faculty member can delegate to the resident those history-taking, examination, ordering and documentation tasks according to the resident's level of proficiency.

Continuity clinic

An important part of training in the outpatient setting is the management of patients over time. The continuity clinic allows an opportunity to learn the provision of outpatient consultation, to follow the progression of neurological disease over time and to evaluate the response to treatment. Patients assigned to the resident should receive care from the same resident over time for as long as possible. Phone calls, prescription requests and other issues between appointments should be handled by the patient's resident physician (under supervision by the assigned attending).

The continuity clinic at Parkland hospital takes place on Monday – Thursday afternoons and on Tuesday, Thursday and Friday mornings. Each resident will have one half-day session every week (except during vacation and neuro ICU rotations). Residents on elective rotations may have two half day clinics per week. The schedule is designed so that continuity clinic does not fall on a call or post-call day. The clinic assignments are set 3 months in advance. See section on vacation and absence policies for rules on canceling or rescheduling clinics.

The faculty to resident ratio should not exceed one faculty supervising 4 residents. The resident must discuss every case with the supervising faculty. Whenever safe and appropriate, the plan of care devised by the resident will be followed, and senior residents should accept increasing responsibility so that they are prepared to provide independent outpatient neurology care at the completion of training. The faculty will ensure the educational value of the clinic and ensure the high quality care of patients.

A nurse practitioner in the Parkland clinic is available to assist with follow-up appointments and medication refills if the resident is not readily available.

Requests for urgent neurology appointments (overbooking)

Demand for outpatient neurology services exceeds capacity. Therefore, requests for new neurology consultations are carefully screened in the patient access center. When accepted, new appointments may be scheduled months in the future. There are often instances when a more urgent appointment is needed. Also, there is a large waiting list for follow-up appointments in the residents' clinics. To provide optimum patient care and maintain availability, the resident must follow certain procedures and take charge of his/her clinic scheduling. The most important feature is communication with the clinic scheduling personnel. For each patient, scheduling instructions must be sent by email to both Loretta Hendrix and Dinah Chu. Use a subject line "Neurology scheduling".

1) Hospital follow-ups – At the time of discharge, send an email indicated the resident that will follow the patient at the time to book (or overbook) the patient. If the resident does not have a continuity clinic at Parkland, the patient may be given an appointment with the nurse practitioner.

2) Urgent appointments – There are urgent neurology appointments available throughout the week. If there is a patient in the ER or a physician phone call regarding an urgent appointment, the resident that approves the urgent visit must send an email authorizing the patient to be added to an urgent clinic appointment.

V SCHOLARLY ACTIVITY

“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. Residents should participate in scholarly activity. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities.”..... From the ACGME Neurology RRC.

Each resident must engage in scholarly activities during their training.

- a) Attendance and participation in didactic presentations related to research design and methods (i.e. evidence-based medicine course and journal club sessions).
- b) individual participation in a research project under the supervision of a neurology faculty member(s). Each year, a list of potential projects will be available to the residents. These could include any of the following or other project types:
 - well-developed case report with scholarly review of the literature that contributes novel or unique aspects
 - retrospective case series
 - prospective case studies
 - basic science or clinical laboratory project

All projects must be performed under the direct supervision of a faculty member (the faculty will have ultimate responsibility for the appropriate conduct of the study and make final decisions on the presentation of data). The project must follow appropriate ethical and scientific standards. Where indicated, submission and approval of IRB or IACUC protocols is required prior to starting the project.

- c) Residents must prepare a 30 to 60-minute presentation to the department describing the conduct and results of their research. Presentation at a national academic meeting is encouraged but not required.
- d) Residents may use elective time in research activities. These blocks must be approved by the program director and the supervising research faculty. An evaluation of the resident’s performance during the research month must be submitted at the end of the rotation.
- e) Except for residents on a defined research track, more than 2 blocks of research time is discouraged but can be approved by the program director in advance for special circumstances.
- f) Additional research opportunities are available (e.g. fellowships, physician-scientist training program) for qualified residents. However, research activities during the residency training period should be limited in scope so as not to interfere with training in clinical neurology.

VI FEEDBACK AND EVALUATION

Evaluation of residents

From the ACGME Neurology RRC:

- ◆ “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.”
- ◆ “The program must provide objective assessments of the core competencies using multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff), document progressive resident performance improvement appropriate to educational level; and provide each resident with documented semiannual evaluation of performance with feedback.”
- ◆ “The evaluations of resident performance must be accessible for review by the resident.”

1. Evaluation of patient care, interpersonal, communication and professional qualities (core competencies):
 - a) At the end of each clinical rotation, the attending is sent an evaluation for each resident assigned. Residents are graded on academic and service goals specific to the rotation and specific to their level of training. These goals are listed in the Section XII of this handbook. Faculty evaluations are not anonymous. A 9 point Likert scale is used.
 - b) Attendings should provide verbal formative evaluation and advice throughout the rotation and review the resident’s performance with the resident at the end of the rotation.
 - c) Several times each year, the program coordinator in conjunction with nurse supervisors will distribute evaluation sheets to the PMH 8 inpatient and 6N continuity clinic nurses, and ZLUH 5th floor nurses. Nurses can check as satisfactory, unsatisfactory or outstanding such items as resident responsiveness to nurse concerns and to patient and family concerns. Nurse signature is optional.
 - c) Periodically throughout the year, the program coordinator will distribute and collect evaluation sheets from inpatients and outpatients. An effort will be made to produce a random sampling of the resident’s patients. These are generally anonymous. Attempts will be made to incorporate opinions from family members as available.
 - d) At the end of each clerkship rotation, medical students are provided with an opportunity to evaluate the resident using a single grading scale and comments. These are anonymous.
 - e) Once each year, in spring, all residents are invited to provide anonymous written commentary on each of the other residents in the program. The comments are compiled by the program coordinator and each resident confidentially receives comments concerning him or her. Apart from program director and coordinator, no other individual may see these comments. After distribution, these comments are not retained in the resident’s record. No record of the peer evaluations or comments are retained by anyone (other than the resident, if he or she chooses).

2. Evaluation of residents' academic performance and medical knowledge:
 - a) The national resident in-service exam (RITE) is taken by all residents on around the first weekend in March. This examination is required. The resident receives a composite score as well as performance on numerous subsets of neurology knowledge. The resident's ranking relative to peers nationwide is reported to the resident and the program.
 - b) At the end of each of the 19 didactic courses, the course supervisor assigns credit and grade based on attendance, participation and/or written examination.
 - c) Supervising attendings rate Medical Knowledge as part of the evaluation described above at the end of each clinical rotation.
 - d) Each year, a practical oral examination is conducted with the help of volunteer patients. The annual practical examination is a required activity. The resident is observed while taking a history and performing a neurological physical examination. The resident then summarizes the clinical presentation and findings, provides a differential diagnosis and presents a plan of care which is evaluated and graded by one or two faculty members. Residents are provided with immediate feedback. If deficiencies are found, a plan of remediation is developed by the program director. Residents are expected to show progressive development of clinical skills in this oral examination. This structured assessment of the history and examination skills also serves to fulfill part of the board examination requirements for ABPN certification (See below).
3. Evaluation of residents' practice based learning and improvement, and system based practice:
 - a) specific steps to improve patient care are proposed to the resident group and program director at any time but especially during regular residents' meetings. After discussion, a specific plan of action or updated policy may be agreed on. Resident contribution to this process and compliance with the improvement goals is monitored by the program director and reported back to residents at semiannual meetings.
 - b) residents are graded for participation and performance in the mandatory module "evidence-based medicine" for acquisition of statistical competence as well as the ability to locate and critically evaluate clinical and scientific information.
 - c) each residents ability to execute specific tasks related to working in the medical system is evaluated as part of the clinical evaluation
 - d) Performance in the "medical systems" didactic course.
4. Process for providing formative feedback and counseling:
 - a) Each January and June, the faculty review compiled evaluations for each resident, and discuss strengths and problem areas for each. Consensus recommendations for the resident are developed. Soon afterwards, the program director meets individually with each resident to review and discuss this compiled evaluation. Participation in the semi-annual reviews are required.
 - b) At the completion of PGY4, following a discussion of each graduating resident by the faculty and Resident Education Committee, the program director completes a written final evaluation, using information from the cumulative evaluations. The resident's competence on each of the 6 core areas listed in the program goals is addressed

Board examination requirements - Clinical Skills Evaluations

The American Board of Psychiatry and Neurology (ABPN) mandates demonstration of clinical skills competency as a basic requirement in order to apply for certification in the specialties of neurology and neurology with special qualification in child neurology. Competency in these skills should be achieved during residency. At the time a resident is applying for admission to the ABPN certification examination, the Board will require written attestation from the training program directors that the resident/candidate has successfully completed **five** required clinical evaluations demonstrating competency in clinical history and examination skills for neurology. The examination must include the following five clinical topics: 1) acute neurology (in hospital ICU or ER setting), 2) episodic outpatient disorder (e.g. headache or seizure), 3) neuromuscular disorder, 4) neurodegenerative disorder (e.g. movement disorder, dementia), 5) child neurology.

Each resident must be evaluated by a minimum of three ABPN-certified neurologists/ child neurologists who are faculty members. Adult neurologists must perform the adult neurology evaluations, and child neurologists must perform the child neurology evaluations. Each evaluation session should last approximately one hour. The residents should be given up to 45 minutes to do the history and neurological examination. Thereafter, he/she should have 10-15 minutes to present a summary of the important findings on history and neurological examination. The remainder of the time should be spent in discussion and feedback from the faculty member who observed the encounter. The individual faculty member will determine if the resident passed all three core components (A. medical interviewing, B. neurological examination, and C. humanistic qualities, professionalism, and counseling skills).

Each year, the department schedules a practical examination to cover one of these five clinical topics (PGY-2: neurodegenerative; PGY-3: neuromuscular; PGY-4: ambulatory). In the PGY4 year, this practical examination will include a live patient examination as well as an examination using case vignettes. Participation in these scheduled oral examinations is required. The remaining two clinical skills examinations (or re-testing for any failed examinations) must be organized by the resident. The acute neurology examination can be completed during the neuro critical care, ER or St. Paul consult rotations. The child neurology examination should be completed during the child neurology rotations.

Evaluation by residents of the faculty and program

- a) Evaluation of clinical rotations and attending physicians should be provided at the end of each clinical rotation via online anonymous system. Residents are required to complete regular evaluation of faculty and of the program. The minimum completion requirement is 75% of assigned evaluations. These evaluations are part of the retained record of the faculty members, and may be used by members of the University Promotion and Tenure Committee when considering appointments.
- b) Twice each year, at the time of semi-annual reviews, the residents complete an evaluation of the program including items such as quality of clinical teaching, didactic teaching and environment. The compiled results are distributed anonymously to the medical education committee.
- c) Anonymous written evaluation of the program, peers and program administration may occur at any time through the online evaluation system. These inputs have meaningful and substantial impact on program updates.

- d) The chief resident may conduct meetings with the residents independent of the faculty as needed, and bring forward concerns to the program director.
- e) Outside of these structured feedback opportunities, the residents may meet with the program director or any other members of the education committee and faculty at any time to provide feedback or raise concerns.

VII PROGRAM MANAGEMENT AND ORGANIZATION

- 1) RESIDENCY PROGRAM DIRECTOR, Steven Vernino MD PhD
Appointed by Chairman of Neurology Department
Responsibilities:
 - Resident recruitment
 - Setting the goals for the program
 - Monitoring the content and ensuring the quality of education toward the program's goals
 - Maintain program accreditation
 - Supervise evaluations of residents
 - Review performance with each resident at least semi-annually (or delegate this duty)
 - Monitor residents for work hour compliance, and for stress and emotional disturbance, including substance abuse
 - Counseling of residents as needed
 - Supervise Chief Resident(s)
 - Supervise the Residency Coordinator
 - Administer Annual Residency Program budget
 - Other administrative duties, including service on the institutional GME committee and interactions with related departments

- 2) RESIDENCY COORDINATOR, Joyce Mohler
Designated by Chairman of Neurology Department
Responsibilities
 - Residency Program duties as assigned by the Residency Director
 - Maintain clinical schedules, and communicate clinical assignments to the hospital and clinic administration
 - Maintain necessary documentation of resident and program information in a secure manner

- 3) CHIEF RESIDENTS, Lydia Sharp MD and Lauren Phillips MD
Elected by Neurology staff and residents
Responsibilities
 - Supervise residents in their adherence to departmental policies
 - Manage resident rotation schedule, call schedule, clinic schedule, journal club schedule, vacation schedule, lecture schedule
 - Monitor residents for fatigue and stress and bring this to program director's attention
 - Maintain working relationship with Residency Director(s) and Neurology residents
 - Communicate residents concerns to the Residency Director(s)

- Attend required chief resident meetings and represent the neurology residency program
- Other duties as assigned by the Residency Director(s)
- Coordinate additional social and academic events for the residents
- Chief residents are additionally responsible for setting the highest example of professionalism. A resident may be removed from the post of chief resident at the decision of the medical education committee (i) for failure to adhere to program policies, procedures and standards of professionalism, (ii) if the duties of chief resident interfere with clinical training or (iii) for failure to perform the required duties of chief resident.

4) ASSOCIATE PROGRAM DIRECTOR, Shilpa Chitnis MD PhD

Responsibilities:

- Perform duties of program director when the Program Director is unavailable
- Assist program director, chief resident and program coordinator with program activities
- Coordinate special academic conferences (resident research grand rounds, clinicopathological conferences, Board review sessions, Unwin conference)
- Coordinate special program activities (ie. graduation ceremonies)

5) DIDACTIC CURRICULUM DIRECTOR

Srikanth Muppidi MD

Responsibilities:

- Review and revise the scope and structure of the didactic lecture series
- Identify and supervise course directors for the didactic courses
- Monitor attendance and completion of each course by the residents
- Evaluate and recommend didactic opportunities provided by other departments, such as neuropathology and neuroradiology.
- Consider and implement improvements in the didactic training and evaluation methods

6) MEDICAL EDUCATION COMMITTEE

Resident Education group:

Mark Goldberg, Department Chairman

Gil Wolfe, Clinical Vice-chair (Chair of clinical competency committee)

Steven Vernino, Residency Program Director/Academic Vice-chair

Shilpa Chitnis, Associate Program Director

Rana Said, Director of Pediatric Neurology Residency Program, CMC

Sri Muppidi, Didactic Curriculum Director

Padraig O'Suilleabhain, Outpatient clinic Director

Worthy Warnack, Service chief, PMH and SPUH

Mark Johnson, Director of stroke unit

Jessica Lee, Director of continuity clinics, service chief at ZLUH

Wen Yu, Director of neurology critical care service, PMH and UH

Olaf Stuve, Chief, Neurology Service, VAMC

Medical School Education group:

Stephen Cannon, Associate Dean of Curriculum
 Mark Agostini, Neurology clerkship director
 Ardith Courtney, Neurology clerkship co-director
 Dennis Burns, Director of medical neuroscience course

Neurology Fellowship group:

Jaya Trivedi, Director of Neurophysiology fellowship program
 Pradeep Modur, Director of epilepsy fellowship program
 Gil Wolfe, Neuromuscular fellowship director
 Chris Hall, Critical Care neurology fellowship director
 Elliott Frohman, Director of Multiple Sclerosis clinics and fellowship program
 Shilpa Chitnis, Movement Disorders fellowship program
 Mark Johnson, Vascular neurology fellowship program

Ad hoc committee members:

Joyce Mohler, Residency and clerkship coordinator
 Chief residents
 Representatives from neurology fellows

Committee Responsibilities:

- Annual and ongoing program review and quality improvement
- Review and revise residency clinical curriculum to optimize patient care and education
- Review and revise clerkship curriculum to optimize patient care and education
- Review and revise the residency didactic curriculum to optimize education experiences
- Negotiate contracts and resource allocation with the clinical entities that provide training to and receive services from the residency program (UT Southwestern and University hospitals, PHHS, VAMC, CMC, UTSW medical school).
- Review and advise on disciplinary matters for residents and students.
- Review and advise on awards for residents and students
- Semiannually, the resident education group (along with the remainder of the clinical teaching faculty) will review evaluations and objective examination results of the residents to formulate a summary of resident performance. The clinical competency committee (CCC) is composed of members of the residency education group and adhoc members of the clinical faculty members. The CCC is responsible to review the progress of individual residents and recommend remediation when needed.
- Each year, the resident and fellowship groups will review allocation of PMH training funds available to support trainee salaries. The committee will determine the number of fellowship positions available each year.

VIII POLICIES AND PROCEDURES

DAILY PROGRESS NOTES

Each day, a resident should write a note in the chart of every assigned primary patient on the neurology service. The progress note should be completed by 9:30am **prior to the start of attending rounds**. A medical student's or intern's note can be referenced, but relevant documentation must be made by a resident. The note can take whichever format the resident finds most effective; the SOAP format works for many. The information that should be included are 1) interval history including patients report, medication list and summary of relevant developments; 2) examination, which should always include selected vital signs and global observation, as well as specific general and neurological findings, positive and negative findings relevant to the clinical problem; 3) results of investigations; 4) assessment and plan, can be as problem list and status.

HAND-OFFS AND SIGN-OFFS (Transitions of Care)

Medicine, especially during residency training, is a team endeavor. Periods of rest for the physician are necessary, and while off service (overnight or weekend), the duty of care must be transferred to an on-call person. Optimal patient care requires a safe and informative hand-off. Certain standardized elements should be included in the information handed off, and the process should be sufficiently standardized that handing and receiving resident can expect the appropriate information be transferred. Except in special circumstances, the primary resident should ensure that active medical problems are stabilized and that critical ancillary tests and procedures are organized prior to handoff. Hand-offs will occur between junior residents (the crosscover resident on call and the primary resident for the patient), but senior residents should supervise and take final responsibility for the hand-off process for their service. The hand-off should include the following components:

- Face-to-face encounter
- Occur at a fixed time and place each day
- Use a standard template for verbal communication
- Use a written sign-out sheet
- Opportunity to confirm information and interactive questions

One method that is recommended is "SAIF-IR"

- ◆ S = short summary of hospital stay, problems, current diagnoses
- ◆ A = active medical problems
- ◆ I = if/then contingency plan. List potential events and suggested action
- ◆ F= follow-up items. Test, procedures, therapies that require attention
- ◆ IR = interactive questions and readback (a repetition of important points)
- ◆ As pertinent: review code status, family dynamics etc.

At the end of a clinical rotation, care for ongoing patients must be transferred to an incoming service. The outgoing junior resident must write a note to provide information to the new resident.

The sign-off note includes

- ◆ demographics and admission date of the patient and/or date of consult
- ◆ brief summary of presenting problem(s) and hospital course

- ◆ current problem list
- ◆ working diagnosis, and any ongoing differential considerations
- ◆ relevant test results and tests pending
- ◆ current medications and changes in medications planned
- ◆ anticipated disposition and relevant social history
- ◆ status of discharge paperwork.

The written sign-off should be supplemented by a verbal communication between the outgoing junior and senior residents on the last day of service.

Consultation sign-off should be clear and straightforward. When a consultation is complete, the clinical note should state the final neurology recommendations and include a statement such as “neurology consultation is complete. Please call if additional questions arise”.

DISCHARGE SUMMARIES

A discharge summary must be completed for each admission (a shorter summary is used for patients released during 23 hour observation). This should generally be completed by the resident assigned to the patient on the day of discharge. Discharge summary should be done by the resident previously caring for the patient if the patient leaves within 24 hours of a new rotation unless new information has significant impact on the diagnosis or treatment or disposition plan. A preliminary/partial discharge summary can be dictated any time after admission. On complex cases, it is appropriate for the resident to complete a preliminary discharge summary at the time of service change.

The discharge summary is best completed on the day of discharge and should always be completed within 48 hours. A delay up to 7 days is permissible for extenuating circumstances. Residents with multiple delinquent charts (more than 30 days delinquent) may be subject to disciplinary action (suspension of hospital employment, withholding wages, or reduction in academic funds) or termination by the hospital.

COMPLIANCE WITH HOSPITAL POLICIES

Residents are employees of Parkland hospital and must comply with all requirements of employment and hospital policies. House-officers must also follow the policies of the institution where they are working (i.e. ZLUH, CMC, SPUH, VAMC) as well as the policies of the University. Residents are required to complete mandatory pre-employment screening and mandatory training sessions. Relevant hospital policies directly involving patient care include cross-out and corrections, signing verbal orders, timely completion of restraint orders, consenting patients for procedures, timely completion of discharge summaries. Hospital requirements also include pre-employment drug testing, background checks, periodic TB screening and completion of HIPAA and other mandatory compliance training. Non-compliance with these policies and requirements will lead to suspension of clinical privileges which may jeopardize ability to remain in the training program. Under certain circumstances and with due notice, PMH may withhold wages of a house-officer for noncompliance.

Residents that consistently violate hospital policies are subject to loss of hospital employment and termination from the training program. Common violations to be

avoided are failure to properly authenticate verbal orders, use of improper abbreviations, failure to submit necessary documentation to hospital administration, failure to complete annual Tb testing and late completion of hospital records (discharge summaries). The hospital typically provides several reminders and warnings before referring the issue for disciplinary action by the program director.

VERBAL ORDERS

Authenticate verbal orders within 48 hours. Verbal orders should only be used when it is not possible to enter orders directly in the chart because of another required activity and because a delay would jeopardize the safety of the patient. All verbal orders must be signed promptly. Since many verbal orders are used by the on-call resident in a cross-cover situation, the patient's primary resident should take responsibility to review the patient's orders each day and co-sign any verbal orders. Authenticating verbal orders is a required responsibility of all residents.

ON CALL AVAILABILITY

The person carrying the on-call pager for PMH emergency department (786-3272) must be on site in Parkland, Zale-Lipshy or South Campus of UT Southwestern at all times. If there is an absence that has been cleared in advance with the service attending and program director, the resident is responsible for ensuring that another resident has possession of the neurology pager. Parkland hospital maintains a schedule of the on-call resident which should be kept updated. At designated times (7am, 4pm, 9pm), the resident should meet in person with the next on-call resident to pass the on-call pager. It is not permissible to leave the pager with another person or in a work area for the on-call resident to pick up later. The resident is responsible for replacing the battery in the on-call pager promptly when needed.

The on-call resident is responsible for providing consultation promptly for emergency room patients and for urgent neurological problems in hospital inpatients. If it is not possible to provide an urgent consult within 60 minutes, the requesting service should be notified of the potential delay in a professional manner. When multiple urgent consultations are requested, the resident should triage the cases to attend to the most urgent or unstable neurological problems first. If there are multiple emergent neurological cases, the on-call resident should contact the second-on-call resident for assistance. If asked, the backup resident should come to the hospital to provide assistance without question. The attending neurologist may also come to the hospital to provide assistance if the number of emergent cases exceeds the capacity of the residents to provide timely management.

The cross cover resident is responsible for the needs of primary neurology inpatients (including general neurology, stroke, neuro ICU and EMU services). Calls from nursing staff for these issues should be directed to the crosscover pager (214-786-1141).

Routine, non-urgent, neurological consultations on inpatients should generally be performed by the residents on the inpatient neurology consult service. Consult requests that are received prior to 2pm should be performed the same day. Consultations requested after 2pm may be completed the same day or held for completion the next day.

ZLUH ADMISSIONS

Patients are admitted to ZLUH under the name of a faculty member who has privileges, only with the advance consent of that faculty member. Thus patients may be admitted to the faculty member currently on Stroke or General teaching service, or alternatively may be directly admitted under the care of another faculty member. In the latter case, the service residents and attending on the inpatient service do not have direct responsibility for the patients care. The admitting faculty member may request help in overnight or weekend coverage, and this can be reasonably accommodated. Private patients of a faculty member who are admitted to one of the teaching services (with the approval by the attending on service) are under the care of the service. The faculty member may make recommendations or requests but should not disrupt the line of responsibility within the service. Discharge summaries on Zale patient admitted to the inpatient resident service must be completed by the assigned resident within 24 hours (using the inpatient service attending as the supervising physician).

NEURO ICU ADMISSIONS

At Parkland and at Zale University hospital, unstable patients may be admitted to the Neuro ICU. If a patient requires ICU care, the resident should first contact the senior neurology resident to discuss the case and then initiate the transfer by requesting an ICU bed (contact the ICU). The junior or senior resident should then notify both the attending physician as well as the neuro critical care service. While in the ICU, the patient is managed by the neurology critical care service but remains a primary neurology patient (on either stroke or general neurology team).

In the ICU, the neurology resident should not try to perform intubations or other ICU procedures. If there is an urgent unstable situation, a code is called. If there is need of elective intubation, the critical care service (or anesthesiology) should be called.

PERFORMING PROCEDURES

There are few procedures in Neurology that need to be mastered. There are also some optional procedures that should be attempted only with direct supervision. The grid below provides guidance. In cases of routine procedures (e.g. neurological examination, phlebotomy), the resident is expected to be proficient at the time of starting residency, but should request help and supervision if needed. In other standard procedures (e.g. lumbar puncture), the resident should perform the first procedure under supervision of attending or senior resident to document proficiency. Documentation is completed through New Innovations online residency management software. In special procedures (e.g. intubation, needle EMG), the resident should perform the procedure only under direct supervision with a faculty physician in attendance. PGY5 fellows may be certified for these procedures.

Always document procedures with a complete note in the patient's chart and include the name of the supervising physician. Always include informed consent statement in your note. In some cases (i.e. routine lumbar puncture), it is appropriate to have a separate written consent document.

Residents are encouraged to keep a log of their procedures because this information may be required for future credentialing.

PROCEDURE GRID FOR NEUROLOGY

Procedure	MS	PGY1	R1	R2	R3	Fellow
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			(PGY2)			(PGY5)
History and examination	A	A	A	A	A	A
Phlebotomy	C	A	A	A	A	A
Lumbar puncture	C	B	B	B	B	B
Nerve conduction study	C	C	C	B	B	B
Needle EMG		C	C	C	C	B
EEG interpretation		C	C	C	B	B
Intubation			C	C	C	B
Central venous access			C	C	C	B
Arterial line			C	C	C	B

Procedures not listed should not be performed

A – may perform procedure unsupervised

B – may perform procedure independently under the general supervision of attending physician (only after documenting competence)

C – may perform procedure only under direct supervision of attending physician or senior resident/fellow that is physically present (and that also has appropriate credentials and competence)

TEACHING MEDICAL STUDENTS

Medical education is a central mission at UT Southwestern. Residents have a very important role in the clinical teaching of 3rd and 4th year medical students. During their neurology clerkship, each medical student will be assigned to an individual junior resident at any particular time. These assignments will be up to 2 weeks in duration. The junior resident should respond to the student questions and concerns, demonstrate neurological history and exam techniques, and supervise procedures as appropriate. The senior resident should set aside time to explain concepts and facts from the fields of basic and clinical neurology and nurture the student's interest in and competence in the field of neurology. The senior residents should also provide a specific time for bedside or didactic teaching of the medical students (2-3 hours per week). Students will evaluate their resident supervisors.

BILLING POLICIES & PROCEDURES/SUPERVISION

Residents on the Parkland and University Hospital services should request a faculty cosignature on each encounter by selecting a supervising attending on each clinical note. The same procedure for supervision applies to neurology consultations performed in the ER. In the outpatient clinics, all patients should be discussed with the supervising attending while the patient is still in clinic. The electronic clinic note should be forwarded to the supervising attending to facilitate documentation.

For neurology consultations, the clinical note should be attached or associated with the consultation order if possible. If not, the consulting attending's name must be provided in the first line of the consultation note. For all patients, diagnosis and ICD code should be provided in either the diagnosis or problem list fields.

Each primary inpatient and routine inpatient consultation should be presented to the attending during daily ward rounds. The attending will submit billing code for each

patient encounters. The attending is expected to see and document an encounter supporting the billing code with every new consultation patient and primary admission.

Emergency room consultations and emergent consultations performed by the **on-call or night float resident** should be presented to the stroke service attending at morning check-out rounds at 7:30 am. The overnight resident should route these clinical notes to the attending for co-signature. The attending should submit a billing code for each of the consultations completed (even though billing documentation requirements, as described below, may not be met for patients that are no longer in hospital).

Emergency room consultations and emergent consultations performed by the **ER resident** during the day should be presented to the PMH consult service attending as soon as possible during the day (before the patient leaves the ER whenever possible). All cases should be reviewed at afternoon consult rounds. The ER resident should route these clinical notes to the appropriate attending for co-signature. The attending should submit a billing code for each of the consultations completed (according to billing documentation requirements for outpatient visits).

All patients seen by residents at the Parkland Continuity Clinic must be discussed with the attending faculty, and the attending faculty member must leave an attestation statement verifying supervision.

Residents are responsible for providing adequate documentation for each and every patient encounter. New consultation notes must include past history, social history and review of systems documentation. Residents should be familiar with billing and coding requirements and be prepared to recommend a level of service for each patient encounter. Documentation must also be completed for cross-cover, procedures and counseling visits with patients.

DRESS AND DECORUM

Neurology residents are expected to conduct themselves with the highest level of professionalism at all times. The physician's appearance and presentation reflect their commitment to their profession and to their patients. Additionally, a professional demeanor will advance the reputation and respect afforded to the physician. As such, several specific expectations should be met. For more information, refer to the Parkland resident handbook section on dress code.

1) **Dress**. A resident should provide a professional appearance when dealing with patients and other medical professionals. White coats are provided by the department and should be worn at all times in clinical settings. The white coat should be clean and pressed (laundering services are provided) and should have the resident's name in a readable location (sharing of white coats is not allowed because of inability to readily identify the resident's proper name). Additionally, name badges should be easily seen.

Other clothing should also be professional. Clean scrub suits are acceptable for residents that are on overnight call or on a hospital service where soiling is possible (such as intensive care unit). At other times on clinical services, clean business attire should be worn. Men are encouraged to wear a tie during clinical activities especially during outpatient clinics. T-shirts, sweatshirts, and jeans are never appropriate. Likewise, athletic shoes or sandals are generally not appropriate unless the footwear is consistent with professional attire. Overly casual attire portrays a lack of commitment

and dedication and erodes patient confidence. Clean clothing and personal hygiene is important. Proper grooming of facial hair is expected. Heavy perfume or cologne is not appropriate since this may affect others with chemical sensitivity. The UT Southwestern graduate medical education committee and Parkland have adopted similar codes for dress.

2) **Decorum**. Neurology resident behavior should be respectful and reflect professionalism at all times. Examples of behaviors that are inappropriate include:

- ◆ Talking or muttering while the attending is teaching or while a colleague is presenting a case or answering a question
- ◆ Using a computer in a clinical area for personal business or entertainment
- ◆ Using a cellphone for personal calls in clinical areas
- ◆ Discussing patient information in public area
- ◆ Use of derogatory terms to describe patients or colleagues
- ◆ Having conversations in languages other than English in clinical or public areas. Clinical business should be conducted in English. Private conversations should not be conducted in common areas.
- ◆ Interrupting, insulting or shouting at a colleague during clinical duties
While it may be necessary to disagree about the approach to a clinical problem, there are clear lines of responsibility and seniority on the clinical services which must be followed. The attending physician has final responsibility on clinical decisions without question. It is better to excuse oneself from a discussion rather than escalate a disagreement.
- ◆ Consistently absent or late for scheduled rounds, meetings or conferences

INTERNET and SOCIAL NETWORKING POLICIES

Professionalism must be displayed at all times, including in online interactions. Hospital and clinic computers are to be used for patient care activities. Occasional use of institutional computers for personal activities (such as email) is acceptable. However, these computers are not to be used for personal entertainment (such as video, music or gaming). Patient confidentiality must also be maintained during online communications outside of work. Disclosure of any identifying patient information over the internet is prohibited and could result in immediate dismissal from employment (hospital HIPAA policy). Special care should be used in email and social networking communications.

Any patient care communication or documentation that are conducted from home should be made using a secure (VPN) connection using the electronic medical record (EPIC).

ACADEMIC BOOK and TRAVEL FUND

Each resident is provided an academic fund to be used for approved books or travel (a total of \$2000 per resident during the residency training). Book purchases should be arranged through the Residency Coordinator office. If you order through the office, you will receive a 10% discount. Books are ordered on the 25th of each month. The funds cannot be used for licensure or examination fees. Residents are encouraged to use part of these funds to attend a national academic meeting such as the annual meeting of the American Academy of Neurology. All distributions from the academic fund are subject to approval by the residency program director.

General limits apply to the academic fund. Up to \$300 (total during residency) may be used for purchases of equipment (e.g. PDA, ophthalmoscope, tuning forks) as long as the items have educational or clinical value and are approved in advance by the program director. Equipment supported by the department (specifically departmental iPad devices) are not included in this \$300 limit. Trip funds are subject to limits imposed by the institution. Unused academic funds are returned to the residency program. All reimbursement requests and book orders must be submitted before May 1 of the PGY4 year (so that the accounts can be closed at the end of the residency training).

LEAVE POLICIES

It is extremely important for residents to plan their absences in advance. Whenever possible, the chief resident should receive notification of planned absences prior to creation of the rotation schedule. Absence requests for the coming academic year that are received prior to May 1 will generally be honored without additional review or approvals. Subsequently, all requests for absences must be submitted at least 3 months in advance for approval by the program director. These requests must be approved by the program director and the supervising attending for the rotation.

Requests for vacation or other absences submitted less than 3 month in advance will generally be rejected unless the absence occurs during an elective or other non-essential activity and the absence is approved by the supervising attending. All requests for absence must be submitted to the program coordinator in writing using the following "request for absence" form. Absences for external board examinations, fellowship interviews or job interviews must be taken from vacation time and approved in advance as with other time off.

The program and hospital provide 15 vacation days per academic year. Whenever 5 weekday vacation days are requested, the subsequent weekend days are also considered time off. If a resident is required to work on an official UT Southwestern or Parkland holiday, an additional vacation day may be added to the vacation balance. This latter rule does not apply to work during a holiday cross-cover schedule (when in doubt discuss with the chief resident or program director).

Procedure for completing the Request for Absence

1) The attending for the rotation needs to be informed of the planned absence, and needs to approve it. If it is not possible to identify the attending who will be supervising at the time for which absence is requested, the chief of the service (e.g. Dr. Van Ness in EMU, Dr. Stuve at VA) can sign. A replacement resident is not provided by the program to the service in the cases of vacation and conference absences. However individual residents may make arrangements so as to provide alternative service coverage in their absence. Some services will require this before approving a request for absence. If a resident makes a good faith effort to get the attending signature, but if approval or response are delayed by more than a week, and if the resident needs to move ahead with travel plans at that stage, the program director will consider approving the absence without attending signature.

2) With 3 months notice, the supervisor or scheduler of the continuity clinic will cancel the continuity clinic. Without 3 months notice, patients with appointments to continuity clinic will not be rescheduled. The resident is responsible for obtaining

coverage. Requests for leave without 3 months notice must have significant personal or academic importance or will generally be denied by the program director.

3) Submit the form to the program coordinator who will forward the request to the program director for approval.

UTSouthwestern Department of Neurology
REQUEST FOR ABSENCE FORM
 (Revised 3/29/06)

NAME _____

Date: _____

NUMBER OF DAYS REQUESTED _____

TYPE OF ABSENCE:

Vacation _____

Conference _____ (complete addendum below)

Other _____ (please specify)

CALENDAR DATES OF ABSENCE:

From _____ To _____

ROTATION _____

APPROVED _____

Attending signature, or if unknown, chief of service

Date

Do you have continuity clinic patients currently with appointments during that period?

___ Yes. If so, who is covering clinic for you? _____

___ No. If not, this is taken as a request to block clinic during this period.

ACKNOWLEDGED _____

Continuity clinic scheduler

Date

APPROVED _____

Residency Program Director

Date

Return this absence form to Residency Coordinator, Room J3.102. Thank you.

CONFERENCE ADDENDUM:

Attach copy of conference brochure including description/registration)

Name: _____ Sponsor: _____

Description/Comments: _____

Location: _____

Dates: _____

PROPOSED BUDGET:

Neurology Department reimbursement requested: Yes _____ No _____

If **yes**, please estimate expenses:

Conference Registration: _____

Transportation/Airfare: _____

Hotel/Motel: _____

Meals: _____

Other (please specify): _____

Total: _____

CONFERENCE TRAVEL

Each resident is expected to attend at least one national academic meeting during their training. The annual meeting of the American Academy of Neurology is the recommended conference. If sufficient travel funds remain in the residents account, additional conferences may be attended. Residents are permitted to attend an approved conference provided they adhere to the following requirements:

1) A written Request for Absence form must be completed as described below. In all cases, absences for conferences must be requested at least 3 months in advance. The request must include a description of and dates of the conference. An itemized budget is necessary if the resident is planning to request reimbursement for their academic account or from the department for conference expenses. (See the Conference Addendum to Request for Absence form). The completed request form must be signed by the Residency Program Director before the resident makes any travel plans. Once the travel request is approved, it should be submitted to the Residency Coordinator. Following the trip, submit ticket stubs and individual receipts to the Residency Coordinator for reimbursement. Airline bookings:

2) Attendance at approved academic meetings does not require vacation time, however, absence from residency program duties for meeting attendance is limited to a cumulative total of 5 days each year. Additional days of absence may be taken as vacation days. In the case of presentation at academic meetings (as described below), the program director may approve additional absences. Except in exceptional circumstances, the cumulative total of absences for academic meetings should not exceed 12 work days for the entire residency program.

3) Each resident is eligible to be reimbursed up to a total of \$2,000 from their academic/educational fund for books and approved conferences during the Neurology residency training. Expenses beyond \$2,000 will not be reimbursed. Except for special circumstances, funding for travel will not be approved for PGY-1 or PGY-2 residents.

4) If an abstract is submitted and selected for presentation, the Department may cover travel expenses (meeting registration, airfare, two nights hotel, meals, and ground transportation). The covered travel expenses may not exceed \$1000. In general, reimbursement for rental cars, alcohol and entertainment are not reimbursed. Institutional limits on per diem charges also apply.

The resident should be first author presenter at an approved meeting in the continental United States. These trips must also be approved by the program director (see request form above), and the resident must use economical travel and lodging (room sharing with other trainees is encouraged). Additional days of conference attendance may be funded through the resident's academic fund. The resident must review their attendance plans and get approval from the program director prior to making travel arrangements. The resident may provide the airline "booking record location" to the Residency Coordinator immediately after booking. She will then arrange direct billing to the Department. If you pay for your airline ticket yourself, please save the ticket stub to give to the Residency Coordinator following your trip. To be reimbursed for your conference registration, hotel and meal expenses, following your conference, please give the Residency Coordinator a copy of the conference registration along with a

front/back copy of your cancelled check or credit card receipt and the original receipts for all other expenses. Allow a minimum of two weeks to receive reimbursement. Limits on expense reimbursement, such as hotel costs, are restricted by university policy. A request for leave must be submitted and approved.

5) External sponsorship for valid educational conferences (e.g. Penry epilepsy conference) is sometimes offered by industry or professional societies such as the AAN. These must be reviewed and approved by the program director in advance. The program director will assess the educational merit of the course and offer the opportunity to appropriate residents. Considerations taken into account in selecting residents include the goals of the conference, the standing of the resident, the clinical services that will be impacted by the absence, and reasonably equitable distribution among equally worthy residents throughout the 3 years of training. When contacted by program director with such an offer, a request for leave must be submitted and approved to ensure clinical duties are covered.

VACATION

Every resident is allowed three weeks of vacation (15 days) per year. Vacations should if possible be taken at the beginning or end of a particular rotation. It is also best to take vacation as whole weeks at a time. Residents may not take vacation while assigned to inpatient hospital services except as specified below.

Vacations must be scheduled as early in the academic year as possible. To avoid difficulties with patient scheduling, vacations for any academic year should be planned and approved by May 1, prior to finalization of the rotation schedule. In all cases, absences must be requested at least 3 months in advance unless extenuating circumstances exist.

Vacations may not be scheduled during the week of Christmas or New Years. Some additional days off during the winter holidays, however, is arranged for each resident.

After the schedule is created, vacations are allowed on the following rotations:

- 1) Neuromuscular at the beginning or end of the rotation.
- 2) Neuropathology
- 3) Aston outpatient rotations
- 4) VA consult service (no more than one week per block, PGY2 resident only)
- 5) Other elective months - at the discretion of the attending.

OUT-OF-TOWN ELECTIVES

Neurology residents (in their PGY3 or PGY4 year of training in neurology) may be allowed to participate in electives out of town when there is a clear educational rationale (i.e. an experience not available at this institution). The elective must be approved by the program director and must be at an ACGME-accredited program. The cumulative length of time spent out of town cannot exceed four weeks. The resident must present a letter or formal evaluation of their performance during the elective from their on-site supervisor when they return to Dallas. This letter will be filed in their folder in the residency office. The department's own evaluation form is acceptable and will be mailed to the appropriate supervisor as needed.

Off campus electives may also be taken under the supervision of adjunct clinical neurology faculty in Dallas as an extension of the training program.

SICK LEAVE

Unpredictable illness may occur which prevents a resident from attending to scheduled duties. To allow adequate coverage (especially for patient care), the resident is responsible for notifying several people about the absence.

- 1) Call the program coordinator as soon as possible (by 7am) at 214-648-4775. If the coordinator is not available, notify the program director by email.
- 2) Notify the chief resident by pager.
- 3) Notify the assigned clinical service. Junior residents on the Parkland services should notify the senior resident on the service. Other residents should notify the supervising attending for the rotation.

Other residents may be called on to cover clinical responsibilities for the sick resident. The chief resident will determine any additional duties for the sick resident to make up for covered work.

The resident on sick leave is expected to use the day to rest and recuperate so he/she can return to work promptly. Absences due to illness that last longer than two days will require medical evaluation with a note from the physician to the program director. Residents with chronic or recurring disorders should speak to the program director about possible changes in their training schedule.

FATIGUE AND WORK HOUR POLICIES

DUTY HOURS

Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time outside of scheduled shifts (even if spent at the duty site). The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. In-house call is defined as those duty hours beyond the normal work day when residents are required to be immediately available in the assigned institution.

There are five ACGME work hours regulations:

- 1) Duty hours are limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities. When residents are called into the hospital from home, the hours spent in-house are counted toward the 80-hour limit.
- 2) Residents must have 1 day each week free from all educational and clinical responsibilities, averaged over a 4-week period. One day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities including answering pages from home.
- 3) There should be a 10 hour period between daily duty periods and after in-house call.

4) Continuous work shift can be no longer than 28 hours. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to four additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical care. No new inpatients may be accepted after 24 hours of continuous duty.

5) In-house call duties cannot be more frequent than every three days (averaged over a four week period). The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident. Residents taking at-home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities, averaged over a 4-week period.

When on Parkland rotations, the chief resident will designate the call schedule for the month to fit within the policy. Daily work hours are detailed on the daily schedules (page 25). The senior residents on service (stroke, general and ER) will similarly come up with a schedule for second-on-call backup coverage which allows a 24-hr per week free period. When at CMC, the child neurology chief resident will arrange the call rotation. At VA, the most senior resident(s) will arrange the call schedule.

If there are insufficient residents to provide 24-7 coverage, attendings must provide coverage. The program director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

FATIGUE AND STRESS

The 80-hour standard is a ceiling, the primary intent of which is to make it unlikely that physicians in training will be providing care while not alert. It is likely some physicians will be excessively fatigued even within this standard. If a resident is excessively fatigued and thus at risk, the resident should contact the program director, chief resident or senior resident on call at that time to see if cross-cover is needed.

Residents and faculty should report to the program director any observations that another resident is excessively fatigued or under stress.

MONITORING OF DUTY HOUR COMPLIANCE

Rotation schedules and continuity clinic schedules will be arranged by chief resident to comply with these standards

Residents must report violations of the policy to the program director immediately, for example if resident is faced with an expectation they continue to work after the 24+4 hour shift or more than 80 hours per week averaged over 4 weeks.

Residents will keep a duty hours log for a 2-4 week period every 3-6 months as assigned by the program director. Compliance with the duty hours log is mandatory. The duty hour log is completed using the New Innovations Residency Management system online.

The prior 6 months compliance with the policy will be reviewed at semiannual reviews.

Residents are also free to go outside the department, (and are encouraged to do this in the case of unresponsiveness from the program director) to report anonymously or openly to the institutional GMEC at 83433, or to the ACGME. All communications to the ACGME regarding alleged non-compliance with ACGME Institutional and/or Program Requirements must be signed by the complainant and be addressed to the Executive Director of the Neurology Review Committee at 515 N. State Street, Suite 2000, Chicago, Illinois 60610.

MOONLIGHTING POLICY

Because residency education is a full-time endeavor, the program director must ensure that moonlighting does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

Moonlighting must be counted toward the 80-hour weekly limit on duty hours

Moonlighting is not prohibited for residents as long as certain circumstances are met. Prior to accepting a moonlighting position, the resident needs to:

- 1) Receive written approval from the Program Director. Factors to be considered by the Program Director include work-hour limits and academic performance (clinical evaluations and didactic coursework). Residents that have received warnings or remediation for academic or professional issues will not be eligible to moonlight.
- 2) Ensure that appropriate malpractice liability coverage is provided. To moonlight, the resident must secure and maintain an active Texas medical license. Once an individual license is obtained, the resident is no longer eligible for the physician-in-training (PIT) license provided by the hospital or use of the hospital DEA numbers. The insurance coverage provided to residents by UT Southwestern for clinical activities performed as part of their residency training will not transfer to outside moonlighting activities.
- 3) Be aware that residents training under a J-type visa are by federal law not permitted to moonlight either in training-enhancement positions or unaffiliated positions.
- 3) Verify that the moonlighting hours and duties will not, in combination with residency duties, exceed the duty hour and fatigue policies of the department.

IX DISCIPLINE AND GRIEVANCE POLICIES

It is the policy of UT Southwestern to supervise residents and fellows in a manner consistent with the educational goals of the applicable residency program and proper patient care, to assess the competence of residents in accordance with the applicable program requirements and standards of professionalism, and to encourage fair, efficient and equitable solutions for problems that arise out of the appointment of residents. In addition, the Accreditation Council of Graduate Medical Education (ACGME) requires the “establishment and implementation of fair institutional policies and procedures for academic or other disciplinary actions taken against residents” and the “establishment and implementation of fair institutional policies and procedures for adjudication of resident complaints and grievances related to actions which could result in dismissal, non-renewal of a resident’s contract or other actions that could significantly threaten a resident’s intended career development.”

Resident Grievances and Concerns

General Grievances.

If a resident has a complaint or grievance related to matters other than job performance, corrective action, discrimination or sexual harassment, the resident should first attempt to resolve it by consulting with the Chief Resident(s) or the Program Director. If the resident is unable to resolve it at that level, the resident should then present the grievance to the Department Chairperson. If the resident is unsatisfied with the Department Chairperson’s decision, recommendation or other handling of the complaint, the resident may present the grievance in written form to the Associate Dean of Graduate Medical Education (GME) who shall provide a written response to the resident within ten (10) business days of receipt of the written complaint. The GME dean is Dr. Susan Cox. The GME website has additional resources for residents. www8.utsouthwestern.edu/utsw/home/medschool/gme

For some issues, the resident can contact Parkland hospital administration. The residents are employees of Parkland and may contact the administrative offices. Elizabeth Ponce is the residency office coordinator. Parkland human resources is another resource.

Sexual Harassment and Discrimination.

If a resident has a complaint or grievance related to discrimination or sexual harassment, the resident shall have the right to address the complaint in accordance with the policies and procedures set forth in the UT Southwestern’s Handbook of Operating Procedures.

Corrective Action

1. Conduct Subject to Corrective Action. Residents may be subject to corrective action as a result of unsatisfactory academic performance and/or misconduct, including but not limited to issues involving knowledge, skills, scholarship, unethical conduct, illegal conduct, excessive tardiness and/or absenteeism,

unprofessional conduct, job abandonment, or violation of application policies or procedures (collectively “job performance”).

2. **Counseling Prior to Corrective Action.** Where the Program Director determines that an adverse evaluation or evaluations indicate(s) unsatisfactory job performance in the program, the resident may be requested to attend a conference with a program representative for purposes of discussion and counseling regarding the Program Director’s concerns prior to the imposition of any corrective action or disciplinary measures. The counseling conference serves as an opportunity to promote a mutual discussion regarding the specific issues or areas of concern, as well as to encourage mutual communications. The Program Director or the Clinical Competence Committee shall designate a representative from the program to conduct the counseling conference with the resident. During the conference, the program representative shall inform the resident of the basis for the unsatisfactory performance assessment and may advise the resident regarding any corrective action that is being considered. The resident shall have an opportunity to respond to the issues raised and may offer any explanation and/or additional information regarding the facts and/or circumstances surrounding the resident’s job performance. The resident may elect to submit a written statement in response to the conference to the program representative. The program representative shall document the events of the counseling conference and any required action by the resident in a written summary, a copy of which shall be retained in the resident’s file. Counseling is not a prerequisite to the imposition of corrective action.
3. **Referral for Investigation.** The Program Director, the Committee, or the Department Chairperson shall refer allegations of (i) sexual harassment or unlawful discrimination made against a resident for investigation by the Equal Opportunity Director of UT Southwestern in accordance with UT Southwestern’s Handbook of Operating Procedures, and (ii) substance abuse or other impairment of a resident for investigation and handling by the Committee on Physician Peer Review and Assistance at Parkland Memorial Hospital.
4. **Imposition of Corrective Action.** “Corrective action” may include, but not be limited to: observation, suspension, non-renewal of contact, or dismissal from the program. In the event the Program Director determines at any time that corrective action is warranted with regard to a resident, the Program Director shall provide written notice to the resident which sets forth: (i) the specific corrective action to be taken, (ii) the reasons for the corrective action, (iii) notice of the resident’s right to an appeal of the corrective action, and (iv) the time period within which the resident must initiate the appeal. In the event that the Program Director determines that the resident’s job performance presents a threat to patient safety or welfare, the resident may be immediately removed from the patient care environment pending a corrective action determination. In addition, the following supplemental requirements shall apply for each of the following corrective action measures:

- a. *Observation or Suspension.* Observation is where the resident is formally notified that there are identified areas of unsatisfactory job performance, which will require remediation and/or improvement if the resident is to continue in the program. Suspension is where the resident is temporarily not permitted to perform his or her job duties due to unsatisfactory job performance, which will require remediation and/or improvement if the resident is to continue in the program. The notice to the resident of either observation or suspension shall set a commencement date and duration period for the observation or suspension status and shall set forth the specific remedial action or improvement that is required during this time period. The Program Director shall re-evaluate the resident at the end of the observation or suspension period and make a determination to (i) continue the observation or suspension period, (ii) remove the resident from observation or suspension status, or (iii) impose another corrective action measure. The Program Director's decision shall be documented in the file and communicated in writing to the resident and the Committee chairperson.
- b. *Non-renewal of Contracts.* In the event the Program Director, the Committee, and/or the Department Chairperson elects not to renew a resident's contract for the next year, the Program Director shall provide the resident with written notice of this decision. Notice must be provided to the resident at least four (4) months prior to the expiration date of the current contract, unless the primary reason for the non-renewal occurs with the four (4) months prior to the expiration date, in which case the Program Director must provide the resident with as much written notice of the non-renewal prior to the expiration date as the circumstances will reasonably allow.
- c. *Dismissal.* Notice of dismissal of a resident from the program shall set forth the effective date of the dismissal.

Appeal of Corrective Action:

A resident shall have the right to appeal any measure of corrective action imposed. The procedure governing the process for resident appeals of corrective action determinations are set forth in the Appeal Procedures, a copy of which is attached hereto as Appendix A.

Appeal Procedures

1. FIRST APPEAL – CLINICAL COMPETENCE COMMITTEE.

a. **Exercise of Right**

A resident shall have a right of appeal of a decision to impose corrective action to the department's clinical Competence Committee. The resident may exercise this right by notifying the chairperson of the committee, in writing, of the resident's intent to appeal within twenty (20) days of the resident's receipt of the notice of corrective action. The current chair of the clinical competence committee for neurology is Dr. Gil Wolfe.

b. **Appeal Conference**

The chairperson shall arrange for an appeal conference to be held among the member of the Clinical Competence Committee and the resident. The appeal conference shall be held within ten (10) business days of the date the chairperson's receipt of the resident's notice of appeal. At the conference, the resident shall have an opportunity to make a statement, to present any written documentation relevant to the issues and to bring any new or additional information to the attention of the committee. The committee chairperson shall within ten (10) days after the date of the appeal conference notify the resident in writing of the decision of the Clinical Competence Committee and the resident's right to appeal the decision.

2. SECOND APPEAL – APPEAL COMMITTEE

a. Exercise of Right

A resident shall have a right of appeal of the decision of the Clinical Competence Committee and a right to a hearing before an ad hoc appeal committee to be appointed by the Program Director. The resident may exercise this right by delivering a written notice of his or her decision to appeal to the Program Director within twenty (20) days after the date of receipt of the decision of the Clinical Competence Committee. The notice of appeal shall state whether or not the resident will have legal counsel in attendance at the hearing and, if so, the name, address and telephone number of legal counsel in writing. Failure of the resident to provide written notice of appeal within said twenty (20) days shall be deemed acceptance of the corrective action and waiver of appeal.

b. Appointment of Appeal Committee; Notice of Hearing

i. Upon receipt of a written notice of appeal of the decision of the Clinical Competence Committee from a resident, the Program Director shall appoint a committee to hear the appeal (the "Appeal Committee"). The Appeal Committee shall be comprised of not less than three (3) members of the applicable department's faculty. The Appeal Committee shall appoint a president chairperson.

ii. The Appeal Committee shall provide the resident with at least fifteen (15) days written notice of the date, time and place for the appeal hearing and the names of the members of the Appeal Committee. The notice will include a written statement of the deficiencies of the resident and a summary statement of the evidence supporting such deficiencies. The notice shall be delivered in person or by regular or certified mail to the resident at the last known address on file for the resident.

iii. The resident may challenge the fairness and impartiality of any member(s) of the Appeal Committee by stating in writing to the Associate Dean of GME the factual basis for the challenge. This challenge must be received by the Associate Dean of GME no less than ten (10) days prior to the hearing date. The Associate Dean of GME shall communicate the challenge to the member and it shall be up to the member challenged to determine whether he or she can serve with fairness and impartiality. If a challenged member determines that he or she cannot be fair and impartial in the consideration of the appeal, a replacement shall be appointed in the same manner as the original member was appointed.

c. Witnesses and Documents

- i. Each party shall provide to the Associate Dean of GME a complete list of all witnesses, a brief summary of the testimony to be given by each, and a copy of each document, record and exhibit to be introduced at the hearing.
- ii. The Associate Dean of GME shall set deadlines for submission of above information and shall provide copies to the other party prior to the hearing.

d. Hearing

- i. The Appeal Committee chairperson shall preside at the hearing, ensure order of presentation and make determinations on the relevancy of testimony and documentary evidence. The Appeal Committee may ask questions of the parties and their witnesses. The chairperson may request consultation with legal counsel during the hearing.
- ii. Each party shall have the right to appear and present evidence in person. The resident will have the right to have legal counsel present in the hearing room. The legal counsel may serve only in an advisory capacity to the resident and may not participate in the hearing. UT Southwestern shall have the right to have a representative from the Office of Associate Vice President for Legal Affairs in attendance.
- iii. UT Southwestern shall designate an institutional representative to present evidence on behalf of UT Southwestern. UT Southwestern shall have the burden of proving the allegations by a preponderance of credible evidence that good cause exists for the corrective action. The resident shall have the opportunity, but shall not be required, to address the committee and present evidence. Both parties shall have the right to introduce witnesses and documentary evidence. The parties shall have the opportunity to cross-examine witnesses.
- iv. If the resident elects to have counsel present during the hearing, the hearing will be recorded by a court reporter furnished by UT Southwestern. Both parties will be allowed to purchase a copy of the transcript from the court reporter. If the resident does not have counsel present, the hearing will be recorded by audio equipment, which shall be furnished by UT Southwestern. UT Southwestern shall make a copy of the audiotape available for the resident upon request.

e. Appeal Committee Decision

- i. The Appeal Committee shall deliberate and prepare, and forward written findings and recommendations to the resident, the Program Director, and the Department Chairperson within five (5) business days after the close of the hearing.
- ii. If the resident disputes the findings and recommendations of the Appeal Committee, the resident may within ten (10) days of receipt of the written findings and recommendation submit a written request for review of the matter to the Department Chairperson. The resident's submission should include only the record of the hearing proceedings, documentary evidence submitted at the hearing, and a written argument setting forth the reasons why the decision was in error. The Department Chairman may, in his or her discretion, elect to have a meeting with the resident and an institutional representative to discuss his or her review of the record. The Department Chairperson shall mail a written decision

to the resident within twenty (20) days of receipt of the resident's request and said decision shall be final and binding.

f. Due Process Challenges

If the resident believes at any stage of the appeal that procedural due process has not been followed, he or she should notify the Associate Dean of GME of the substance of the alleged deficiency. If the Associate Dean of GME finds a material deficiency in the procedural due process afforded the resident he or she shall institute appropriate remedial action.

X CALENDAR FOR 2011-2012

Block	Resident start Date	(Holidays)	Didactic course
	June 1, 2011		Intro for incoming PGY2s
1	July 1, 2011	Jul 4	Emergency neurology
2	August 1, 2011		Ethics / EMG
3	August 29, 2011	Sep 5	EBM / EEG
4	Sept 26, 2011		TBD
5	October 24, 2011		TBD
6	November 21, 2011	Nov 24-25	TBD
7	December 19, 2011	Dec 26	Neuropathology
8	January 16, 2012	Jan 16	Neurology board review
9	February 13, 2012	Feb 20	TBD
10	March 12, 2012		TBD
11	April 9, 2012	Apr 20	TBD
12	May 7, 2012	May 28	TBD
13	June 6, 2012		TBD

- Official institutional holiday schedule not yet released

Hospital duties will be unchanged during holidays (i.e. night float continues) except for the block 7 holidays. In block 7, the chief resident will arrange a coverage schedule to allow additional days off around the end of the calendar year. Residents on outpatient services will assist with covering the inpatient services during these times. On designated holidays (listed above), outpatient clinics are closed.

At the start of each block, resident hospital services officially start at 6pm on Sunday (for night float) and 7am on Monday for all other residents. Residents are expected to communicate with the previous service residents and meet together promptly on Monday morning to assign service responsibilities. The incoming senior residents on the inpatient services should discuss patient assignments on Sunday evening with their outgoing counterparts so that residents can pre-round on their new patients prior to 7am if needed. Change of service for attendings will be every 2 weeks.

Didactic courses

- ◆ The course schedule is listed above in the annual calendar
- ◆ Lectures are in F2.300 except during blocks 2, 3 and 13 when there are concurrent noon lectures and one of the courses is held in J3.100
- ◆ Lectures start at 12:10pm and run till 1pm every Monday, Tuesday and Thursday
- ◆ The 2nd and 4th Thursday of each month are neuro-ICU conferences in Sprague 7
- ◆ Grand rounds occurs every Wednesday noontime from September to May
- ◆ Unwin conference occurs Friday from 12 - 12:45pm (usually in Sprague 7)
- ◆ A weekly resident administrative meeting occurs at 12:45p each Friday immediately following the Unwin conference.
- ◆ Attendance is expected of all residents who are not at the VA or night float
- ◆ Residents at the VA and at CMC will be able to participate in M/T/Th noon didactics by live Webinar
- ◆ Clinical duties have been scheduled to allow attendance, and faculty do not expect residents to perform clinical duties from noon to 1 each day

Additional activities that must be attended unless clinical duties prevent:

- ◆ Neuroradiology rounds at the VA are held each morning at 8:30am. All residents assigned to the VA neurology service must attend
- ◆ Neuroradiology rounds at Parkland are held every other Thursday afternoon
- ◆ Professor rounds/Dr. Rosenberg clinical conference is held most Friday afternoons at 2 pm on 8W. An inpatient of interest is selected by the general neurology senior, who presents the history and physical. Dr. Rosenberg discusses the protocol and the analytic method, then the patient is interviewed and examined. The goal of the conference is to demonstrate the process for elucidating and interpreting clinical information, additionally to discuss the relevant basic and clinical neurology.

XI SERVICES

LOCKERS

Lockers are available in the hospitals for storage of personal items. However, the department and hospital are not responsible for lost or stolen items. At Parkland, lockers are located in the neurology resident call room area. At St. Paul, lockers are located in the staff services area on the 3rd floor. Residents who wish to use a locker may obtain a combination lock from the residency program office (Joyce Mohler). The program keeps a record of these locks and combinations. At the end of each academic year, the lockers must be emptied. Remaining locks may be removed.

RESIDENT OFFICES

Shared office space for residents is provided by the program. The main resident office is on the South Campus in room J3.127. This private office has computers and reference material for resident use only. A resident office is also provided at the VA medical center in the neurology administrative area. Residents may also use computer facilities in the resident work room areas on Parkland (8W), St. Paul University hospital (8th floor) or at Children's hospital (in neurology outpatient clinic area)

LAUNDRY

A container for soiled lab coats is located in J3.106. Soiled laundry is picked up each Monday and laundered items returned on Thursday.

MAIL & E-MAIL

Mailboxes are assigned to each resident in the mailroom of the 3rd floor of the J building. Please check your mail frequently as there may be important notices of required meetings and lectures. The mail room is accessible at all times using a punch-code you will be provided. All residents have an email address and should check messages daily. Much of the program communication including important notices and information are distributed by e-mail. Resident email accounts originate in Parkland and are accessed through groupwise server. To activate your account, call support services at 2-5999 while sitting at a terminal. To access your Parkland email account from outside computers go to gw.swmed.edu and choose the Parkland hyperlink. Log on with your Parkland network username and your Parkland email (if different from network) password.

LIBRARY SERVICES

Since the medical school library does not permit removal of journals and similar material, there are times when it is necessary to photocopy in the library. If you are new to the program, your name will be added to our account and you will receive a photocopying card along with instructions for its use. Most journal articles published in the past 10 years are available electronically (e-journal subscriptions) through the library website. Training classes for the library website are available.

You are limited to 1500 departmentally paid copies for the year. Your usage is monitored each month and you may be billed for excess copies or be asked to return your card if your copy total exceeds 1500. If you need multiple copies, make a

"master" copy in the library and photocopy the remainder on the Departmental copier in J3.106. The Neurology Residency Coordinator will assist you.

DEPARTMENTAL TEXTBOOKS

A number of textbooks are provided by the department in neurology work areas. These textbooks are considered to be department property and should not be taken out of these areas. Additional references are available in the residency office or from faculty member's personal collections. If a resident wishes to borrow a departmental textbook and remove it from its usual location, the resident should "check out" the book by notifying Joyce Mohler. If a book is damaged or lost, the program may replace the item using money from the resident's book fund. Residents are expected to be respectful and honest in using this resource.

PAGER INSTRUCTIONS

A pager card is provided to each resident. Note that the more common 786-xxxx pagers use the 214 area code. Text paging can be accomplished through the clinical paging (on-call) system. Navigate to the Parkland or UT Southwestern website to find this paging system.

CASH REIMBURSEMENT

The Interdepartmental Requisitions (IDRs), which requires prior approval, is the only permissible form of payment for supplies, slides or other materials or services which are paid for with Departmental funds. Cash reimbursements will not be made unless authorized by the Chairman or his designee.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

As part of your benefits, residents have access to the EAP. This program offers personal or family counseling at no charge. While residents are encouraged to talk with the program director or faculty mentor about any issues that affect their well-being, residents may utilize the EAP without prior discussion with the program or hospital administration. All services are confidential and are provided by a third-party service. Use of these services are not reported to the hospital or the residency program. Residents may contact the EAP directly by calling Deer Oaks (214-559-2171). Additional information about EAP benefits can be obtained from the residency staff services office at Parkland.