UC San Diego Health

Surgical Critical Care Fellowship Handbook

2019-2020

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I. INTRODUCTION - MISSION STATEMENT

The goal of the Surgical Critical Care Fellowship Program at UC San Diego Health, Department of Surgery, is to provide an outstanding exposure to complex surgical critical care and develop administrative skills compatible with making fellows able to emerge into a leadership role. Specific educational agenda and set of core didactic experiences have been developed to assure that the aspects of critical care that are core to this understanding and the skills essential to delivering excellent critical care are provided.

II. PROGRAM PHILOSOPHY AND GOALS AND OBJECTIVES

Philosophy

The care of the most severely ill or injured patients requires the cooperation of multiple specialties, but we believe that surgeons with advanced knowledge and training are the vital central element. The goal of this residency is to provide an intensive one-year experience in surgical critical care which will train surgeons to assume a leadership role in the care of critically ill patients and be prepared to assume an administrative role in managing a busy surgical intensive care unit. The specific goals in this regard are to obtain experience in the multidisciplinary care of sick surgical patients and have exposure to all elements of the domain of critical care knowledge and related procedures. This will form a focus of clinical material upon which to develop the basics of administrating a busy SICU and integrating multiple practitioners in this complex environment.

The educational philosophy is to teach not only the individual basics of care of sick surgical patients, but to teach the integration of care through multiple practitioners in the interdisciplinary process. Philosophically we maintain an open unit which is integrated with the primary surgeon and teaches the critical care fellows how to manage patients in this environment which is the most likely environment the fellow will encounter in their practice. An additional philosophic goal is to have exposure to all types of surgical critical care patients to maintain an expanded knowledge.

The initial year of the residency focuses on gaining advanced skills and knowledge in clinical aspects of patient care and the basics of surgical intensive care administration. This year is ACGME accredited and leads to Certification in Critical Care Surgery after examination by the American Board of Surgery. Candidates desiring to pursue a career in academic surgery or to obtain further clinical exposure may participate in an optional second year of training. Options include completing the American Association for Surgery of Trauma (AAST) Acute Care Surgery (ACS) Fellowship, or non-accredited Research + Clinical Fellowship which will offer the opportunity to focus on a specific area of scholarly pursuit while continuing to participate in clinical management. There are also options for international global trauma and acute care surgery electives, pediatric trauma and pediatric surgical care as well as a Burn Surgery Fellowship. Fellows are urged to make a decision regarding a second year of fellowship by December of their first year so that funding can be secured. More information on these second-year programs is available separately.

A surgical critical care fellow will be directly involved in all phases of care of critically ill surgical patients. The focus of the clinical experience will center around the 20-bed combined surgical intensive care unit at Hillcrest, with additional rotations to include the 8 bed burn unit, the Jacobs 3G ICU with 12 beds, and the Sulpizio Cardiovascular Center CVICU with 12 beds. Please

refer to rotation schedule below. The case mix on the intensive care units includes approximately 50% trauma patients, 30% general surgery and transplant patients, 10% burn patients, and 10% cardiothoracic surgery. In addition, subspecialty admissions in other surgical subspecialties are admitted to this unit. The trauma resuscitation area is a physical part of the surgical intensive care unit. Initial resuscitation management of trauma patients is a unique and integral part of the training in surgical critical care offered in this residency. Trauma resuscitation may involve emergency surgical procedures required for stabilization but will not involve surgical procedures done on an elective or semi-elective basis.

The fellow will take in-house call every fourth to seventh night during which they will be responsible for care of all of the SICU and incoming injured patients under the supervision of an attending faculty member. One of the attending faculty will make daily rounds in the SICU. The daily SICU rounds consist of clinical decision making, integrated with didactic teaching. Topics of daily discussion are based on current clinical problems to allow for practical application of newly acquired knowledge. A sit down hourly conference is part of each day's rounding Monday through Friday and is based on collected readings and current patient problems.

Didactic teaching is accomplished through a number of specific conferences. These include: 1) daily bedside rounds and daily conferences covering topics from a teaching syllabus prepared specifically for the surgical intensive care unit at UCSD; 2) Thursday morning critical care lecture series; 3) weekly research committee where clinical projects and the basics of clinical research are reviewed; 4) Thursday noon afternoon journal club which covers core topics throughout the year; 5) alternating Friday orthopedics combined conference; 6) Wednesday morning Surgery M&M where complications are discussed; 7) monthly SICU user group where concepts of administration are discussed with the nursing staff and other paramedical personnel supporting the SICU; 8) monthly Resident Core Lecture Series, and 9) fellows are invited to attend the monthly Medical Audit Committee for the care of injured and sick patients within San Diego County and allowed to see how this process is administrated.

<u>Goals and Objectives</u>

1. Become proficient in surgical critical care knowledge in the following areas:

    a. Cardiothoracic-respiratory resuscitation
    b. Physiology, pathophysiology, diagnosis, and therapy of disorders of the cardiovascular, respiratory, gastrointestinal, genitourinary, neurologic, endocrine, musculoskeletal, and immune systems as well as of infectious diseases.
    c. Metabolic, nutritional, and endocrine effects of critical illness
    d. Hematologic and coagulation disorders
    e. Critical obstetric and gynecologic disorders
    f. Trauma, thermal, electrical, radiation, inhalation and immersion injuries
    g. Monitoring and medical instrumentation
    h. Critical pediatric surgical conditions
    i. Pharmacokinetics and dynamics of drug metabolism and excretion in critical illness
    j. Ethical and legal aspects of surgical critical care
    k. Principles and techniques of administration and management
    l. Biostatistics and experimental design

2. Become proficient in surgical critical care skills in the following areas:
    a. Respiratory airway management including endoscopy and management of respiratory systems.
    b. Circulatory: invasive and noninvasive monitoring techniques, including transesophageal and precordial cardiac ultrasound and application of transvenous pacemakers, computations of cardiac output and of system and pulmonary vascular resistance; monitoring electrocardiograms and management of cardiac assist devices.
    c. Neurological: the performance of complete neurological examinations; use of intracranial pressure monitoring techniques and the electroencephalogram to evaluate cerebral function; application of hypothermia in the management of cerebral trauma.
    d. Renal: the evaluation of renal function, peritoneal dialysis and hemofiltration, knowledge of the indications of complications of hemodialysis.
    e. Gastrointestinal: utilization of gastrointestinal intubation and endoscopic techniques in the management of the critically ill patient; application of enteral feeds, management of stomas, fistulas, and percutaneous catheter devices.
    f. Hematologic: application of autotransfusion, assessment of coagulation status, appropriate use of component therapy.
    g. Infectious Disease: classification of infections and application of isolation techniques, pharmacokinetics, drug interactions, and management of antibiotic therapy during organ failure, nosocomial infections, indications for applications of hyperbaric oxygen therapy.
    h. Nutritional: application of parenteral and enteral nutrition, monitoring and assessing metabolism and nutrition.
    i. Monitoring/bioengineering: use and calibration of transducers, amplifiers, and recorders.
    j. Miscellaneous: use of special beds for specific injuries; employment of pneumatic antishock garments, traction, and fixation devices.

1. Details of Goals and Objectives - Core Knowledge

1.a. Cardiothoracic-respiratory resuscitation.

Exposure: Daily SICU rounds; SICU daily resident conference. Fellows are exposed to cardiothoracic-respiratory resuscitation on a daily basis. In addition, fellows will maintain ACLS and BLS skills. The fellows interact on a daily basis with SICU faculty and cardiothoracic surgery service, as well as the cardiology consult service in day-to-day clinical work.

Specific objectives are: Scientific American Critical Care of the Surgical Patient- Cardiac Resuscitation; Critical Care Journal Club: weekly; Critical Care/Trauma Case Conference: weekly

1.b. Physiology, pathophysiology, diagnosis, and therapy of disorders of the cardiovascular, respiratory, gastrointestinal, genitourinary, neurologic, endocrine, musculoskeletal, and immune systems as well as of infectious diseases.

Exposure: Daily SICU rounds; SICU daily resident conference. All topics are covered when faced in the SICU and discussed extensively on daily teaching rounds. The SICU faculty is experienced and well qualified, and additional specialty support is obtained

through interaction with consultants and attendings from other surgical services, includingtransplant, infectious disease, orthopedics, and neurosurgery. In addition, specific conferences with neurosurgery and orthopedics occur.

Specific objectives are: Scientific American Critical Care of the Surgical Patient – Organ Systems and Scientific Foundations; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: monthly combined Resus Conference (Neurosurgery); Combined Conference (Orthopedics): every other week.

1. c. Metabolic, nutritional, and endocrine effects of critical illness.

Exposure: Daily SICU rounds; SICU daily resident conference. This aspect of surgical critical care will be acquired through daily interaction with critical care faculty, supplementary reading, and formal lecture material. The metabolic and nutritional care of surgical patients is a fundamental component of treatment. The discussion of metabolism, appropriate feeding of patients, and the use of enteral feeding to prevent complications is part of routine daily care.

Specific objectives are: Scientific American Critical Care of the Surgical Patient – Endocrine/Metabolic; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly

1. d. Hematologic and coagulation disorders.

Exposure: Daily SICU rounds; SICU daily resident conference. The majority of hematologic and coagulation disorders will be covered by critical care faculty with participation with hematology consulting attendants in unusual cases. The format includes daily clinical interactions over patients who have developed specific coagulation disorders as well as didactic material.

Specific objectives are: Scientific American Critical Care of the Surgical Patient - Hematology; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly

1. e. Critical obstetric and gynecologic disorders.

Exposure: Daily SICU rounds; SICU daily resident conference. The fellow will be involved in the care of critically ill patients in the OB/GYN service and any patient admitted to the SICU is generally managed primarily by the SICU service. The OB/GYN staff rely heavily on input from the SICU service in the management of their patients and the attending staff provides specialty-specific input. Clinical material will be supplemented with reading and lecture topics.

Specific objectives are: Scientific American Critical Care of the Surgical Patient - Surgical Critical Care of Special Populations (Pregnant, Geriatric, Pediatric), Critical Care Journal Club: weekly.

1. f. Trauma, thermal, electrical, radiation, inhalation and immersion injuries.

Exposure: Daily SICU rounds; SICU daily resident conference. The fellows will participate extensively in the management of patients admitted to San Diego County's Level I Trauma Center. The trauma system in San Diego and the trauma center at UCSD have a nationwide reputation for excellence. Many of the critical care faculty have a strong dedication to the care of the trauma patient and contribute actively to the literature. The burn unit is also quite busy serving a large region of Southern California and trauma and burn experience is central to our training. Participation on the burn service is optional, but some fellows have chosen to participate and have found this to be a useful experience.

Specific objectives are: In addition to the high volume experience, specific didactic exercises include: Scientific American Critical Care of the Surgical Patient - Burns, Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly; Combined Resus Conference (Neurosurgery): monthly; Combined Conference (Orthopedics): every other week.

1. g. Monitoring and medical instrumentation.

Exposure: Daily SICU rounds; SICU daily fellow conference. There is a vast clinical experience in the use of clinical monitoring devices including all components of hemodynamic, intracranial pressure, and respiratory monitoring. The majority of SICU patients are monitored invasively and provide a rich basis for this experience. We are involved in clinical research evaluating and developing modality such as continuous cardiac output measurement and non-invasive measurements of intracranial pressure measurement. In addition, metabolic monitoring and respiratory monitoring are active clinical projects at UCSD.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly.

1. h. Critical pediatric surgical conditions.

Exposure: Daily SICU rounds when pediatric patients are admitted to the trauma service; SICU daily fellow conference when pediatric critical care issues are discussed as part of the main topic for the day. The fellow will be involved in the care of pediatric patients who are injured.

Specific objectives are: Scientific American Critical Care of the Surgical Patient, Critical Care Journal Club: Pediatric components of all topics are discussed weekly; Critical Care/Trauma Conference: weekly

1. i. Pharmacokinetics and dynamics of drug metabolism and excretion in critical illness.

Exposure: Daily SICU rounds; SICU daily resident conference. The SICU has an active clinical pharmacy service. Fellows will interact on a daily basis with pharmacy staff as well as in a lecture setting. Pharmacokinetics are measured directly in the surgical ICU pharmacy, a unique aspect of our SICU, and fellows are exposed to the techniques and mathematics of drug monitoring and drug calculations. In addition, active discussion of

drug metabolism and excretion is discussed on daily rounds as the pharmacist is part of the multidisciplinary daily rounding team.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly

1. j. Ethical and legal aspects of surgical critical care.

Exposure: Daily SICU rounds; SICU daily resident conference. Attendings on the surgical critical care service are deeply involved in both the ethical and legal issues surrounding critical care. One faculty member is currently serving on the Hospital Ethics Committee and interactions with faculty will be supplemented by reading material and teaching conferences. The fellow is expected to participate in all case referrals to the ethics committee and participate in this important process.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly; UCSD Resident Core Lecture Series: monthly.

1. k. Principles and techniques of administration and management.

Exposure: Daily SICU rounds; SICU daily resident conference. Active effort is made to involve the fellows in the skills necessary for efficient administration and management with an eye toward a leadership role during their career. The fellows will work closely with the nursing and various SICU support services and with the medical director of the intensive care unit to learn the principles of administration. The fellows participate actively in the SICU user's group meetings which functions to fulfill the administrative issues. Fellows also participate in the evaluation of outcomes and the process of continuing quality improvement within the SICU and are actively involved in the development of guidelines and guideline derived outcome measures. The fellows are actively involved in the ongoing structure and content of the educational program as well, and are actively involved in changing this to suit their individual needs.

Specific objectives are: Scientific American Critical Care of the Surgical Patient, SICU Quality Assurance Committee; San Diego Medical Audit Committee; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly; UCSD Resident Core Lecture Series: monthly.

1. l. Biostatistics and experimental design.

Exposure: The fellows are involved with several active ongoing clinical research projects and there is a full-time epidemiologist in our department who provides a core biostatistics course during the Wednesday afternoon research conferences to which the fellows attend. In addition, there is a hospital based formal eight- week statistics course which fellows participate in and reinforces the foundation of biostatistics.

In addition, the department is involved in many clinical SICU studies including the evaluation of DVT prophylaxis, immunologic assessment of infection risk, evaluation of an anti-CD-18 antibody, the use of a blood substitute, and the evaluation of enteral vs.

parenteral nutrition for immune modulation. In addition, there are multiple projects in neurosurgery, cardiothoracic surgery, and the fellows are exposed to ongoing clinical projects in addition to having the opportunity to participate in these specifically.

Overall, our department is extensively involved in all types of research including epidemiology, clinical projects, and basic bench research with NIH sponsorship.

Specific objectives are: Scientific American Critical Care of the Surgical Patient, Critical Care Journal Club: weekly; Biostatistics videos – video series at http://trauma.ucsd.edu.

2. Details of Goals and Objectives – Critical Care Skills

2. a. Respiratory airway management including endoscopy and management of respiratory systems.

Exposure: Daily SICU rounds; SICU daily resident conference. Fellows will participate in the airway management of all patients in the ICU and the initial management of trauma patients. There is an active bronchoscopy service and fellows will participate and log SICU bronchoscopies. Specific protocols for airway management are followed and use of bronchoscopy and endoscopy to assess complex airways is practiced on a daily basis.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly.

2. b. Circulatory: invasive and noninvasive monitoring techniques, including transesophageal and precordial cardiac ultrasound and application of transvenous pacemakers, computations of cardiac output and of system and pulmonary vascular resistance; monitoring electrocardiograms and management of cardiac assist devices.

Exposure: Daily SICU rounds; SICU daily resident conference. The supervised use of invasive and noninvasive techniques in the SICU occurs on a daily basis. All modalities used during the average year include arterial lines, pulmonary artery catheters, transesophageal echo, measurement of mixed venous blood gases, calculation and interpretation of ECGs, treatment of acute arrhythmias, the use of transvenous pacemakers, the use of external pacemakers, the use of ECMO and IABP. The fellows are actively involved in any patients needing this kind of care and are exposed to the principles and pitfalls.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conference: weekly.

2. c. Neurological: the performance of complete neurological examinations; use of intracranial pressure monitoring techniques and the electroencephalogram to evaluate cerebral function; application of hypothermia in the management of cerebral trauma.

Exposure: Daily SICU rounds; SICU daily resident conference. The fellows are directly involved in the care of head trauma and post neurosurgical patients through supervised clinical activity and a close relationship with the department of neurosurgery. All care on neurosurgical patients is shared with the neurosurgery service and neurosurgery

attendings. Treatment modalities include maintenance and calibration of ICP monitors, the development of a new non-invasive ICP measuring device, interpretation and treatment of ICP problems, and the management of cerebral perfusion pressure, barbiturate coma, vasospasm, and optimization of cerebral perfusion pressure.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club; Critical Care/Trauma Conferences: weekly Combined Resus Conference (Neurosurgery): monthly.

2. d. Renal: the evaluation of renal function, peritoneal dialysis and hemofiltration, knowledge of the indications of complications of hemodialysis.

Exposure: Daily SICU rounds; SICU daily resident conference. Involvement in the SICU dialysis therapy under the supervision of the nephrology service is an almost daily occurrence. Approximately 50 patients per year receive dialysis therapy in the SICU, both hemodialysis and by continuous therapy. A core NIH sponsored prospective randomized trial comparing these two has been recently completed in the surgical intensive care unit and is representative of the involvement of the nephrology service in the care of these patients. The fellows are exposed to all of this activity and actively participate in the management of these patients. The nephrology attendings are very committed to surgical intensive care and enhance the fellow's experience immensely. In addition to this, core knowledge is supplemented by readings and conferences.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. e. Gastrointestinal: utilization of gastrointestinal intubation and endoscopic techniques in the management of the critically ill patient; application of enteral feeds, management of stomas, fistulas, and percutaneous catheter devices.

Exposure: Daily SICU rounds; SICU daily resident conference. The postoperative care of general surgery and trauma patients provides the basis for exposure to gastrointestinal skills in addition to other patients. This includes the placement of feeding tubes, the use of endoscopy, and the use of percutaneous endoscopy to place long term feeding tubes. This is all provided under the supervision of critical care and general surgery attending staff and, in addition, the management of stomas, fistulas, and percutaneous catheter devices is done with the enteral stoma nurse and the interventional radiology service.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. f. Hematologic: application of autotransfusion, assessment of coagulation status, appropriate use of component therapy.

Exposure: Daily SICU rounds; SICU daily resident conference. The use of autotransfusion, the assessment of coagulation status, and the appropriate use of component therapy is a daily occurrence in the SICU. The autotransfuser is used in trauma patients following chest trauma and the assessment of coagulation and use of component therapy is part of the care of virtually every patient in the ICU.

Specific courses include: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. g. Infectious Disease: classification of infections and application of isolation techniques, pharmacokinetics, drug interactions, and management of antibiotic therapy during organ failure, nosocomial infections, and indications for applications of hyperbaric oxygen therapy.

Exposure: Daily SICU rounds; SICU daily resident conference. The classification of infections and use of appropriate isolation techniques, the discussion of pharmacokinetics, drug interactions and the management of antibiotic therapy is part of daily work in combination with the pharmacy service and the infectious disease service along with the critical care attendings. Evaluation of unit microbial flora and antibiotic sensitivity is accomplished on a monthly basis and guidelines using this information for use of antibiotics are developed and used for the care of all patients. The SICU has also been a study site for the CDC National Nosocomial Infection Study and we follow standard protocols for the prevention of nosocomial infection. In addition, we have specific procedures and policies for containment and body substance isolation practice to which the fellows are exposed. The fellow will also perform part of the supervisory function in maintaining these protocols throughout the hospital environment.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. h. Nutritional: application of parenteral and enteral nutrition; monitoring and assessing metabolism and nutrition.

Exposure: Daily SICU rounds; SICU daily resident conference. Daily interaction with the nutrition service and to formulate feeding plans and provide follow-up evaluation as part of daily care. The fellows have hands on experience with direct and indirect calorimetry measurements. In addition, the fellow will participate in the formulation of monitoring data to determine the adequate compliance with guidelines regarding enteral and parenteral feeding.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. i. Monitoring/bioengineering: use and calibration of transducers, amplifiers, and recorders.

Exposure: Daily SICU rounds; SICU daily resident conference. All fellows are supervised and instructed in the calibration and troubleshooting of all equipment in the SICU on an ongoing basis. This is done through interaction with the attendings, the nursing staff, the anesthesia technical support staff, and employees from the bioengineering department. In addition, this is supplemented by readings and specific prepared materials in the SICU handbook.

Specific objectives are: Scientific American Critical Care of the Surgical Patient; Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly.

2. j. Miscellaneous: use of special beds for specific injuries; employment of pneumatic antishock garments, traction, and fixation devices.

Exposure: Daily SICU rounds; SICU daily resident conference; The use of special beds and the use of antishock garments, traction and fixation devices is part of the exposure of fellows during the care of trauma patients with orthopedic injuries. The use of special beds for pulmonary problems including rotobeds and prone ventilation devices is part of daily experience.

Specific objectives are: Scientific American Critical Care of the Surgical Patient Critical Care Journal Club: weekly; Critical Care/Trauma Conferences: weekly; Combined conference (Orthopedics): bimonthly.

III. CORE COMPETENCIES

Fellows are expected to demonstrate the skills, knowledge, and attitudes to meet the requirements of the following core competencies listed below. Fellows are educated on the core competencies through exposure at daily SICU rounds and weekly Grand Rounds. Fellows are also encouraged to attend core lectures presented by the UCSD Graduate Medical Education Committee to complement their daily experience.

1. Patient Care
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice

1. Patient Care:

a. Effectively lead patient care issues with clear communication to team, patients, family, and attendings
b. Accurately synthesize size complex clinical data and propose clear treatment plans
c. Actively lead team decision making
d. Capably perform procedures suitable to trauma and surgical critical care with attending supervision

2. Medical Knowledge:

a. Demonstrate effective decision making based on adequate knowledge
b. Effectively correlate basic sciences knowledge with clinical scenarios
c. Exhibit a desire for additional knowledge
d. Appropriately use learning resources
E. Fluent with pharmacology and physiology as it pertains to surgical critical Care
    1) Reads the current literature
    2) Demonstrates investigatory and analytical thinking approach to clinical situations

3. Practice-Based Learning & Improvement:

a. Participate in conferences, M&M, etc.
b. Knowledge of evidence-based medicine applied to critical care
c. Adequately use scientific data to help solve clinical problems
d. Actively contribute to team's education by providing recent and current data as a result of literature searches

4. Interpersonal & Communication Skills:

a. Maintain professional and cordial relationships with patients, staff, and co-workers and faculty
b. Demonstrate the ability to listen and to accept constructive criticism
c. Demonstrate the ability to communicate efficiently with the team members, attendings, referring and consulting physicians

5. Professionalism:

a. Demonstrate compassion, respect and integrity in the work environment
b. Flawlessly uphold the professional standards of the surgical critical care/trauma services
c. Respect differences in gender, age, culture, disability or educational levels
d. Contribute to all educational activities of the surgical critical care/trauma services
e. Has commitment to ethics of confidentiality and informed consent

6. Systems-Based Practice:

a. Understand one's position within the team, specialty, profession and society
b. Demonstrate sensitivity and awareness at the cost of health care delivery
c. Advocate for cost-conscious and effective patient care
d. Develop skills as a "team leader"
e. Develop skills (administrative or otherwise) to organize and lead a busy clinical service

IV. ORGANIZATIONAL STRUCTURE AND INSTITUTIONS

The UCSD Surgical Critical Care Program is developed with the surgical intensive care unit as the primary area of focus. The rotation schedule will include alternating one-month blocks with rotations on the following four services: Surgical ICU Hillcrest, Trauma, Burns, and the Surgical ICU at Jacobs. The fellow will have consulting responsibility for the patients admitted to the surgical intensive care unit that are not on the trauma service or those that are part of the trauma service and resuscitation room. It is expected that the fellow on the SICU/Critical Care Service will round daily with each team in the morning along with the general surgery residents and the anesthesia residents on the rotation, and use this opportunity to create the plans of care for each patient in the SICU. A similar process will occur on the trauma service and, in addition, the fellow will participate on an every fourth to fifth day basis on supervising and initiating resuscitations of trauma patients as the fellow comes through the surgical intensive care unit based

resuscitation room when the fellow is on call and participates in anything required for acute stabilization. The fellow is specifically not to become involved in elective surgical procedures except with great exception.

The rotation schedule for the year will alternate back and forth between four services and each of these services will be the focus from which the fellow interacts directly with all other components of the educational program. Rounds on either of these services will be conducted by a faculty member and group and one-on-one interaction will occur on a daily basis. The fellow's responsibility will be to become knowledgeable about essentially every patient on that service and be prepared to have a plan of care for each of these patients.

Typical Trauma/Surgical Critical Care Rotation Schedule

4 Week Block	**Fellow #1 Rotation**	**Fellow #2 Rotation**	**Fellow #3 Rotation**
1	Trauma	Surgical ICU	Burn ICU
2	La Jolla ICU/ 1wk Vacation	Trauma	Surgical ICU
3	Surgical ICU	La Jolla ICU/ 1wk Vacation	Trauma
4	Trauma	Surgical ICU	La Jolla ICU/ 1wk Vacation
5	La Jolla ICU/ 1wk Vacation	Trauma	Surgical ICU
6	Surgical ICU	La Jolla ICU/ 1wk Vacation	Trauma
7	Trauma	Surgical ICU	La Jolla ICU/ 1wk Vacation
8	La Jolla ICU/ 1wk Vacation	Trauma	Surgical ICU
9	Surgical ICU	La Jolla ICU/ 1wk Vacation	Trauma
10	Trauma	Surgical ICU	La Jolla ICU/ 1wk Vacation
11	La Jolla ICU/ 1wk Vacation	Trauma	Surgical ICU
12	Surgical ICU	La Jolla ICU/ 1wk Vacation	Trauma
13	Burn ICU	Surgical ICU	La Jolla ICU/ 1wk Vacation

V. CONFERENCES AND RESPONSIBILITIES

The conferences the fellow is expected to attend include:

Name of Conference	Frequency	Location	Responsible for Organization of Sessions	Presenters
Trauma & Acute Surgery Handover Rounds	Daily 0645	UCSD Hillcrest Main Hospital	Surgical Critical Care Faculty and Fellows	Surgery Residents
SICU Teaching Rounds	Daily a.m.	UCSD Hillcrest Main Hospital	Surgical Critical Care Attending	Surgical Critical Care Attending and **Surgical ICU Fellow**
SICU Daily Sit Down Conference	M, T, Th ~11 a.m.	UCSD Hillcrest Main Hospital	Surgical Critical Care Attending	Surgery Residents
General Surgery M&M	Weekly, Wednesday 6:30 a.m.	UCSD Moores Cancer Center, 2nd Floor, Goldberg Auditorium	General Surgery/ Surgical Critical Care	Surgery Residents
General Surgery Grand Rounds	Weekly, Wednesday 7:30 a.m.	UCSD Moores Cancer Center, 2nd Floor, Goldberg Auditorium	General Surgery Faculty	Surgery Residents
Surgical Critical Care Journal Club	Weekly, Thursday 12:00 p.m.	MPF Bloom Conference Room, Rm 2-256	Surgical Critical Care	**Surgical ICU Fellow**
Trauma Resuscitation Review & Critical Care Conference	Weekly, Thursday 7:00 a.m.	UCSD Hillcrest Main Hospital, Inpatient Tower, ACR, Rm 1-117	Surgical Critical Care Faculty	Surgical Critical Care Fellow or Trauma-SCC Faculty
Trauma-Surgical Critical Care Research Committee	Thursday 1:00pm	MPF Bloom Conference Room, Rm 2-256	Surgical Critical Care Faculty and Fellows	Trauma-SCC Faculty and **Fellows**
Basic Science Research Conference	Weekly (Optional) Friday 11:00 a.m.	Clinical Teaching Facility (CTF) B, 3rd Floor, Rm 313A	Surgical Critical Care Faculty	Surgery Residents
Division Business Meeting	Bi-weekly, Tuesday 7:00 a.m.	MPF Bloom Conference Room, Rm 2-256	Trauma/Burn/ Surgical Critical Care Faculty	Trauma/Burn/Critical Care Faculty
San Diego County Medical Audit Committee	Monthly, 3rd Monday 3:00 pm	County of San Diego EMS Services, 6255 Mission Gorge Road, San Diego, CA 92120	County of San Diego Emergency Medical Services	Trauma-SCC Faculty
Combined Trauma/ Radiology Conference	Monthly, 4th Thursday 3:00 p.m.	UCSD Hillcrest, Main Hospital, Lasser Conference Room, 1-115	Surgical Critical Care/ Radiology Faculty	**Surgical ICU Fellow** and Radiology Resident
Combined Trauma/ ED Conference	Monthly, 4th Thursday 4:00 p.m.	UCSD Hillcrest Main Hospital, Inpatient Tower, 3rd Floor, Rm 3-310	Surgical Critical Care/ ED Faculty	Emergency Medicine Residents
Combined Neuro/Trauma Conference	Monthly, Last Thursday 7:00 a.m.	UCSD Hillcrest Main Hospital, Inpatient Tower, ACR, Rm 1-117	Surgical Critical Care Faculty /Neurosurgery Faculty	Alternately **Surgical ICU Fellow** & Neurosurgery residents
Combined Trauma/Ortho Conference	Bi-monthly, Friday 7:00 a.m.	UCSD Hillcrest Main Hospital, ACR, Rm 1-117	Critical Care/Orthopedics Faculty	Alternately **Surgical ICU Fellow** & Orthopedics residents

PRESENTATION DESCRIPTION/EXPECTATIONS:

Each of these conferences has a unique perspective and is integrated to either provide an administrative experience, a quality assurance component, or a specific didactic goal and objective. The integration of these into the overall goals and objectives of the program are outlined in detail and the conferences outlined above give you the daily sequence to make this compatible with a weekly schedule. They are designed to be scattered throughout the week so as to not encumber any one particular day and should allow plenty of time for patient care in addition to personal study. The details of the critical care conferences and the critical care journal club are in Section II Goals and Objectives.

TRAUMA-SCC FELLOW LECTURE (length: 1hr)

45-50 minute high-quality lecture on the assigned trauma-SCC topic, with 10-15 minutes for questions/discussion at the end. The lecture must include relevant background information, basic evaluation/management of the injury/condition, and review of the historical and recent literature. You may also choose to focus on a particular injury within the assigned topic, as some of the topics are rather broad (i.e.

Evaluation/management of rib fractures for thoracic trauma). *See the suggested rules for PowerPoint presentations.

VIDEO TAPE REVIEW (length: 1hr)

Each month, the assistant trauma program manager (Lori Herman) will give you a disc drive with recordings of various trauma resuscitations. You will usually pick 4-5 of the videos to review during conference where you will highlight various aspects of the resuscitations (ie. What went well? What could have been better?) and make teaching points. It is suggested you choose one resuscitation with good teamwork, one with not-so-good teamwork and any others that were interesting or problematical. The reviews are protected under the California Evidence Act as peer review activities, the focus is not blame but improved performance by the team.

SELECT CASE REVIEW (length: 1hr)

Similar to M&M. The assistant trauma program manager (Lori Herman) will email you a list of selected cases to review (usually 3-5 cases). These could be just interesting cases or cases where a complication or death occurred. You will provide a short case presentation of the trauma/hospital course followed by a teaching point and review of associated literature.

NEUROTRAUMA LECTURE (length: 1hr)

45-50 minute lecture on the assigned neurotrauma topic, with 10-15 minutes for questions/discussion at the end.

TRAUMA/RADIOLOGY CONFERENCE (length: 1hr)

The SICU fellow will pick 5-7 interesting cases from the preceding month/weeks that involve interesting radiology findings. These can be both trauma and general surgery cases. Cases should be emailed to **Giovanna Casola** gcasola@ucsd.edu no later than the Friday before this Tuesday conference (4th Tuesday of the month at 3:00pm). The trauma fellow will provide a short vignette regarding the presentation of the patient and hospital course followed by review of relevant imaging by a radiology resident. Try to stick to body imaging and not neuro imaging if possible.

TRAUMA/ED CONFERENCE (length: 1hr)

Held on the 4th Tuesday of each month at 4:00pm. Presented by the ED resident recently on trauma.

ORTHO/TRAUMA CONFERENCE (length: 30minutes)

A joint conference held with our colleagues in Ortho trauma on the 2nd and 4th Fridays of the month. On the 2nd Friday conference, the trauma fellow is expected to provide a 20 minute presentation followed by 10 minutes of questions/discussion. The presentation should be case based (highlighting a recent collaborative case between trauma/ortho if possible) with a teaching point and brief review of associated literature.

*NOTES ON PRESENTATIONS

Good presentations help educate the team and your partner Fellows. There is no better way to master a topic than to teach it in a masterly way.

1. **Presentations are expected to be of HIGH QUALITY.**
   These should be created from the current literature. All key facts and figures should be referenced on the bottom of the slide. Important trials, metanalysis or guidelines should be presented on their own slide. Last minute, wordy, "cut and paste" jobs from textbooks, Up-To-Date, etc., are obvious and unacceptable. Try to create a presentation worthy of an expert at a scholarly meeting, because that is what you are going to be. Spelling and grammatical errors annoy the audience and make the faculty grumpy.
2. **Be on time – make sure everything works.**
   It's your show! It is the Fellows responsibility to ensure the show starts on time and everything works. Presentations start on time, i.e. a 0700 show may follow a 0645 Handover, so you may have to visit the conference room a bit earlier in the morning (i.e. 0630) to ensure it's unlocked, the equipment is there, etc. You may have to leave rounds slightly early to be ready. Make sure your thumb drive or laptop functions with the projector/monitor as expected a day in advance until you're sure all is reliable. Ask for help if there are issues beforehand.
3. **Presentations should be case-based.**
   It's more interesting, relevant and educational for all if you start with a case presentation, ideally one that you saw, ideally at UC San Diego. If you don't know of such a case, your attendings do, so ask them. You can close the show with the case's resolution so that all present can apply the knowledge they gained.
4. **Reference the UC San Diego Protocol.**
   In most cases, we have a protocol for the injury or condition, ensure you show and explain this. Also, someone in your faculty have probably written on the topic, include those articles as they are based on the same population you're treating.
5. **Remember that you are the presenter, not PowerPoint**.
   Use your slides to emphasize a point, keep yourself on track, and illustrate a point with a graphic or photo. Don't read the slides. Some of the best presentations are almost entirely pictures and/or short lists.
6. **Slides should be uncluttered:**
   Don't make your audience read the slides. Keep text to a minimum (6-8 lines per slide, no more than 4 lines, and not more than 30 words per slide). The bullet points should be headlines, not news articles. Write in sentence fragments using key words, and keep your font size 24 or bigger. Good pictures are better than a slide full of text.
7. **KISS – Keep it simple, seriously: Black, Dark Blue or White themes.**
   No weird colors or cute themes, make it easy on the eyes and all about the message. Use easy to read fonts like Arial, Calibri or Times New Roman. Avoid animations or sound effects unless they are relevant.
8. **Never include anything that makes you announce, I don't know if everyone can read this, but…."**
   Make sure they can read it before you begin. If unsure, print out your slides on letter-sized paper, and drop them to the floor. The slides are probably readable if you can read them while you're standing.
9. **Embed videos and CT Scans into the slide:**
   Avoid switching from PowerPoint to PACS etc. Learn how to embed these into your slides and spare your audience the agony of watching you try to make PACS or video player work.
10. **Use high quality pictures and media.**
    There are excellent sources for pictures in Scientific American CCSP, ATOM and ASSET courses and on our website and manuals. Use them.

If you have questions, issues, problems – please ask!

VI. DECISION MAKING AUTHORITY/SUPERVISION POLICY

The fellow will initially be given responsibility commensurate with experience and aptitude. As the resident matures, clinical responsibility will also increase. The resident will be responsible for daily rounds in the SICU and responsible to participate and oversee the care of patients and supervise the general surgery residents and medical students in this setting. The fellow will participate in management decisions with the aid and supervision from critical care attending staff. The fellow will also interact with attending staff from other primary surgical services in reaching clinical strategies and management decisions in a collaborative process which teaches the elements of working in an open unit. The fellow is responsible for writing orders, assessing patients, performing procedures, and integrating the care on either of the two rotations.

The SICU is an open unit and the ultimate clinical responsibility lies with the admitting surgical attending. Operationally, this responsibility is delegated to a degree depending on the given faculty member to the SICU team. The fellow will be expected to fill the role as the situation dictates ranging from senior consultant to primary decision maker under the supervision and guidance of the attending SICU staff.

A. Relation to Faculty:

Relation to faculty and the fellow will essentially always be one-on-one with direct supervision by an individual faculty member assuming responsibility for each and every patient and each and every care decision or procedure. Faculty will be kept informed at all times of any major changes, and as such, will assume responsibility along with the fellow for any problems in relation to the general surgery residents. The fellow is to work directly with the general surgery residents in a supervisory capacity and have the expectation to not only supervise, but teach and educate residents at the junior levels. With regard to the chief resident and the trauma surgery service and other general surgery services, fellows are to have a collaborative and complimentary interaction, but are to never have direct responsibility for the same patients. When a patient is in the SICU, the general surgery resident on any service maintains control of the patient and the surgical critical care fellow provides a consulting and collaborative relationship. With regard to patients in the resuscitation room, the surgical critical care fellow is responsible for patients on the night and day that the fellow is on call, but otherwise the general surgery residents are responsible during their days on call with the appropriate attending.

B. Relation to Residents:

The critical care fellow will function as a junior faculty member in that the program has accepted only board eligible general surgery trainees into this residency. The critical care fellow will have supervisory responsibility over general surgery residents and anesthesia residents on assignment in the SICU. Interaction with the surgical critical care unit attending staff will be one-on-one and the critical care fellow will be responsible to make rounds on a daily basis with the attending. In addition, the critical care fellow will develop individual relationships with each attending on the surgical staff and each resident group in the local general surgery training program and work directly with each specific attending and resident group who has patients in the SICU. This includes general surgery attendings, transplant attendings, neurosurgery attendings, cardiothoracic attendings, and any other attendings having patients present. The critical care fellow and the assigned

SICU general surgery residents make rounds with these primary teams and participate in the decision making and provision of care. Most policies and procedures are generated within the intensive care unit environment by input from all practitioners through a multidisciplinary SICU users group in which the critical care fellow participates. Through this process, policies and procedures are reviewed and modified. The attending staff will provide supervision and more senior guidance as well as teaching in both clinical and didactic sessions.

C. Relation to Medical Students:

The critical care fellow has a responsibility to the medical students to not only supervise them and make sure that anything they are involved in with patients is supervised, they also have a responsibility to teach the medical students and provide impromptu continuous teaching opportunities directly related to specific patients. The critical care fellow will also be asked to provide informal evaluation of medical students rotating in the SICU under their supervision, so a final evaluation done by the Critical Care attending is consistent with the overall evaluation of the team.

VII. FELLOW DUTY HOURS AND WORKING ENVIRONMENT POLICY

A. Work Standards

The standard work schedule for the fellow shall be 6:45 a.m. – 5:00 p.m.

The fellow shall accrue vacation at the official rate of 13.33 hours per month. This provides a total of 20 vacation "working days" per year.

Vacation leave will be scheduled in advance at the beginning of the academic year and shall be:

- 4 one week blocks

Changes in leave must be requested by the fellow in writing in advance on a "UCSD Departmental Approval of Absence Form" and scheduled with the agreement of the Program Director.

B. Duty Hours

Duty hours are limited to 80-hours per week averaged over a 4-week period. A template was designed to clearly explain to all members of the Critical Care Service (attendings and critical care fellows) when and at what time the fellow should start their daily activities, as well as when they should leave the hospital post call and days off.

The duty hours will be in accordance with the UCSD and ACGME Housestaff Duty Hours and Working Environment Policies/Procedures.

C. Monitoring of Duty Hours

Fellows and faculty will be provided copies of the rules pertaining to ACGME requirements for limited fellow duty hours. These rules will be discussed in a divisional meeting in which faculty and fellows attend. Minutes will be kept of this meeting.

Each month, fellows will be required to enter their duty hours online through the MedHub online logging module. The results will be evaluated by the Program Director on a regular basis to assure compliance with ACGME resident duty hour requirements.

In addition, the program director meets on a frequent basis with the fellow one-on-one to specifically address working hours, fatigue, any particular problems, and the goals and expectations of the rotation.

D. On-Call Activities

Call is "in-house" call. Fellows will be on call every fourth to seventh night (four to seven timesper month-) and will go home on the following day by 10:45am; when they are on the trauma rotation, they are usually around until about 5:00 pm and when they are on a critical care rotation they can regularly leave in the early afternoon most days.

Fellows will keep track of hours on call on a monthly basis and log hours online via

MedHub. They will follow their progress and when they are over hours, they will report it to the program director, who must review any overages.

Through the scheduling process, fellows will be guaranteed at least one weekend per month off and at least one complete day out of seven relieved of all clinical responsibilities. Should this for some reason not occur, fellows should notify the program director.

Sample hours schedule, 1 in 7 call, 4 days off per 28 days:

Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Wk
10.25	10.25	10.25	10.25	**17.25**	**6.75**	**OFF**	65
10.25	10.25	10.25	10.25	10.25	**17.25**	**6.75**	75.25
10.25	10.25	**17.25**	**6.75**	10.25	**OFF**	17.25	72.75
10.25	10.25	10.25	**17.25**	**6.75**	**OFF**	**OFF**	54.75

E. Moonlighting

Fellows in the Surgical Critical Care training program are not allowed to moonlight.

F. Support Services

Sleeping quarters and scrubs are available through the hospital service. Also, on line access to a great number of scientific journals is available to each fellow in their offices through the UCSD website digital library and Scientific American Critical Care of the Surgical Patient. A full function cafeteria is open during hospital hours and available to house staff during this time. Vending machines are available in the cafeteria during on-call hours. There is a housestaff lounge by the Hillcrest cafeteria.

G. Pay

Salary will be $71,033 per year. In addition, office supplies and equipment needs will be paid for by the division. The division will also sponsor a fellow to participate in one educational conference per year, not to exceed $1,000 per year.

H. Duty Hours Exception

Fellows will be allowed to exceed the 80-hour limit only for educational purposes and if they document why they stayed (i.e. special case, conference, or need to provide patient continuity). This will not exceed 10% or 8 hours per week, on average. In the event of

being over, they will make it up subsequently to stay in compliance with the average overall.

If called back in, they will count the hours they are in the hospital toward the 80-hour week.

For further information on the Working Environment Policy please refer to the UCSD Housestaff Working Conditions Policy (Appendix V).

VIII. SCHOLARLY ENVIRONMENT

The faculty is committed to maintenance of a scholarly environment including multiple specific activities.

A. Simulation Curriculum:

The Division has several opportunities for fellows to become proficient in education via simulation:

1. Human Patient Simulators: The Division owns two human patient simulators, a METI® iStan and a METIman, located at the SRL building, 130 Dickinson. These are computer-controlled, realistic, full size mannequins that can create a high-fidelity replica capable of exhibiting a wide range of physiologic and pathology. Simulation sessions are held bimonthly, usually Thursdays or Fridays, and fellows are expected to teach residents and medical students individual and team management of Critical Care problems. The HPS Curriculum is published on the Division website.
2. Partial Task Trainers: The Simulab® CentraLineMan is an ultrasound compatible partial mannequin at the SRL which can be used for central line training for internal jugular and subclavian vein approaches.
3. The Advanced Trauma Operative Management (ATOM) Course is an effective method of increasing surgical competence and confidence in the operative management of penetrating injuries to the chest and abdomen. The course consists of six 30-minute lectures followed by a three-hour lab session during which the student will manage 14 different injuries. The Division teaches about 8 ATOM labs per year, and Fellows will be trained in ATOM. Fellows who become ATLS Instructors can also be trained by the Division to become ATOM Instructors.
4. The Advanced Surgical Skills for Exposure in Trauma (ASSET) Course uses human cadavers to teach surgical exposure of anatomic structures that when injured may pose a threat to life or limb. It is excellent continuation of the ATOM course. The course is about six hours and taught about 3 times per year. Fellows will be trained in
   ASSET. Fellows who become ATLS Instructors can also be trained by the Division to become ASSET Instructors.

B. Ultrasound Curriculum

The Division has opportunities for fellows to become proficient using beside ultrasound:

1. Equipment: The Division operates three SonoSite® M-Turbo ultrasound machines located in the SICU, BICU and Trauma Bays.
2. The Fellows are also given access to two Butterfly® iQ handheld ultrasound devices with iPads – these are kept in the SICU and in the Fellow's office in Hillcrest. Fellows are expected to upload 25 ultrasound studies to the Cloud Server to allow proctoring for future credentialing in ultrasound.

3. On-Line Training: There are online courses on the trauma.ucsd.edu website on Central line insertion and Critical Care ultrasound. These are also useful for training rotating residents and medical students.
4. Hands-on Course: There is a practical course held early each academic year to allow practice and assessment of bedside ultrasound skills with phantoms and live models, including central line insertion, thoracentesis/paracentesis, FAST and Limited Echo.
5. RDMS credential: Fellows interested in obtaining the Registered Diagnostic Medical Sonographer (RDMS) credential can be proctored for twelve months and be recommended for examination by the ARDMS/APCA. Fellows are also able to be proctored for the POCUS credential in Point-of-Care-Ultrasound, fellows can be sponsored by the faculty. See https://apca.org/

C. GME Competency Education Program

UC San Diego Health participates in the AMA's GME Competency Education Program which is a series of online educational modules designed to complement teachings in patient settings and didactic curriculums in residency and fellowship programs. It helps fellows develop ACGME milestones to meet core competency requirements. The fellow is required to complete four modules by the end of the academic year, one on sleep deprivation and three other modules of their choice. Please refer to Appendix II for a list of topics.

D. Evidence-Based Guideline Development

The process of evidence-based guideline development will be undertaken. This will be done through business meetings and clinical research activities to maintain and create exposure to this important process. Active research is available in several areas and an elective second year can be chosen to pursue research on a more full-time basis. During the year of the clinical fellowship, research will be primarily limited to retrospective clinical research for participation in ongoing clinical activities. All critical care faculty are actively involved in research related to critical care, either basic science or clinical care. In addition, opportunity exists within the department for an interested fellow to pursue research in epidemiology or public health issues and outcomes research. All fellows are encouraged to develop clinical projects under the supervision of clinical staff and an optional year exists to pursue specific bench research. It is expected that fellows with a strong research interest will plan to spend an additional optional year and the second year is extremely flexible to accommodate these interests.

There are excellent facilities for research in a number of areas. The intensive care unit is modern with full instrumentation and highly computerized. We have been actively involved in clinical trials for several years and the personnel, including nursing staff, and know-how are in place and allow the fellow to be complimentary to this process rather than central. Active prospective trials are always underway in the SICU and Trauma unit..

E. Basic Science Research

The faculty also have strong basic science research interests involving many areas, particularly in immune response to trauma and burns. This is funded by both public and private sources. The division operates a basic science laboratory with MD and PhD faculty with NIH and other

agency funding. Collaboration with other UC research organizations, and with other San Diego based research institutions is common.

F. Epidemiology Research

In addition to this, the division has an active epidemiologic research effort including NIH funded evaluation of critically ill patients following injury. The division maintains a large database containing physiologic data on patients in the SICU and a large registry with data on over 30,000 injured patients which provide strong opportunities for retrospective research. We also have access to nationwide patient databases such as NIS, NRD, NTDB and TQIP. We also have access to state longitudinal data via the California OSHPD database. In addition, the advanced statistical and analytical expertise is available in-house.

G. Additional Program Information

We have never maintained a specific research requirement for fellows in that the clinical demands of a busy initial year are substantial. Previous fellows have been involved in clinical investigation including the initiation of clinical studies, but it has not been a requirement.

On-line access to UC and national libraries is available to each fellow through their computer.

The program uses the Scientific American Critical Care of the Surgical Patient Weekly Curriculum to provide the basis for background reading and weekly journal clubs.

To assist the fellows in oral presentations and scholarly presentations or any manuscripts, reasonable secretarial support and photographic needs will be met. Manuscript preparation, when appropriate, should be requested through the program director and he will assure that appropriate secretarial support to get manuscripts prepared.

The final component of scholarly environment includes a full-time epidemiologist and statistician who are part of the department and available to help the fellows with any research needs. Biostatician support is also available with the UC Altman Clinical Translational Research Institute.

EVALUATION METHODOLOGY

A. Evaluation of the Fellow by Faculty

The fellow will be required to maintain a case log of all operative procedures. In addition, the fellow will be provided case logs of their critical care experience in the surgical intensive care unit and their resuscitation experience. The fellows are strongly encouraged to maintain a log of ultrasounds performed and observed as well as bedside procedures. This will allow the fellow to review and maintain an active understanding of their experience and adjust during the year for any inadequacies. In addition, this will allow the program director to assure that operative experience does not exceed the rules of the RRC. Lastly, each fellow is encouraged to develop a Critical Care Index Case (CCIC) log of at least 25 patients who best represent the full breadth of critical care management. At least two out of the seven categories that follow should be applicable to each chosen patient. The completed CCIC log should include experience, with at least one patient, in all seven of the following essential categories: ventilatory management, bleeding (non- trauma) greater than 3 units, hemodynamic instability, organ dysfunction/failure, dysthymias, invasive line management/monitoring, and nutrition. The American Board of Surgery will require a case log of Critical Care cases to be submitted with the Program Directors Signature at the end of the month.

Due to the close ratio of faculty to fellows, evaluation of each fellow occurs on a contemporaneous ongoing daily basis through feedback and personal interaction between the fellows and the faculty. In addition, a formal performance evaluation of the fellow by the faculty is completed twice per year by the Program Milestones committee using the ACGME Milestones developed specifically for Surgical Critical Care. Milestones are competency-based developmental outcomes (e.g., knowledge, skills, attitudes, and performance) that can be demonstrated progressively by the fellow from the beginning of their education through graduation to the unsupervised practice of their specialties. (see Appendix IV). Lastly, a final (summative) evaluation is completed by the Faculty during the final period of the fellowship verifying that the fellow has demonstrated sufficient competence to enter practice without direct supervision.

The fellows will also be evaluated by the trauma program manager, trauma nurse practitioners, and students semiannually. They will also be encouraged to undergo a self-evaluation process on their own.

B. Evaluation of the Faculty and Program by Fellow

The fellows will be expected to evaluate the faculty using standardized forms on a semiannual basis (see page 24). The fellows will also be expected to evaluate the program annually using a standardized form (see page 25-26).
The fellows will also be encouraged and asked to participate in the Q 6-month evaluation of the core objectives and goals by providing feedback as to how to modify the program on an ongoing basis. This is covered through other evaluation methods such as active discussions with the fellows during our weekly Divisional Meeting and Journal Club Meeting.

Fellows are encouraged to discuss any issues or concerns regarding the fellowship program, their progress in the fellowship, and the correction of any identified problems.

Before the completion of the training period, fellows are asked to participate in the SCC Program Evaluation Committee meetings to provide written guidance to the faculty and program director about their overall assessment of the program and ideas for improvement.

The feedback received by fellows is used to improve the educational program and the curriculum is updated in the handbook as needed.

DIVISION OF TRAUMA
SURGICAL CRITICAL CARE FELLOWSHIP PROGRAM
FACULTY EVALUATION (Completed by Fellow)

Evaluator: **Subject:**

Please evaluate performance of faculty in the following areas.

Quality of rounds as a teaching mechanism

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Quality of clinical setting as a teaching mechanism

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Quality of teaching of administrative leadership, socioeconomic issues, ethical issues & outcomes assessment

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Quality of teaching the 6 core competencies: Medical Knowledge, Interpersonal & Communication Skills, Patient Care, Professionalism, Practice-based Learning, Systems-based Practice

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Quality of conferences

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Quality of teaching medical knowledge

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Availability of faculty member

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Helpfulness in constructing differential diagnosis

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Overall assessment

Excellent ☐ Good ☐ Average ☐ Marginal ☐ Unsatisfactory ☐ N/A ☐

Additional comments (Remaining characters 5000)

SURGICAL CRITICAL CARE FELLOWSHIP PROGRAM
FINAL PROGRAM EVALUATION FORM

Evaluator: **Subject:**

Please check yes or no to the following questions. If you answer "no," please provide details.

Do you feel prepared for the oral and written exams administered by the American Board of Surgery

Yes ☐ No ☐ N/A ☐

Comments
Remaining Characters: 5000

Were the program goals and objectives identified for Critical Care accomplished

Yes ☐ No ☐ N/A ☐

Comments
Remaining Characters: 5000

Were didactic conferences adequate in quality and quantity

Yes ☐ No ☐ N/A ☐

Comments
Remaining Characters: 5000

Did adequate attending supervision exist within the program

Yes ☐ No ☐ N/A ☐

Comments
Remaining Characters: 5000

Did the program provide sufficient faculty advisement such as consultation and support

Yes | No | N/A

Comments
Remaining Characters: 5000

Did the program provide adequate training of the 6 core competencies: patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning, and systems-based practice?

Yes | No | N/A

Comments
Remaining Characters: 5000

Additional comments

Comments
Remaining Characters: 5000

IX. QUALITY IMPROVEMENT

The division has a number of programs for quality improvement and members of the division have been national leaders in the development of programs in critical care and trauma. Maintenance of quality improvement will occur through daily rounds, the SICU users group, data collected by each of the paramedical services, and data collected on all patients through each surgical service.

Complications and deaths are presented at Wednesday morning Morbidity and Mortality conference and patient group specific complication trending is reviewed on a regular basis. Specific trends relative to ventilator use, nutritional use, compliance with the pharmacy guidelines (antibiotics and paralysis drugs) drug reactions, blood use, and a number of other disease specific complications that are reviewed on a monthly basis. The critical care fellow will be exposed to all these techniques and participate specifically in the presentation of cases, the review of problems as they occur, and the development of quality improvement solutions.

All injured patients undergo autopsy and most other patients dying in the SICU will undergo autopsy and autopsy findings will be correlated through the quality improvement process. An expedited medical record system and abstracted information on a computerized registry along with reports designed specifically to support the quality improvement process are formatted to assist the fellow in learning this process.

X. ELIGIBILITY, RECRUITMENT, SELECTION NONDISCRIMINATION, PROMOTION, EVALUATION AND DISMISSAL PROCESS

Our policies and practices are contained in the institutionally developed document called the UCSD Policy on Eligibility, Selection, Nondiscrimination, Promotion, Evaluation and Dismissal of Housestaff in ACGME Accredited Graduate Medical Education Training Programs. Please refer to Appendix V.

A. Fellow Eligibility. Applicants with one of the following qualifications are eligible for appointment to the UCSD Surgical Critical Care Residency:

1. Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME.)

2. Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).

3. Graduates of medical schools outside the United States and Canada who meet one of the following qualifications.

    a) Have received a currently valid certificate from the Educational Commission for Foreign Medical Graduates and are in compliance with the license requirements of the State of California.

    b) Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.

4. Graduates of medical schools located outside the United States who have completed a Fifth Pathway program provided by a LCME-accredited medical school will be in compliance with the license requirements of the State of California.

B. Recruitment Process

The recruitment process starts by posting an advertisement to science journals. Fellows then apply by completing an application online via the Surgical Critical Care and Acute Care Surgery Fellowship Application Service (SAFAS) website managed by the Surgical Critical Care Program Directors Society.

Based on an initial screening, candidates are invited for one day to meet faculty and other key personnel.

The program has participated in the Surgical Critical Care Match and the program director reserves the right to define the number of spots that will be made available to the match, 1, 2, or 3 as well as to hire fellows off match within the quota (2 for instance) accredited by the ACGME.

C. Fellow Selection

UCSD selects from among eligible applicants on the basis of their preparedness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. The UCSD Surgical Critical Care Program does not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.

D. Enrollment of Noneligibles

UCSD will not appoint noneligible individuals.

XI. GRIEVANCE PROCEDURES

Should a fellow have a specific grievance, he/she is encouraged to use the office of Graduate Medical Education to assist with this process and follow a procedure. At our institution, our policy is the institutionally developed policy for corrective action/discipline hearing and appeal which is contained in our House Officer Policy and Procedure Document (HOPPD). Please refer to Appendix V.

III. MONITORING STRESS, BURNOUT AND FATIGUE

Given the stressfulness and complexity of working with critically ill or highly injured patients, the monitoring of stress and fatigue and the attention to its signs and symptoms is an important priority for the Division of Trauma. Any indication that fellows are physically, psychologically, or personally stressed, burnt out and/or fatigued will be immediately identified, the fellow will be relieved of all clinical duties, and the faculty will assume all responsibilities of the fellow until this problem can be dealt with. During the evaluation process, the program director will ask the fellows about stress and fatigue. In addition, as part of the Core Curriculum there are SACCSP modules on Physician Well Being and Impairment as well as modules in the IPM series. Any fellow seeing a colleague or feeling personally fatigued and/or in a stressful situation is asked to identify this immediately to the program director or to other faculty members so that this can be identified.

Fellows should not attempt to drive a vehicle if excessively tired. Should a fellow need to use a shared ride or taxi to get home safely when fatigued, this must be reported to the program director who will cover the cost.

XIII. ADDITIONAL PROGRAM INFORMATION AND STATISTICS

A. SCCM In-Training Examination (MCCKAP)

In 1998 fellows began participating in the SCCM In-Training Examination process. Fellows are requested to take this examination and the cost of this will be provided by the program.

B. Board Certification Rates

For the past 12 years, all critical care fellows have passed the American Board of Surgery Certifying Exam for Surgical Critical Care.

In addition, the residency has undergone multiple internal reviews by the Graduate Medical Education Committee of the School of Medicine, UCSD, and no deficiencies have been cited.

C. Career Paths of Graduates

Approximately 75 percent of all graduates are currently employed at academic institutions.

XIV. APPENDICES

Appendix I

Conference Schedules

Appendix II

GME Competency Education Program

Appendix III

Required Readings
Suggested Readings

Appendix IV

ACGME Milestones

Appendix V

UCSD Housestaff Duty Hours and Working Environment Policy

Appendix I

SURGICAL CRITICAL CARE JOURNAL CLUB WEEKLY TOPICS

Thursdays at Noon,
Bloom Conference Room 2-256, MPF, 402 Dickinson St.

August 8, 2019 – July 30, 2020

- Articles are to be distributed to the Club by the SICU Fellow NLT than Sunday Evening weekly.
- The SICU Fellow will present the article listed for that week, plus another article on the topic of their own choosing.
- Beyond a description of the question, methods, results and conclusions, the SICU Fellow should attempt to discuss any biases or methodological issues that may be present in the studies.
- (*Hint: Google the article title and "journal club" to find critiques of the major articles online.)
- All Club Members should review the articles prior to the Journal Club.
- Fellows should also review the associated module in "Scientific American Critical Care of the Surgical Patient Weekly Curriculum" which will be auto-emailed on Sunday night.
- Fellows are also encouraged to answer the 5 self-assessment questions after each Weekly Curriculum module. Results (or lack thereof) are visible to the PD.
- **Due to a dispute between UC and Elsevier, some articles may not be available via UC Libraries, if unable to access, please let the PD know.

Journal Club Date	ABS Topic	SACCSP Weekly Curriculum Topic	Top 100 Contemporary Critical Care Studies / Guideline/ Review (This paper and 1 fellow-selected paper to be presented)	Fellow Presenting
8/8/2019	Shock –Overview	8002 Diagnosis and Treatment of States of Shock	The ProCESS Investigators. A Randomized Trial of Protocol-Based Care for Early Septic Shock (ProCESS study). New Engl J Med 2014;epublished March 18th	Dr Raschke
8/15/2019	Vasoactive Drugs	8001 Inotropes and Vasopressors for Various Types of Shock	Annane. Norepinephrine plus dobutamine versus epinephrine alone for management of septic shock: A randomised trial. Lancet 2007; 370:676-684	Dr Raschke
8/22/2019	Cardiac Physiology	Cardiac Anatomy and Physiology	Morelli. Effect of Heart Rate Control With Esmolol on Hemodynamic and Clinical Outcomes in Patients With Septic Shock. A Randomized Clinical Trial. JAMA 2013;310(16):1683-1691	Dr Raschke
8/29/2019	Angina, MI, Hypertensive Crisis, and Pulmonary Edema	8009 Cardiac Support Devices	Slaughter. Advanced heart failure treated with continuous-flow left ventricular assist device. N Engl J Med 2009;361(23):2241-51	Dr Raschke
9/5/2019	Shock	Cardiac Tamponade	Thiele. Intraaortic Balloon Support for Myocardial Infarction with Cardiogenic Shock (IABP-SHOCK II Trial). NEJM epublished ahead of print August 27th 2012	Dr Reilly
9/12/2019	Respiratory Physiology	Respiratory Physiology	Guérin. Prone Positioning in Severe Acute Respiratory Distress Syndrome (PROSEVA). New Engl J Med 2013;368:2159-2168	Dr Reilly
9/19/2019	Respiratory Monitoring and	Physiology of Mechanical Ventilation	The Acute Respiratory Distress Syndrome Network. Ventilation with Lower Tidal	Dr Reilly

	Mechanical ventilation		Volumes as Compared with Traditional Tidal Volumes for Acute Lung Injury and the Acute Respiratory Distress Syndrome. N Engl J Med 2000; 342:1301-1308	
9/26/2019	Weaning and Extubation	Physiologic Assessment and Real-World Application	Girard. Efficacy and safety of a paired sedation and ventilator weaning protocol for mechanically ventilated patients in intensive care (Awakening and Breathing Controlled trial): a randomised controlled trial). Lancet 2008;371(9607):126-134	Dr Santorelli
10/3/2019	Respiratory Failure	Assessment of Respiratory Failure	**Papazian. Neuromuscular blockers in early acute respiratory distress syndrome. N Engl J Med 2010;363:1107-1116**	Dr Santorelli
10/10/2019	Renal Failure	Physiology – The Renal System	Is contrast exposure safe among the highest risk trauma patients? Kim DY, Kobayashi L, Costantini TW, Chang D, Fortlage D, Curry T, Wynn S, Doucet J, Bansal V, Coimbra R. J Trauma Acute Care Surg. 2012 Jan;72(1):61-6; discussion 66-7. doi: 10.1097/TA.0b013e31823f36e0. PMID: 22310117	Dr Santorelli
10/17/2019	Renal Support Therapy	Renal Support Therapy	Ronco. Effects of different doses in continuous veno-venous haemofiltration on outcomes of acute renal failure: a prospective randomised trial. Lancet 2000;356:26-30	Dr Santorelli
10/24/2019	Acute Kidney Injury	Acute Kidney Injury	Palevsky. Intensity of renal support in critically ill patients with acute kidney injury. N Engl J Med 2008; 359:7-20	Dr Santorelli
October 31, 2019	Rhabdomyolysis	8301 Rhabdomyolysis	An Official ATS/ERS/ESICM/SCCM/SRLF Statement: Prevention and Management of Acute Renal Failure in the ICU Patient: an international consensus conference in intensive care medicine.	Dr. Munden
November 7, 2019	Acid Base Disorders	Acid Base Disorders	Strong ion difference and gap predict outcomes after adult burn injury.	Dr. Munden
November 14, 2019	Brain Death	8223 Brain Death 8029 Brain Death Protocol	Thyroid hormone resuscitation after brain death in potential organ donors: A primer for neurocritical care providers and narrative review of the literature.	Dr. Munden
November 21, 2019	Glucose / Endocrine Emergencies	8017 Glucose Control (DKA, Hypoglycemia, Hyperosmolar) 8020 Role of Hemoglobin A1c in Operative Patients	ICE-SUGAR Study Investigators. Intensive versus Conventional Glucose Control in Critically Ill Patients. N Engl J Med 2009;360:1283-97	Dr. Munden
November 28, 2019 (Thanksgiving)	Steroid Replacement in Critical Care	8018 Steroid Replacement in Critical Care	SUGGESTED READING: Single induction dose of etomidate versus other induction agents for endotracheal intubation in critically ill patients.	No Club.
December 5, 2019	Infections	8043 Appropriate Antibiotic Selection and Use for ICU Patients.	Kumar. Initiation of inappropriate antimicrobial therapy results in a fivefold reduction of survival in human septic shock. Chest 2009; 136(5):1237-1248.	Dr Reilly
December 12, 2019	Infection Control	2232 Infection Control in Surgical Practice	Chlorhexidine bathing and health care-associated infections: a randomized clinical trial.	Dr Reilly
December 19, 2019	Infectious Diseases	Immunocompromised patient and Opportunistic Infections	Vincent. International Study of the Prevalence and Outcomes of Infection in Intensive Care Units. JAMA. 2009;302(21):2323-2329	Dr Reilly
December 26, 2019 (Holidays)	Infectious Diseases (Holiday)	Viral Fungal and Atypical Infection	SUGGESTED READING: Sprung. Hydrocortisone Therapy for Patients with Septic Shock. N Engl J Med 2008;358:111-124	No Club.
January 2, 2019 (Holidays)	Infectious Diseases (Holiday)	CNS Infection	SUGGESTED READING: de Jonge. Effects of selective decontamination of the digestive tract on mortality and acquisition of resistant bacteria in intensive	No Club.

			care: a randomised controlled trial. Lancet 2003;362:1011-1016	
January 9, 2020	Transfusion and Blood Component Therapy	Hematology – Tranfusion Therapy	Hebert. A multicenter, randomized, controlled clinical trial of transfusion requirements in critical care. N Engl J Med 1999;340:409-17	Dr Raschke
January 16, 2020	DVT and PE. Prophylaxis, Diagnosis, and Treatment	8344 Deep Vein Thrombosis and Venous Thromboembolism in the Critically Ill	Prevention of VTE in nonsurgical patients: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines.	Dr Raschke
January 23, 2019	GI: Hepatic Failure	8320 Acute Liver Failure	Modern Management of Acute Liver Failure.	Dr Raschke
January 30, 2020	Pancreatitis	GI- Pancreatitis, Biliary Disease	Mier. Early versus late necrosectomy in severe necrotzing pancreatitis. Am J Surg 1997;173:71–5	Dr Reilly
February 6, 2020	Nutrition	8241 Enteral and Parenteral Nutritional Support 2233 Nutritional Support	Casaer. Early versus Late Parenteral Nutrition in Critically Ill Adults. NEJM 2011;365:506-517	Dr Reilly
February 13, 2019	GI- UGI Bleeding	GI- UGI Bleeding	Villanueva. Transfusion Strategies for Acute Upper Gastrointestinal Bleeding. N Engl J Med 2013;368:11-21	Dr Reilly
February 20, 2019	GI – LGI Bleeding	GI – LGI Bleeding	ACG Clinical Guideline: Management of Patients With Acute Lower Gastrointestinal Bleeding.	Dr Santorelli
February 27, 2019	CNS Emergencies, Stroke, Delirium	Acute Neurologic Events, New techniques in hemorrhage control	Effect of Haloperidol on Survival Among Critically Ill Adults With a High Risk of Delirium: The REDUCE Randomized Clinical Trial.	Dr Santorelli
March 5, 2020	Coagulopathy	Hematology – Assessment of Hemostasis	Thromboelastogram does not detect pre-injury anticoagulation in acute trauma patients.	Dr Santorelli
March 12, 2020	BCVI	8222 Blunt Cerebrovascular Injury	Endovascular stenting is rarely necessary for the management of bluntcerebrovascular injuries.	Dr Santorelli
March 19, 2020	Trauma – Special Populations	8178 Special Populations (Pediatric, Geriatric, Pregnant)	Nonaccidental Trauma in Pediatric Surgery.	Dr Raschke
March 26, 2020	Burns	Burns & Inhalation Injury	Hypertonic salt solution for peri-operative fluid management	Dr Raschke
April 2, 2020	Cardiovascular Monitoring	8101 Invasive Monitoring in the Intensive Care Unit	Harvey. Assessment of the clinical effectiveness of pulmonary artery catheters in management of patients in intensive care (PAC-Man): a randomised controlled trial. Lancet 2006;366:472-477	Dr Raschke
April 9, 2020	Competency based care - malpratice	Competency based care - Malpractice	Implementation of a standardized handoff protocol for post-operative admissions to the surgical intensive care unit.	Dr Raschke
April 16, 2020	Interpreting Statistical Studies	Research Principles – Interpreting Statistical Studies	An introduction to implementation science for the non-specialist. Bauer MS, Damschroder L, Hagedorn H, Smith J, Kilbourne AM. BMC Psychol. 2015 Sep 16;3:32. doi: 10.1186/s40359-015-0089-9.	Dr Reilly
April 23, 2020	Trauma – Special Populations	Pediatric Shock	Maitland. Mortality after Fluid Bolus in African Children with Severe Infection (FEAST Trial). N Engl J Med 2011;364:2483-2495	Dr Reilly
April 30, 2020	Competency based care - EBM	Competency based care - EBM	Prasad. A Decade of Reversal: An Analysis of 146 Contradicted Medical Practices. Mayo Clinic Proceedings 2013;88(8):790-798	Dr Reilly
May7, 2020	Competency Based Care – Bedside Procedures Pt1	Competency Based Care – Bedside Procedures	Does size matter? A prospective analysis of 28-32 versus 36-40 French **chest tube** size in trauma. **Inaba** K, Lustenberger T, Recinos G, Georgiou C, Velmahos GC, Brown C, Salim A, Demetriades D, Rhee P.	Dr Reilly

			J Trauma Acute Care Surg. 2012 Feb;72(2):422-7. doi: 10.1097/TA.0b013e3182452444.	
May 14, 2020	Pharmacy	8260 Pharmacokinetics, Metabolism, and Dose Adjustment	If some is good, more is better: An enoxaparin dosing strategy to improve pharmacologic venous thromboembolism prophylaxis.	Dr Santorelli
May 21, 2020	Surgical palliative care	Surgical palliative care	A Randomized Trial of Palliative Care Discussions Linked to an Automated Early Warning System Alert.	Dr Santorelli
May 28, 2020	Surgical palliative care	Medical Futility	Evidence-Based Care of Geriatric Trauma Patients Surg Clin North Am. 2017 Oct;97(5):1157-1174. doi: 10.1016/j.suc.2017.06.006	Dr Santorelli
June 4, 2020	Competency Based Care – Bedside Procedures Pt2	Bedside procedures	Randomized, prospective, observational simulation study comparing residents' needle-guided vs free-hand ultrasound techniques for central venous catheter access. Ball RD, Scouras NE, Orebaugh S, Wilde J, Sakai T. Br J Anaesth. 2012 Jan;108(1):72-9. doi: 10.1093/bja/aer329.	Dr Santorelli
June 11, 2020	Transplant	Post-op ManagementTransplant	Glucocorticosteroid-free versus glucocorticosteroid-containing immunosuppression for liver transplanted patients.	Dr Raschke
June 18, 2020	Ultrasound	Critical Care Ultrasonography	**Image-based resuscitation of the hypotensive patient with cardiac ultrasound: An evidence-based review.**	Dr Raschke
June 25, 2020	Monitoring	Monitoring/Bioengineering	Asfar. High versus Low Blood-Pressure Target in Patients with Septic Shock (SEPSISPAM study). New Engl J Med 2014;370:1583-1593	Dr Raschke
July 2, 2020	ECMO Pt1	8011 Extracorporeal Membrane Oxygenation	Extracorporeal Membrane Oxygenation for Severe Acute Respiratory Distress Syndrome.	Dr Santorelli
July 9, 2020	ECMO Pt 2	8011 Extracorporeal Membrane Oxygenation	Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial.Peek GJ, Mugford M, Tiruvoipati R, Wilson A, Allen E, Thalanany MM, Hibbert CL, Truesdale A, Clemens F, Cooper N, Firmin RK, Elbourne D; CESAR trial collaboration. Lancet. 2009 Oct 17;374(9698):1351-63. doi: 10.1016/S0140-6736(09)61069-2.	Dr Santorelli
July 16, 2020	End-of-Life Care	Competency Based Practice – End of Life Care	Randomized Trial of Communication Facilitators to Reduce Family Distress and Intensity of End-of-Life Care. Curtis JR, Treece PD, Nielsen EL, Gold J, Ciechanowski PS, Shannon SE, Khandelwal N, Young JP, Engelberg RA. Am J Respir Crit Care Med. 2016 Jan 15;193(2):154-62. doi: 10.1164/rccm.201505-0900OC.	Dr Santorelli
July 23., 2020	Respiratory – Ventilation	Invasive and Non-Invasive Ventilation	Effect of Noninvasive Ventilation Delivered by Helmet vs Face Mask on the Rate of Endotracheal Intubation in Patients With Acute Respiratory Distress Syndrome: A Randomized Clinical Trial. Patel BK, Wolfe KS, Pohlman AS, Hall JB, Kress JP. JAMA. 2016 Jun 14;315(22):2435-41. doi: 10.1001/jama.2016.6338. PMID:27179847	Dr Reilly
July 30, 2020	Ventilator Weaning	Weaning	A prospective study of indexes predicting the outcome of trials of weaning from mechanical ventilation. Yang KL, Tobin MJ. N Engl J Med. 1991 May 23;324(21):1445-50. PMID: 2023603	Dr Reilly

Appendix I (continued)

CONFERENCE SCHEDULE (AY 2019-2020)

THURSDAY TRAUMA/ACS EDUCATION CONFERENCE

WHEN: 7:00-8:00AM

LOCATION: ACR conference room

AUGUST 2019

- 1—faculty/guest lecture - TBA
- 8—trauma fellow lecture (Thoracic Trauma) – Dr Raschke
- 15—video tape review - Dr Raschke
- 22—select case review - Dr Raschke
- 29—neuro-trauma conference (Initial evaluation and management of TBI) – Dr Raschke

SEPTEMBER 2019

- 5— trauma fellow lecture (Cardiac and Thoracic Vascular Injury) – Dr Reilly
- 12— video tape review – Dr Reilly
- 19— CANCELLED FOR AAST
- 26—select case review – Dr Santorelli

OCTOBER 2019

- 3—faculty/guest lecture - TBA
- 10— trauma fellow lecture (Splenic Injury) – Dr Santorelli
- 17— video tape review – Dr Santorelli
- 24— trauma fellow lecture (Liver/Hepatobiliary Injury) – Dr Santorelli
- 31— select case review (week of ACS) Dr Munden

NOVEMBER 2019

- 7—video tape review – Dr Munden
- 14—select case review – Dr Munden
- 21— neuro-trauma conference (Severe TBI—neuroprotective strategies, intracranial hypertension and surgical management) – Dr Munden
- 28— CANCELLED FOR THANKSGIVING

DECEMBER 2019

- 5—faculty/guest lecture - TBA
- 12— trauma fellow lecture (Pelvic Trauma) – Dr Reilly
- 19— video tape review – Dr Reilly
- 26— CANCELLED

JANUARY 2020

- 2— faculty/guest lecture - TBA
- 9— trauma fellow lecture (Hollow Viscous Injury) – Dr Raschke
- 16— video tape review – Dr Raschke
- 23— select case review – Dr Raschke
- 30— neuro-trauma conference (Blunt cerebrovascular Injury) – Dr Reilly

FEBRUARY 2020

- 6—faculty/guest lecture - TBA
- 13—trauma fellow lecture (Pancreatic and Duodenal Injury) - Dr Reilly
- 20—video tape review – Dr Santorelli
- 27—select case review – Dr Santorelli

MARCH 2020

- 5—faculty/guest lecture - TBA
- 12—trauma fellow lecture (Genitourinary trauma) – Dr Santorelli
- 19—video tape review – Dr Raschke
- 26—select case review – Dr Raschke

APRIL 2020

- 2—faculty/guest lecture - TBA
- 9—trauma fellow lecture (Extremity Trauma/Peripheral Vascular Injury) – Dr Raschke
- 16—video tape review – Dr Reilly
- 23—select case review – Dr Reilly
- 30—faculty/guest lecture - TBA

MAY 2020

- 7—trauma fellow lecture (Geriatric Trauma) – Dr Reilly
- 14—video tape review – Dr Santorelli
- 21—select case review – Dr Santorelli
- 28—neuro-trauma conference (Management of acute spinal cord/spine injuries) – Dr Santorelli

JUNE 2020

- 4—faculty/guest lecture - TBA
- 11—trauma fellow lecture (Neck Trauma) – Dr Raschke
- 18—video tape review – Dr Raschke
- 25—select case review – Dr Raschke

JULY 2020

- 2—CANCELLED
- 9—trauma fellow lecture (trauma induced coagulopathy/massive transfusion) – Dr Santorelli
- 16—video tape review – Dr Santorelli
- 23—select case review – Dr Reilly
- 30 – End of Year Review - All

THURSDAY TRAUMA/ACS EDUCATION CONFERENCE

Faculty/Guest Lecture Topics:

- **Palliative care (TBD)**
- **Pain management (Timothy Furnish, MD)**
- **Difficult airway/basic anesthesia (ACCM faculty)**
- **Pediatric trauma (Radys faculty/Summer Kirtley RN)**
- **Burns (Dr Lee, Dr Godat, Dt Higginson)**
- **Ultrasound in trauma/critical care (Jay Doucet, MD)**
- **Acute pancreatitis (Amy Liepert, MD)**
- **Small bowel obstruction (Leslie Kobayashi, MD)**
- **Acute appendicitis (Laura Godat, MD)**
- **Necrotizing soft tissue infections (Todd Costantini, MD)**
- **Colitis (infectious/ischemic/diverticulitis)**
- **Blast/Ballistics (Jay Doucet, MD)**
- **Severe TBI / Brain death (Dr Jessica Weaver)**
- **Hernias (Dr Doucet)**
- **Peptic Ulcer Disease (Dr Kobayashi / Dr Doucet)**

Appendix I (continued)

TRAUMA/RADIOLOGY CONFERENCE SCHEDULE AY 2019-2020

WHEN: 4TH Tuesday each month, 3:00pm

LOCATION: Lasser Conference Room

DATES / Fellow Presenting

- August 27, 2019 Dr Raschke
- September 24, 2019 Dr Santorelli
- October 22, 2019 Dr Santorelli
- November 26, 2019 Dr Reilly
- December 24, 2019 CANCELLED FOR HOLIDAY
- January 28, 2020 Dr Reilly
- February 25, 2020 Dr Santorelli
- March 24, 2020 Dr Raschke
- April 28, 2020 Dr Reilly
- May 26, 2020 Dr Santorelli
- June 23, 2020 Dr Raschke
- July 28, 2020 Dr Reilly

Appendix I (continued)

TRAUMA/ED CONFERENCE SCHEDULE AY 2019-2020

WHEN: 4TH Tuesday each month, 4:00 PM

LOCATION: 3rd floor conference room

DATES:

- August 27, 2019 Dr. Dennis Liu
- September 24, 2019 Dr. Ioan Belovarski
- October 22, 2019 Dr. Aaron Lee / Dr Matt Correia
- November 26, 2019 Dr. Max Caccese
- December 24, 2019 CANCELLED FOR HOLIDAY
- January 28, 2020 Dr. Emily Sbiroli
- February 25, 2020 Dr. Eileen Shi
- March 24, 2020 Dr. Michael Self
- April 28, 2020 Dr. Ben Liotta
- May 26, 2020 Dr. Claire Wang
- June 23, 2020 Dr. Rahul Nene
- July 28, 2020 TBA

Appendix I (continued)

ORTHO TRAUMA CONFERENCE
WHEN: 7:00-8:00 2nd and 4th FRIDAYS of month
LOCATION: ACR conference room

DATE	TEAM RESPONSIBLE
August 9, 2019	TRAUMA (Raschke)
August 23, 2019	ORTHO
September 13, 2019	TRAUMA (Reilly)
September 27, 2019	ORTHO
October 11, 2019	TRAUMA (Santorelli)
October 25, 2019	ORTHO
November 8, 2019	TRAUMA (Munden)
November 22, 2019	ORTHO
December 13, 2019	TRAUMA (Reilly)
December 27, 2019	ORTHO
January 10, 2020	TRAUMA (Raschke)
January 24, 2020	ORTHO
February 14, 2020	TRAUMA (Reilly)
February 28, 2020	ORTHO
March 13, 2020	TRAUMA (Santorelli)
March 27, 2020	ORTHO
April 10, 2020	TRAUMA (Raschke)
April 24, 2020	ORTHO
May 8, 2020	TRAUMA (Reilly)
May 22, 2020	ORTHO
June 12, 2020	TRAUMA (Raschke)
June 26,2020	ORTHO
July 10, 2020	TRAUMA (Santorelli)
July 24, 2020	ORTHO

SUGGESTED ORTHO-TRAUMA CONFERENCE TOPICS FOR TRAUMA FELLOWS

1. VTE prophylaxis and management
2. Pelvic Fractures and hemodynamic instability – Algorithms
3. Initial Management of Spinal Trauma
4. Compartment Syndrome
5. The Mangled Extremity
6. Management of open fractures – literature and guidelines
7. Necrotizing Soft Tissue infection – workup and management
8. Damage control orthopedics
9. Extremity vascular injury – workup and options for management
10. Antibiotics and Tetanus prophylaxis in extremity trauma
11. Outcomes and long-term disabilities in extremity trauma
12. Screening, workup and management of cervical spine trauma

Appendix I (continued)

PRESENTATIONS BY FELLOW:

DR ANDREA MUNDEN, MD (8)

- October 31, 2019 Journal Club - Fluid and Electrolyte Disorders
- November 7, 2019 Journal Club -Acute Kidney Injury
- November 14, 2019 Journal Club - Renal Replacement Therapy
- November 21, 2019 Journal Club - GI Bleeding – Treatment and Prophylaxis
- November 7, 2019 Video tape review
- November 8, 2019 ORTHO/TRAUMA CONFERENCE
- November 14, 2019 Select case review
- November 21, 2019 Neuro-trauma conference (Severe TBI—neuroprotective strategies, intracranial hypertension and surgical management)

Appendix I (continued)

PRESENTATIONS BY
DR ERIC RASCHKE, MD (31)

- August 8, 2019 Journal Club - Hemodynamic Monitoring
- August 8, 2019 Trauma fellow lecture (Thoracic Trauma) – Dr Raschke
- August 9, 2019 ORTHO-TRAUMA CONFERENCE
- August 15, 2019 Journal Club - Respiratory Monitoring and Mechanical ventilation
- August 15, 2019 Video tape review - Dr Raschke
- August 22, 2019 Select case review - Dr Raschke
- August 22, 2019 Journal Club - Weaning and Extubation
- August 27, 2019 TRAUMA / RADIOLOGY CONFERENCE
- August 29, 2019 Neuro-trauma conference (Initial evaluation and management of TBI)
- August 29, 2019 Journal Club - Shock –Overview
- January 9, 2020 Journal Club 0 Hepatic Failure
- January 9, 2020 Trauma fellow lecture (Hollow Viscus Injury) – Dr Raschke
- January 10, 2020 ORTHO-TRAUMA CONFERENCE
- January 16, 2020 video tape review – Dr Raschke
- January 16, 2020 Journal Club - Burns and Inhalation Injury
- January 23, 2020 select case review – Dr Raschke
- January 23, 2020 Journal Club -Nutritional Assessment and Support
- March 19, 2020 Journal Club - Posttraumatic Immunosuppression
- March 24, 2020 TRAUMA / RADIOLOGY CONFERENCE
- March 26, 2020 Journal Club -Brain Death
- April 2, 2020 Journal Club -Coma, Stroke, Seizures, Delirium
- April 9, 2020 Journal Club -Blunt Cerebrovascular Injury
- April 10, 2020 ORTHO-TRAUMA CONFERENCE
- June 11, 2020 Trauma fellow lecture (Neck Trauma) – Dr Raschke
- June 11, 2020 Journal Club S-pecial Populations (Pediatric, Geriatric, Pregnant)
- June 12, 2020 ORTHO-TRAUMA CONFERENCE
- June 18, 2020 Video tape review – Dr Raschke
- June 18, 2020 Journal Club -Steroid Replacement in Critical Care
- June 23, 2020 TRAUMA / RADIOLOGY CONFERENCE
- June 25, 2020 Select case review – Dr Raschke
- June 25, 2020 Journal Club -Geriatric Surgical Patient

Appendix I (continued)

PRESENTATIONS BY
DR LINDSAY REILLY (33)

- September 5, 2019 Trauma fellow lecture (Cardiac and Thoracic Vascular Injury)
- September 5, 2019 Journal Club - Vasoactive Drugs
- September 12, 2019 Video tape review – Dr Reilly
- September 12, 2019 Journal Club - TBI/Intracranial Hypertension
- September 13, 2019 ORTHO/TRAUMA CONFERENCE
- September 19, 2019 Journal Club - Angina, MI, Hypertensive Crisis, and Pulmonary Edema
- November 26, 2019 TRAUMA / RADIOLOGY CONFERENCE
- December 5, 2019 Journal Club - Pneumonia in the ICU
- December 12, 2019 trauma fellow lecture (Pelvic Trauma)
- December 12, 2019 Journal Club - Fever in the ICU
- December 13, 2019 ORTHO/TRAUMA CONFERENCE
- December 19, 2019 Video tape review – Dr Reilly
- December 19, 2019 Journal Club - Antibiotics, Antifungals, Antivirals
- January 9, 2020 Journal Club - Hepatic Failure
- February 14, 2020 ORTHO/TRAUMA CONFERENCE
- January 16, 2020 Journal Club - Burns and Inhalation Injury
- January 23, 2019 Journal Club - Nutritional Assessment and Support
- January 28, 2020 TRAUMA / RADIOLOGY CONFERENCE
- January 30, 2020 Neuro-trauma conference (Blunt cerebrovascular Injury)
- January 30, 2020 Journal Club - Acid Base Disorders
- February 13, 2019 Trauma fellow lecture (Pancreatic and Duodenal Injury)
- February 13, 2019 Journal Club - Rhabdomyolysis
- April 16, 2020 Video tape review
- April 16, 2020 Journal Club - Pharmacology / Pharmacokinetics
- April 23, 2020 Journal Club - Drug Overdose – Poisonings
- April 23, 2020 Select case review
- April 28, 2020 TRAUMA / RADIOLOGY CONFERENCE
- April 30, 2020 Journal Club - Extracorporeal Circulation (ECMO)
- May 7, 2020 Journal Club - Deep Soft Tissue Infections / Necrotizing Fasciitis
- May 8, 2020 ORTHO/TRAUMA CONFERENCE
- July 23., 2020 Select case review – Dr Reilly
- July 23., 2020 Journal Club - Quality Assurance in the ICU
- July 30, 2020 Journal Club -Infection Control

Appendix I (continued)

PRESENTATIONS BY
DR JARRETT SANTORELLI (33)

- September 24, 2019 TRAUMA/RADIOLOGY CONFERENCE
- September 26, 2019 Select case review – Dr Santorelli
- September 26, 2019 Journal Club: ACLS Protocols / Pacing, Cardioversion, Cardiac Arrest
- October 3, 2019 Journal Club: Chest injury
- October 10, 2019 Trauma fellow lecture (Splenic Injury)
- October 10, 2019 Journal Club: Clotting, Bleeding Disorders, and Thrombocytopenia
- October 11, 2019 ORTHO/TRAUMA CONFERENCE
- October 17, 2019 Video tape review – Dr Santorelli
- October 17, 2019 Journal Club: Transfusion and Blood Component Therapy
- October 22, 2019 TRAUMA/RADIOLOGY CONFERENCE
- October 24, 2019 Trauma fellow lecture (Liver/Hepatobiliary Injury) – Dr Santorelli
- October 24, 2019 Journal Club: DVT and PE. Prophylaxis, Diagnosis, and Treatment
- February 20, 2019 Video tape review
- February 20, 2019 Journal Club: Glucose / Endocrine Emergencies
- February 25, 2020 TRAUMA/RADIOLOGY CONFERENCE
- February 27, 2019 Select case review
- February 27, 2019 Journal Club: Transplantation – ICU Aspects
- March 5, 2020 Journal Club: Sepsis / Septic Shock
- March 12, 2020 Trauma fellow lecture (Genitourinary trauma)
- March 12, 2020 Journal Club: Immune Dysfunction in Shock and Sepsis
- March 13, 2020 ORTHO/TRAUMA CONFERENCE
- May 14, 2020 Journal Club: Acalculous Cholecystitis / Pancreatitis
- May 21, 2020 Journal Club: Trauma Resuscitation
- May 26, 2020 TRAUMA/RADIOLOGY CONFERENCE
- May 28, 2020 Neuro-trauma conference (Management of acute spinal cord injuries)
- May 28, 2020 Journal Club: New Techniques in Hemorrhage Control
- June 4, 2020 Journal Club: Abdominal Trauma
- July 2, 2020 Journal Club: Musculoskeletal Injuries
- July 9, 2020 Trauma fellow lecture (trauma induced coagulopathy/massive transfusion
- July 9, 2020 Journal Club: Trauma Imaging
- July 10, 2020 ORTHO/TRAUMA CONFERENCE
- July 16, 2020 Video tape review
- July 16, 2020 Journal Club: ICU Palliation/End-of-Life Care

Record of Trauma Resuscitation Conference, August 2018 – July 2019

DATE	TOPIC	PRESENTER 7AM-8AM	PRESENTER 3PM-4PM	PRESENTER 4PM-5PM
08/02/18	Lecture: Pediatric Resources at Hillcrest	Summer Kirtley, RN		
08/09/18	Lecture: Evaluation and Management of Thoracic Trauma	Nikolas Kappy, MD		
08/16/18	Video Tape Reviews	Nikolas Kappy, MD		
08/23/18	Select Case Review	Nikolas Kappy, MD		
08/28/18	Trauma/Radiology Conference		Nikolas Kappy, MD	
08/28/18	Trauma/ED Conference			Matt Correia, MD
08/30/18	Neuro-Trauma Conference Lecture: Initial Evaluation and Management of TBI	Nikolas Kappy, MD		
09/06/18	Evaluation and Management of Cardiac and Thoracic Vascular Injury	Daniel Ludi, MD		
09/13/18	Videotape Review	Daniel Ludi, MD		
09/20/18	Select Case Review	Daniel Ludi, MD		
09/25/18	Trauma/Radiology Conference		Daniel Ludi, MD	
09/25/18	Trauma/ED Conference			Vishnu Parthasarathy, MD
09/27/18	Conference cancelled for AAST			
10/04/18	Lecture: Evaluation and Management of Splenic Injury	Meghan Cochran-Yu, MD		
10/11/18	Videotape Review	Meghan Cochran-Yu, MD		
10/18/18	Lecture: Acute Appendicitis	Meghan Cochran-Yu, MD		
10/23/18	Conferences Cancelled for ACS			

	Meeting			
10/25/18	Select Case Review	Meghan Cochran-Yu, MD		
11/01/18	Lecture: Evaluation and Management of Hepatic Injuries	Nikolas Kappy, MD		
11/08/18	Videotape Review	Nikolas Kappy, MD		
11/15/18	Select Case Review	Nikolas Kappy, MD		
11/22/18	Cancelled due to Thanksgiving Holiday			
11/27/18	Trauma/Radiology Conference-Cancelled due to National Radiology Conference			
11/27/18	Trauma/ED Conference			Jack Storey, MD
11/29/18	Neuro/Trauma Conference. Lecture: Management of Sever TBI	Daniel Ludi, MD		
12/06/18	Lecture: Management of the Difficult Airway and Basic Anesthesia Principles for Trauma	Anush Minokadeh, MD		
12/13/18	Lecture: Evaluation and Management of Pelvic Trauma	Daniel Ludi, MD		
12/20/18	Videotape Review	Daniel Ludi, MD		
12/25/18	Conference Cancelled due to Holiday			
12/27/18	Conference Cancelled			
01/03/19	Conference Cancelled due to New Year's Holiday			
01/10/19	Lecture: Evaluation and Management of Hollow Viscous Injury	Meghan Cochran-Yu, MD		
01/17/19	Videotape Review	Meghan Cochran-Yu, MD		
01/22/19	Trauma/Radiology Conference		Meghan Cochran-Yu, MD	
01/22/19	Trauma/ED Conference			Sam McGlone, MD
01/24/19	Select Case Review	Meghan Cochran-Yu,		

		MD		
01/31/19	Neuro-Trauma Conference Blunt Cerebrovascular Injury	Meghan Cochran-Yu, MD		
02/07/19	Videotape Review	Nikolas Kappy, MD		
02/14/19	Lecture: Evaluation and Management of Pancreatic and Duodenal Injuries	Nikolas Kappy, MD		
02/21/19	Select Case Review	Nikolas Kappy, MD		
02/26/19	Trauma/Radiology Conference Cancelled			
02/26/19	Trauma/ED Conference			Aaron Lee, MD
02/28/19	Guest Lecture, Diane Wintz, MD, Trauma Medical Director, Sharp Memorial	Diane Wintz, MD		
03/07/19	Lecture: Brain Death-Controversies and Diagnosis	Jamie Labuzetta, MD		
03/14/19	Lecture: Evaluation and Management of Genitourinary Trauma	Daniel Ludi, MD		
03/21/19	Videotape Review	Daniel Ludi, MD		
03/26/19	Trauma/Radiology Conference	Daniel Ludi, MD	Daniel Ludi, MD	
03/26/19	Trauma/ED Conference			Megan Tresenriter, MD
03/28/19	Select Case Review	Daniel Ludi, MD		
04/04/19	Lecture: Small Bowel Obstructions	Leslie Kobayashi, MD		
04/11/19	Lecture: Evaluation and Management of Extremity Trauma and Peripheral Vascular Injury	Meghan Cochran-Yu, MD		
04/18/19	Videotape Review	Meghan Cochran-Yu, MD		
04/23/19	Trauma/Radiology Conference		Meghan Cochran-Yu, MD	
04/23/19	Trauma/ED Conference			Aaron Lee, MD

04/25/19	Select Case Review	Meghan Cochran-Yu		
05/02/19	Lecture: Blast Ballistics/Mass Trauma	Jay Doucet, MD		
05/09/19	Lecture: Geriatric Trauma	Nikolas Kappy, MD		
05/16/19	Videotape Review	Nikolas Kappy, MD		
05/21/19	Trauma/Radiology Conference, 3:00pm-4:00pm			
05/21/19	Trauma/ED Conference, 4:00pm-5:00pm			
05/23/19	Select Case Review	Nikolas Kappy, MD		
05/30/19	Neuro/Trauma Conference	Nikolas Kappy, MD		
06/06/19	Lecture: Transfusion and Trauma	Jay Doucet, MD		
06/13/19	Lecture: Neck and Trauma	Daniel Ludi, MD		
06/20/19	Videotape Review	Nikolas Kappy, MD		
06/25/19	Trauma/Radiology Conference, 3:00pm-4:00pm			
06/25/19	Trauma/ED Conference, 4:00pm-5:00pm			
06/27/19	Select Case Review	Meghan Cochran-Yu, MD		
07/04/19	Cancelled due to Holiday			
07/11/19	Lecture: Trauma Induced Coagulopathy/Massive Transfusion	Meghan Cochran-Yu, MD		
07/18/19	Videotape Review	Meghan Cochran-Yu, MD		
07/23/19	Trauma/Radiology Conference, 3:00pm-4:00pm			
07/23/19	Trauma/ED Conference, 4:00pm-5:00pm			
07/25/19	Select Case Review/Year in Review	Meghan Cochran-Yu, MD		

Appendix II

GME Competency Education Program
"Introduction to the Practice of Medicine (IPM)"
Online Educational Series

UC San Diego Health Sciences has contracted with the AMA to provide a series of online modules called the "Introduction to the Practice of Medicine (IPM)" to residents and fellows in order to meet the ACGME requirements for education and training in a number of Core Competency areas. The IPM modules are MANDATORY for all residents and fellows in ACGME accredited programs. Residents in core (first board) training programs will be required to complete six IPM modules each year for the first three years of training, thereafter, four modules per year for programs longer than three years. Fellows will be required to complete four modules per year of accredited training.

The level specific required modules were discussed and approved by the Graduate Medical Education Committee (GMEC) and are as follows:

Residents in ACGME accredited core training programs:

PGY1:

1. Sleep Deprivation
2. Patient Safety: National Patient Safety Goals
3. Patient Safety: Identifying Medical Errors
4. Resident Intimidation
5. Medical Record Documentation: Impact
6. Confidentiality

PGY2:

1. Sleep Deprivation
2. Quality Improvement Panel
3. Conflict of Interest Issues
4. Cultural Competency in Healthcare
5. Module of program or resident choice
6. Module of program or resident choice

PGY3:

1. Sleep Deprivation
2. Anatomy of the Litigation Process
3. Introduction to Personal Finance
4. Module of program or resident choice (optional: Medical Liability Insurance: Protection for your Practice Journey)
5. Module of program or resident choice
6. Module of program or resident choice

Residents in core programs above PGY3:

1. Sleep Deprivation

2. Module of program or resident choice
3. Module of program or resident choice
4. Module of program or resident choice

Fellows at any PGY level in ACGME accredited program (each year of fellowship):

1. **Sleep Deprivation**
2. **Module of program or fellow choice**
3. **Module of program or fellow choice**
4. **Module of program or fellow choice**

These assignments must be completed by the end of the respective academic year. Many of the modules are only 20-25 minutes in length. After viewing the video, a short assessment is to be completed. If you receive an 80% or higher on the assessment, you will be able to print a certificate of completion to give to your program coordinator. An individual program can decide to require more modules than the basic mandatory requirements above. Program coordinators will track resident/fellow participation and ensure that mandatory minimum requirements are being met by all residents/fellows in their program.

You will automatically become an AMA member at no charge. You may opt out of this membership for any reason and still have full access to the IPM modules. For your convenience, we have added a link to the IPM login site to the New Innovations Home Page under System-Wide Notices, and to the UCSD GME website.

For those who have not as yet accessed the IPM site, the attached IPM User Training Guide will give you instructions on how to login and use the site.

To log in:

IPM Login: http://ucsd.knowbase.com

Username: your UCSD email address

Temporary Password: ipm (if you have not already logged in)

You may also access the IPM site on any tablet device. The technical requirements are as follows:

- Internet Explorer 7.0 or higher or Google Chrome
- Adobe Acrobat Reader 8.0 or higher
- Adobe Flash Player 10.0 or higher

Appendix III

Required Readings

1) Scientific American Critical Care of the Surgical Patient (provided free of charge)
2) Journal Club Readings
3) Selected Assigned Articles
4) Top Critical Care Studies Website
   a) Top 100 Contemporary Critical Care Studies

Suggested Readings

1. Marino PL: The ICU Book. Wolters Kluwer 2013
2. Moore EE ed: Trauma, McGraw Hill 8th Edition 2017
3. Asensio: Current Therapy of Trauma and Surgical Critical Care, 2e Elsevier, 2015

The Division has over 60 textbooks of critical care available to the fellows to be used as needed.

APPENDIX IV

The Surgical Critical Care Milestone Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education,
and
The American Board of Surgery

July 2015

The Surgical Critical Care Milestone Project

The Milestones are designed only for use in evaluation of fellows in the context of their participation in ACGME-accredited residency or fellowship programs. The Milestones provide a framework for assessment of the development of the fellow in key dimensions of the elements of physician competency in a specialty or subspecialty. They neither represent the entirety of the dimensions of the six domains of physician competency, nor are they designed to be relevant in any other context.

Surgical Critical Care Milestones

Chair: Mark A. Malangoni, MD

Working Group

Karen J. Brasel, MD
Laura Edgar, EdD, CAE
David N. Herndon, MD
Fred Luchette, MD, MS
Peggy Simpson, EdD
David Spain, MD
Steven C. Stain, MD
Samuel A. Tisherman, MD

Advisory Group

Timothy P. Brigham, MDiv, PhD
James C. Herbert, MD
Lenworth Jacobs, MD
John R. Potts III, MD

Milestone Reporting

This document presents milestones designed for programs to use in semi-annual review of fellow performance and reporting to the ACGME. Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for fellow performance as a fellow moves from entry into fellowship through graduation. In the initial years of implementation, the Review Committee will examine milestone performance data for each program's fellows as one element in the Next Accreditation System (NAS) to determine whether fellows overall are progressing.

For each period, review and reporting will involve selecting milestone levels that best describe a fellow's current performance and attributes. Milestones are arranged into numbered levels. Tracking from Level 1 to Level 5 is synonymous with moving from novice to expert in the subspecialty.

Selection of a level implies that the fellow substantially demonstrates the milestones in that level, as well as those in lower levels (see the diagram on page v).

Level 1: The fellow demonstrates milestones expected of an incoming fellow with little experience in the area of study.

Level 2: The fellow is advancing and demonstrates additional milestones, but is not yet performing at a mid-fellowship level.

Level 3: The fellow continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for fellowship.

Level 4: The fellow has advanced so that he or she now substantially demonstrates the milestones targeted for fellowship. This level is designed as the graduation target.

Level 5: The fellow has advanced beyond performance targets set for fellowship and is demonstrating "aspirational" goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional fellows will reach this level.

Additional Notes

Level 4 is designed as the graduation *target* and *does not* represent a graduation *requirement*. Making decisions about readiness for graduation is the purview of the fellowship program director. Study of Milestone performance data will be required before the ACGME and its partners will be able to determine whether milestones in the first four levels appropriately represent the developmental framework, and whether Milestone data are of sufficient quality to be used for high-stakes decisions.

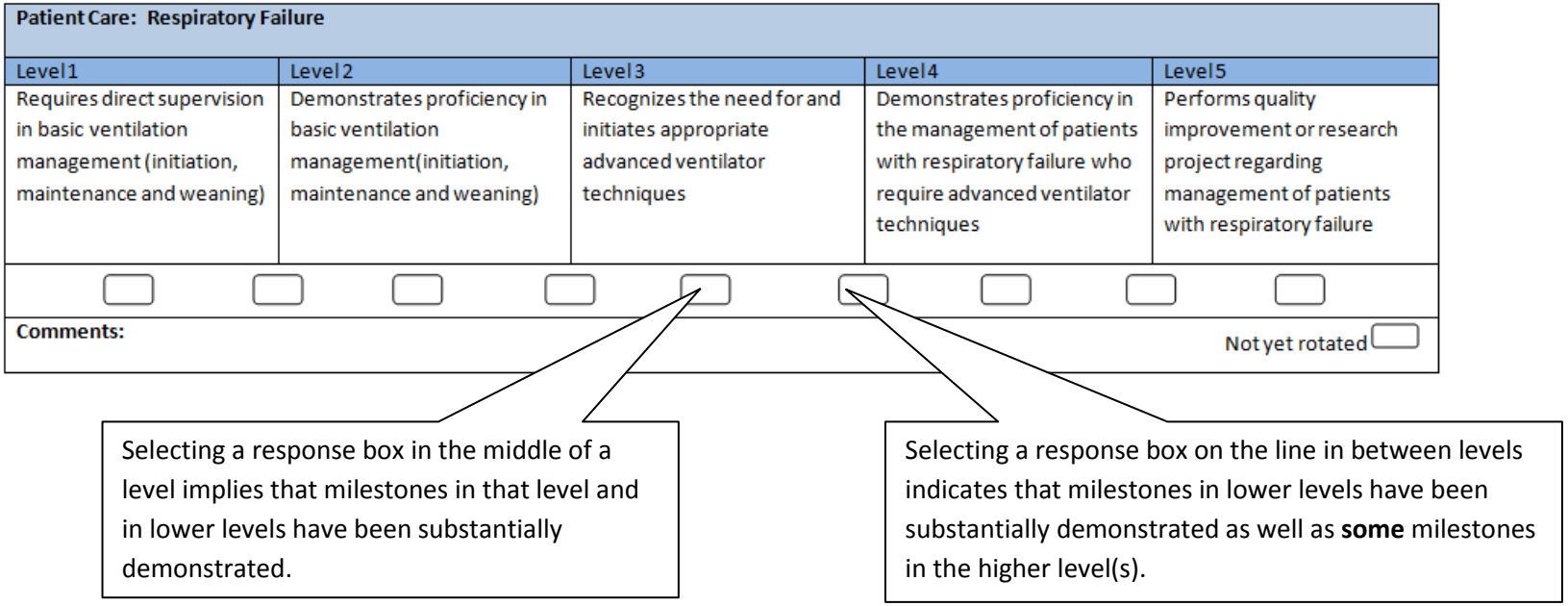
Examples are provided with some milestones. Please note that the examples are not the required element or outcome; they are provided as a way to share the intent of the element.

Some milestone descriptions include statements about performing independently. These activities must occur in conformity to ACGME supervision guidelines, as well as to institutional and program policies. For example, a fellow who performs a procedure independently must, at a minimum, be supervised through oversight.

In addition, some milestones include a statement of limited knowledge and basic knowledge. The intent of these descriptions is that a fellow with limited knowledge is likely a fellow who has come from an area outside of surgery or who is completing the fellowship before finishing his or her surgery residency. A fellow who begins the program with basic knowledge will more likely have completed a general surgery residency program.

Answers to Frequently Asked Questions about Milestones are available on the Milestones web page: http://www.acgme.org/acgmeweb/Portals/0/MilestonesFAQ.pdf.

The diagram below presents an example set of milestones for one sub-competency in the same format as the ACGME Report Worksheet. For each reporting period, a fellow's performance on the milestones for each sub-competency will be indicated by selecting the level of milestones that best describes that fellow's performance in relation to those milestones.



Patient Care — Respiratory Failure				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision in basic ventilation management (initiation, maintenance, and weaning)	Demonstrates proficiency in basic ventilation management (initiation, maintenance, and weaning)	Recognizes the need for and initiates appropriate advanced ventilator techniques	Demonstrates proficiency in the management of patients with respiratory failure who require advanced ventilator techniques	Completes quality improvement or research project regarding management of patients with respiratory failure
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Medical Knowledge — Respiratory Failure (Ventilator-Associated Events)				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of the diagnosis of ventilator-associated events	Demonstrates limited knowledge of techniques to prevent and treat ventilator-associated events	Demonstrates basic knowledge for identification, diagnosis, prevention, and treatment of ventilator-associated events	Demonstrates comprehensive knowledge for identification, diagnosis, prevention, and treatment of ventilator-associated events	Completes quality improvement or research project on the identification, diagnosis, prevention, or treatment of ventilator-associated events
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Patient Care — Nutritional Support				
Level 1	Level 2	Level 3	Level 4	Level 5
Can identify the appropriate indications for nutritional support in critically-ill patients	Requires direct supervision in assessment and initial management of nutritional support in critically-ill patients	Independently performs assessment of nutritional needs and initiates appropriate nutritional support in critically-ill patients	Demonstrates proficiency in the nutritional assessment and management for special populations of critically-ill patients	Completes quality improvement or research project in nutritional assessment or management of critically-ill patients
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: Not yet rotated ☐				

Medical Knowledge — Nutritional Support				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of nutritional assessment of critically-ill patients	Demonstrates basic knowledge of nutritional requirements of critically-ill surgical patients	Demonstrates knowledge of nutritional requirements for special populations of critically-ill surgical patients (e.g., those with liver failure, GI tract fistulae, acute kidney injury, sepsis, burns)	Demonstrates comprehensive knowledge of nutritional requirements for special populations of critically-ill surgical patients	Completes quality improvement or research project on the nutritional requirements of critically-ill surgical patients
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: Not yet rotated ☐				

Patient Care — Shock/Resuscitation				
Level 1	Level 2	Level 3	Level 4	Level 5
Needs direct supervision to recognize and treat patients in shock	Independently recognizes a patient in shock and initiates appropriate resuscitation	Demonstrates the ability to individualize resuscitation based on the type of shock and assessment of the response to therapy with appropriate monitoring	Demonstrates proficiency in the resuscitation of all types of shock in special patient populations (e.g., those at extremes of age, with complex co-morbidities, or who are immunosuppressed) Utilizes and interprets appropriate advanced monitoring techniques (e.g., echocardiography, non-invasive and invasive hemodynamic monitoring)	Completes a quality improvement or research project or develops a protocol for shock resuscitation
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Medical Knowledge — Shock/Resuscitation				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of the types of shock	Demonstrates basic knowledge of multiple types of shock and basic resuscitation regimens	Demonstrates advanced knowledge of multiple types of shock, as well as of appropriate options for treatment	Demonstrates comprehensive knowledge of the pathophysiology, diagnosis, and treatment of all types of shock in special patient populations (e.g., those at extremes of age, with complex co-morbidities, or who are immunosuppressed)	Demonstrates the ability to interpret current medical literature on shock and resuscitation to improve teaching, quality of care, or research
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Patient Care — Acute Kidney Injury				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to recognize and initially treat patients with acute kidney injury	Recognizes and initiates treatment of acute kidney injury	Diagnoses the causes and types of acute kidney injury; initiates management and assesses response to treatment Independently provides care to prevent acute kidney injury	Demonstrates proficiency in the recognition and comprehensive management of patients with acute kidney injury Demonstrates proficiency in management of patients requiring renal replacement therapy	Completes quality improvement or research project regarding management of patients with acute kidney injury
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Medical Knowledge — Acute Kidney Injury				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates a limited knowledge of the types of acute kidney injury	Demonstrates basic knowledge of the various types of acute kidney injury	Demonstrates advanced knowledge of the various types of and methods to manage acute kidney injury Demonstrates knowledge of strategies to prevent acute kidney injury	Demonstrates comprehensive knowledge of pathophysiology, diagnosis, and treatment of all types and severities of acute kidney injury Demonstrates knowledge of the physiologic perturbations of all forms of renal replacement therapy	Demonstrates the ability to interpret current medical literature to improve teaching, quality of care, and research related to acute kidney injury
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Patient Care — Trauma and Burns				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to recognize common critical care conditions in injured patients (e.g., brain injury, flail chest, compartment syndromes, rhabdomyolysis, coagulopathy, wound management)	Recognizes common critical care conditions in injured patients and provides initial management	Recognizes and appropriately treats critical care conditions in severely injured patients Prioritizes treatment of the multiply injured patient Recognizes and treats common complications in severely injured patients	Demonstrates proficiency in the comprehensive management of severely injured patients at the extremes of age and with complex co-morbidities Recognizes and treats more unusual complications in severely injured patients	Completes quality improvement or research project regarding the critical care treatment of injured patients
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Medical Knowledge — Trauma and Burns				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of the pathophysiology of injured patients	Demonstrates basic knowledge of the pathophysiology of severely injured patients	Demonstrates basic knowledge of the pathophysiology of and anticipated complications in severely injured patients	Demonstrates comprehensive knowledge of the pathophysiology, prevention, and management of complications in severely injured patients	Completes quality improvement or research project on pathophysiology or complications in severely injured patients
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Patient Care — Cardiac Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to identify and treat common cardiac disorders (e.g., acute myocardial infarction, dysrhythmias, heart failure)	Applies the principles of Advanced Cardiac Life Support (ACLS)	Independently recognizes and treats common cardiac disorders	Demonstrates proficiency in the diagnosis and treatment of complex cardiac disorders (e.g., valve disorders, biventricular failure, pulmonary hypertension, hypertensive crisis)	Completes quality improvement or research project in cardiac disorders
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: Not yet rotated ☐				

Medical Knowledge — Cardiac Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of cardiac physiology	Demonstrates basic knowledge of cardiac pathophysiology	Demonstrates basic knowledge of cardiac pathophysiology and treatment of common cardiac disorders	Demonstrates comprehensive knowledge of cardiac pathophysiology and treatment of complex cardiac disorders	Completes quality improvement or research project on pathophysiology or complications of cardiac disorders
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: Not yet rotated ☐				

Patient Care — Neurologic Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to recognize the stages and treatment of coma, delirium, and other neurologic disorders	Appropriately assesses patients with coma, delirium, and other neurologic disorders	Recognizes and treats multiple etiologies of coma, delirium, and other neurologic disorders	Proficient in prevention, diagnosis and treatment of multiple etiologies of coma, delirium, and other neurologic disorders	Completes quality improvement or research project regarding the critical care treatment of patients with coma, delirium, and other neurologic disorders
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				Not yet rotated ☐

Medical Knowledge — Neurologic Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of physiology of neurologic disorders (e.g., coma, delirium, seizures)	Demonstrates basic knowledge of pathophysiology of neurologic disorders	Demonstrates basic knowledge of pathophysiology and treatment of neurologic disorders	Demonstrates comprehensive knowledge of pathophysiology and treatment of neurologic disorders	Completes quality improvement or research project on pathophysiology or treatment of neurologic disorders
☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				Not yet rotated ☐

Patient Care — Gastrointestinal (GI) Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to diagnose acute GI disorders (e.g., *C. difficile* colitis, GI bleeding, hepatic failure, intestinal ischemia, post-operative complications, pancreatitis)	Independently diagnoses acute GI disorders Requires direct supervision to manage patients with acute GI disorders	Diagnoses and appropriately manages acute GI disorders without direct supervision	Demonstrates proficiency in the comprehensive management of acute GI disorders	Completes quality improvement or research project regarding management of acute GI disorders
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not yet rotated ☐				

Medical Knowledge — GI Disorders of Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge of acute GI disorders (e.g., *C. difficile* colitis, GI bleeding, hepatic failure, intestinal ischemia, post-operative complications, pancreatitis)	Demonstrates basic knowledge of the pathophysiology and diagnosis of acute GI disorders	Demonstrates knowledge of the pathophysiology, diagnosis, prevention, and treatment of acute GI disorders	Demonstrates comprehensive knowledge of the diagnosis, prevention, and treatment of acute GI disorders	Completes quality improvement or research project on the diagnosis, prevention, or treatment of acute GI disorders
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not yet rotated ☐				

Patient Care — Infectious Diseases of Critically-Ill Surgical Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to diagnose common infectious diseases and infectious complications	Demonstrates the ability to diagnose and initiate management for common infectious diseases and infectious complications	Demonstrates the ability to diagnose and manage most infectious diseases and infectious complications	Demonstrates proficiency in the comprehensive management (prevention, diagnosis, and treatment) of infectious diseases and infectious complications Demonstrates appropriate antimicrobial stewardship	Completes quality improvement or research project regarding management of an infectious complication
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Medical Knowledge — Infectious Diseases of Critically-Ill Surgical Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates limited knowledge needed to diagnose infectious diseases in critically-ill surgical patients	Demonstrates basic knowledge of the pathophysiology and diagnosis of infectious diseases in critically-ill surgical patients	Demonstrates knowledge of the pathophysiology, diagnosis, prevention, and treatment of most infectious diseases and infectious complications	Demonstrates comprehensive knowledge of diagnosis, prevention, and treatment of infectious disease and infectious complications Demonstrates comprehensive knowledge of antimicrobial stewardship	Completes quality improvement or research project on the diagnosis, prevention or treatment of infectious complications
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet rotated ☐

Patient Care — Procedural Competence*				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to perform common intensive care unit (ICU) procedures	Performs some common ICU procedures independently	Demonstrates proficiency in the performance of common ICU procedures Can identify when a patient is at high risk for complications from a common ICU procedure	Proficient in performance of ICU procedures in patients at high risk for complications Proficient in management of procedural complications	Performs advanced procedures (e.g., extracorporeal membrane oxygenation [ECMO], intra-aortic balloon pump [IABP], transvenous pacing, inferior vena cava filter placement)
☐	☐	☐	☐	☐
Comments:				Not yet rotated ☐

*Procedural competence includes the following:

- airway management (e.g., bag valve mask, supraglottic airways, intubation, surgical airway)
- catheter placement (e.g., arterial, central venous, dialysis access, pulmonary artery)
- ultrasound evaluation and procedural guidance
- chest tubes and thoracentesis
- bronchoscopy
- complex wound care (e.g., fasciotomy, negative pressure therapy, burn wound care)

Systems-based Practice — Administrative Responsibility				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates basic knowledge of how health care systems operate Can identify system factors that contribute to medical errors and is aware of the impact of variations in care	Understands how patient care is provided in the health care system and identifies specific system failures that can affect patient care Follows protocols and guidelines for patient care	Makes suggestions for changes in the health care system that may improve patient care Reports problems with technology (e.g., devices and automated systems) or processes that could produce medical errors	Participates in work groups or performance improvement teams designed to reduce errors, improve patient safety, and improve health outcomes Understands the appropriate use of standardized approaches to care, and participates in creating protocols of care	Leads a performance improvement team to reduce errors and/or improve health outcomes
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Systems-based Practice — Coordination and Transitions of Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires direct supervision to provide effective written and verbal communication to prevent medical errors	Usually utilizes appropriate forms of communication (e.g., face-to-face, telephone, and electronic) to ensure accurate transitions of care and optimize communication across systems and the continuum of care	Effectively and regularly utilizes all appropriate forms of communication (e.g., face-to-face, telephone, and electronic) to ensure accurate transitions of care and optimize communication across systems and the continuum of care	Takes a leadership role in ensuring accurate transitions of care and optimizing communication across systems and the continuum of care	Completes quality improvement or research project regarding coordination or transitions of care
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐				
Comments: Not yet achieved Level 1 ☐				

Practice-based Learning and Improvement — Improvement of Care				
Level 1	Level 2	Level 3	Level 4	Level 5
Actively participates in morbidity and mortality (M&M) and/or other quality improvement (QI) conferences with comments, questions, and accurate presentation of cases Changes personal behaviors in response to feedback from supervisors Delineates when and how errors or adverse events affect the care of patients	Evaluates own patient outcomes and the quality and efficacy of care of patients through appraisal and assimilation of scientific evidence Uses relevant literature to support discussions and conclusions at M&M and/or other QI conferences Performs basic steps of a QI project (e.g., generates a hypothesis, conducts a cause-effect analysis, develops method for study) Demonstrates how to modify care practices to avoid errors	Evaluates own patient care outcomes in a systematic manner and identifies opportunities for improvement Identifies probable causes for complications and deaths at M&M and/or other QI conferences, as well as appropriate strategies for improving care	Exhibits ongoing self-evaluation and improvement that includes reflection on practice, tracking, and analyzing patient outcomes, integrating evidence-based practice guidelines, and identifying opportunities to make practice improvements Discusses or demonstrates application of M&M and/or other QI conference conclusions to own patient care Leads a QI activity relevant to patient care outcomes	Participates in an institutional committee that is responsible for performance in practice improvement, and helps develop QI activities Publishes the results of a QI project or clinical trial Recognizes opportunities for improvement in patient care using process analysis and initiates a corrective action plan
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Comments:				Not yet achieved Level 1 ☐

Practice-based Learning and Improvement — Teaching				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires prompting to impart educational information clearly and effectively to other health care team members	Communicates educational material accurately and effectively at the appropriate level for learner understanding Accurately and succinctly presents patient cases appropriate for learning environment	Demonstrates an effective teaching style when responsible for a conference or formal presentation	Recognizes teachable moments and readily and respectfully engages the learner Facilitates conferences and case discussions based on assimilation of evidence from the literature	Demonstrates highly effective teaching with an interactive educational style and engages in constructive educational dialogue Develops an educational curriculum or an evaluation system for other learners Presents or publishes educational research
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Practice-based Learning and Improvement — Self-Directed Learning				
Level 1	Level 2	Level 3	Level 4	Level 5
Completes learning assignments as directed	Selects an appropriate evidence-based information tool to answer specific questions while providing care	Demonstrates the ability to use multiple resources to improve patient care	Routinely synthesizes current scientific literature and other resources for self-directed learning and improvement of patient care	Presents at local, regional, or national activity; optional conferences; and/or self-assessment programs
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments: Not yet achieved Level 1 ☐				

Professionalism — Professionalism and Personal Behavior				
Level 1	Level 2	Level 3	Level 4	Level 5
Demonstrates behavior that conveys caring, honesty, and genuine interest in patients and families in most circumstances Requires reminders to respect patient confidentiality and privacy	Demonstrates an understanding of the importance of compassion, integrity, respect, sensitivity and responsiveness to patients and families, and is able to exhibit these behaviors consistently in common and uncomplicated situations Demonstrates a commitment to continuity of care by taking personal responsibility for patient care outcomes Recognizes the limits of his or her knowledge and asks for help when needed	Manifests these behaviors consistently in complex and complicated situations Ensures patient care responsibilities are performed and continuity of care is maintained Accepts responsibility for errors in patient care and can initiate corrective action Consistently demonstrates integrity in all aspects of care and professional relationships	Serves as a role model for ethical and professional behavior Consistently places the interests of patients ahead of self-interests when appropriate Maintains composure in accordance with ethical principles even in stressful situations	Demonstrates leadership and mentoring regarding these principles Develops organizational policies and education to support the application of these principles in the practice of medicine
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Professionalism — Ethical Issues in Critically-Ill Patients				
Level 1	Level 2	Level 3	Level 4	Level 5
Can describe basic bioethical principles Able to identify ethical issues (e.g., end-of-life care, surrogacy, futility)	Consistently identifies ethical issues in practice Able to discuss, analyze, and manage common clinical situations	Able to effectively analyze and manage ethical issues in complicated and challenging clinical situations	Serves as a role model for consistently considering and managing ethical issues in practice	Serves as a member of an institutional Ethics Committee Performs research or presents locally, regionally, or nationally on ethical problems in critically-ill patients
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Professionalism — Personal Responsibility				
Level 1	Level 2	Level 3	Level 4	Level 5
Does not complete operative Case Logs, duty hour logs, or perform other assigned and required administrative tasks (e.g., visa renewal, credentialing, obtaining a medical license) in a timely fashion without excessive written and verbal reminders or prodding	Usually prompt in attending conferences, meetings, operations, and other activities Usually responds promptly to requests from faculty and departmental staff members	Ensures that those under his or her supervision respond appropriately to their responsibilities in a timely fashion Exhibits a clear understanding of personal responsibilities (clinical and administrative)	Serves as a role model for promptness and attendance for conferences, meetings, operations, and other activities on all rotations Performs clinical and administrative responsibilities in an exemplary manner without prompting	Serves as a resource for the program and mentoris other learners about accountability and responsible, professional conduct
☐	☐	☐	☐	☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Professionalism — Healthy Work Environment				
Level 1	Level 2	Level 3	Level 4	Level 5
Requires frequent direct supervision to comply with duty hours and to recognize personal health issues	Demonstrates knowledge of the institutional resources available to manage personal, physical, and emotional health (e.g., acute and chronic disease, substance abuse, mental health problems) Complies with duty hours standards Can identify the principles of physician wellness and fatigue mitigation	Monitors personal health and wellness, and appropriately mitigates fatigue and/or stress Is effective and efficient in time management and consistently arrives fit for duty	Sets an example by promoting healthy habits and creating an emotionally healthy environment for co-workers Models appropriate management of personal health issues, fatigue, and stress	Recognizes and appropriately addresses health issues in other members of the health care team Is proactive in modifying schedules or intervening in other ways (e.g., required nap, counseling, referral for services, report to program director) to ensure that caregivers and those under his or her supervision maintain personal wellness and do not compromise patient safety
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Interpersonal and Communication Skills — Effective Communication with Patients and Families				
Level 1	Level 2	Level 3	Level 4	Level 5
Communicates with patients and their families in an understandable and respectful manner Effectively communicates basic health care information to patients and families	Customizes communication, taking into account patient and family characteristics (e.g., age, literacy, cognitive disabilities, cultural differences) Provides timely updates to patients and families	Effectively delivers complex and difficult information to patients and families Can delineate strategies for negotiating conflict	Proficiently individualizes and leads difficult discussions specific to patient and family needs, (e.g., end-of-life, explaining complications) Effectively negotiates and manages conflict among patients, families, and the health care team	Develops novel tools for effective communication with patients and families Effectively mentors other health care providers in communication skills and conflict management
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

Interpersonal and Communication Skills — Effective Communication with the Health Care Team				
Level 1	Level 2	Level 3	Level 4	Level 5
Exchanges limited patient information with team members Responds politely and promptly to requests for care coordination activities	Effectively shares and exchanges patient information with some members of the health care team	Anticipates and plans for effective communication of relevant information to all members of the health care team Demonstrates basic ability to lead a health care team using effective communication styles Can delineate strategies for negotiating conflict within the health care team	Effectively leads a health care team responsible for the care of critically-ill patients using individualized communication strategies Utilizes strategies to prevent conflict within the health care team Effectively negotiates and manages conflict within the health care team	Serves as a resource for negotiating and managing conflict within the health care system Effectively mentors other health care providers in leadership, communication skills, and conflict management
☐	☐	☐	☐	☐ ☐ ☐ ☐ ☐
Comments:				Not yet achieved Level 1 ☐

APPENDIX V

UCSD MEDICAL CENTER

HOUSE OFFICER POLICY AND PROCEDURE DOCUMENT

REVISED JULY 1, 2012

UC San Diego
HEALTH SCIENCES

TABLE OF CONTENT

HOUSE OFFICER POLICY AND PROCEDURE DOCUMENT

STATEMENT OF COMMITMENT TO GRADUATE MEDICAL EDUCATION

The University of California, San Diego School of Medicine and Medical Center are committed to graduate medical education (GME) as a central component of their mission to improve the health of the public. UCSD seeks to educate outstanding physicians and medical scientists. Investing in graduate medical education assures that current residents and future generations of health care professionals are prepared for California's and the nation's evolving health care needs. In this context UCSD Healthcare is committed to providing the necessary educational, financial and human resources required to assure excellence throughout the continuum of graduate medical education.

The School of Medicine and the Medical Center provide a supportive and challenging educational environment within which residents of diverse backgrounds can prepare themselves for careers characterized by commitment to excellence in service to others through patient care, research, teaching, and lifelong learning. Faculty members offer residents state-of-the-art knowledge, demonstrate the latest developments in patient care, model compassionate and ethical care, and provide guidance and supervision to ensure patient health and safety.

UCSD School of Medicine and Medical Center furnish a financially secure and educationally enriched environment for organized GME programs in which resident physicians develop personal, ethical, clinical and professional competence under careful guidance and supervision. Programs will assure the safe and appropriate care of patients, and the progression of resident physician responsibility consistent with each physician's clinical experience, knowledge and skill.

The graduate medical education program is designed to provide residents with the knowledge, skills and attitudes that serve as the basis for competent and compassionate clinical practice, scholarly research and public service. Residents are encouraged to develop the capacity for self-evaluation and moral reflection to sustain a lifetime of responsible and committed practice of medicine. The educational program prepares residents to continue their own education and to teach their patients and colleagues throughout their working years. UCSD's GME Programs are committed to ensuring that trainees understand the scientific foundation of medicine, apply that knowledge to clinical practice, and extend that knowledge through scholarly research. In addition, GME Programs provide the experience necessary for residents to master the clinical skills needed to evaluate and care for their patients.

UCSD School of Medicine offers opportunities for collaboration with colleagues throughout the School of Medicine and its basic sciences departments. Such an environment offers a broad array of educational opportunities in graduate medical education. This includes great diversity in patient populations, specialty services, technological resources and educational programs.

While each residency program is designed to meet the unique requirements of the specialty, including the achievement of the ACGME-defined general competencies, and development milestones, UCSD is responsible for ensuring a safe and supportive learning environment for all residents. The Graduate Medical Education Committee (GMEC) establishes educational policy, monitors the clinical learning environment for residents, reviews affiliation agreements, facilitates annual performance improvement activities of each program, develops cross-residency educational programs and serves as an advocate for residents. The Associate Dean for Graduate Medical Education-DIO, directs the Office of Graduate Medical Education and, together with GMEC ensures that each of the graduate medical education programs meets or exceeds all Institutional, Common, and Program Specific Requirements promulgated by the Accreditation Council for Graduate Medical Education (ACGME) and its individual Residency Review Committees (RRC's).

PURPOSE OF HOUSE OFFICER POLICY AND PROCEDURE DOCUMENT

The purpose of this document is to provide a statement of UCSD policy applicable to all House Officers (House Officer) at UCSD who have received the degree Doctor of Medicine, Osteopathic Medicine or an equivalent degree and have been accepted into an organized program of the University for the purpose of obtaining (a) the advanced education or training leading to eligibility for licensure or recognition in a specialty or subspecialty field in one of the health professions; or (b) post-doctoral preparation for an academic career in a clinical field. To the extent possible, the University shall uniformly and equitably apply the published policies and standards affecting the House Officer.

For purposes of these policies and procedures, House Officers shall include interns, residents, and clinical fellows.

ACGME ACCREDITED GRADUATE MEDICAL EDUCATION TRIANING PROGRAMS SPONSORED BY UCSD

Anesthesiology
- Adult Cardiothoracic Anesthesiology
- Critical Care Medicine
- Pain Medicine

Emergency Medicine
- Medical Toxicology
- Pediatric Emergency Medicine
- Undersea and Hyperbaric Medicine

Family Medicine
- General Preventive Medicine
- Sports Medicine

Internal Medicine
- Medicine – Allergy and Immunology
- Medicine – Cardiovascular Disease
  - ^ Clinical Cardio Electrophysiology
  - ^ Interventional Cardiology
- Medicine – Dermatology
  - ^ Procedural Dermatology
- Medicine – Endocrinology, Diabetes and Metabolism
- Medicine – Gastroenterology
- Medicine – Geriatrics
- Medicine – Hematology and Oncology
- Medicine – Infectious Diseases
- Medicine – Nephrology
- Medicine – Pulmonary Disease and Critical Care
- Medicine – Rheumatology

Neurology
- Child Neurology
- Clinical Neurophysiology
- Vascular Neurology

Ophthalmology

Orthopedic Surgery
- Orthopedics – Hand Surgery

Pathology – Anatomic and Clinical
- Hematopathology
- Neuropathology

Pediatrics
- Pediatrics – Behavioral and Developmental
- Pediatrics – Cardiology
- Pediatrics – Critical Care
- Pediatrics – Endocrinology
- Pediatrics – Gastroenterology
- Pediatrics – Hematology/Oncology
- Pediatrics – Infectious Diseases
- Pediatrics – Medical Genetics
- Pediatrics – Neonatal–Perinatal Medicine
- Pediatrics – Nephrology
- Pediatrics – Pulmonology

Psychiatry
- Child and Adolescent Psychiatry
- Geriatric Psychiatry

Radiation Oncology

Diagnostic Radiology
- Neuroradiology
- Nuclear Medicine
- Vascular and Interventional Radiology

Reproductive Medicine
- Female Pelvic Medicine/Reconstructive Surgery

Surgery
- Cardiothoracic Surgery
- Neurological Surgery
- Otolaryngology
  - ^ Neurotology
  - ^ Pediatric Otolaryngology
- Plastic Surgery
- Surgical Critical Care
- Urology
  - ^ Pediatric Urology
- Vascular Surgery

Combined Programs:
- Family Medicine/Psychiatry
- Internal Medicine/Pediatrics

HOUSE OFFICER RESPONSIBILITIES - POSITION DESCRIPTION

The goal of a graduate medical education training program is to (a) provide trainees (interns, residents, and fellows) with an extensive experience in the art and science of medicine in order to achieve excellence in the diagnosis, care and treatment of patients and (b) when applicable, to establish trainee's eligibility to participate in the relevant ABMS Specialty Board examination. To achieve this goal, the trainee agrees to do the following:

1. Develop and participate in a personal program of self - study and professional growth with guidance from the Medical School's teaching staff.
2. Under the supervision of the Medical School's teaching staff, participate in safe, effective and compassionate patient care, consistent with the trainee's level of education and experience.
3. Participate fully in the educational activities of the residency/fellowship program and assume responsibility for participation in the teaching of more junior physicians, of medical students and of students in allied health professions.
4. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures and policies of the institution.
5. Participate in the standing committees of the Medical Staff and institutional committees, as assigned by the Program Director, especially those that relate to patient care review activities.
6. Develop an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and the practice of medicine. Learn cost containment measures in the provision of patient care.
7. Perform all duties in accordance with the established practices, procedures and policies of the institution, its programs, clinical departments and other institutions to which the resident/fellow is assigned.
8. Adhere to the moonlighting policies of UCSD and to the program in which the resident/fellow is appointed.
9. Comply with the duty hour and working condition policies of UCSD and the program in which the resident/fellow is appointed. This includes, in part, participation in monitoring processes and completion of surveys or data entry into GME database management systems as required by the training program, the Medical Center and the ACGME.
10. Adhere to the program's call schedule and schedule of assignment.
11. Document patient care in the medical record in a timely fashion as per Medical Staff policy.
12. Adhere to the ACGME Institutional Requirements and to the ACGME - RRC Program Requirements for the specialty in which the resident/fellow is in training.
13. Participate in the evaluation of the training program and its faculty.
14. Comply with the licensure requirements of the State of California, and the laws of the State and Federal Governments.
15. Comply with UCSD House Officer eligibility criteria as well as specific/special requirements of Affiliated Institutions to which trainee may rotate as part of his/her training. These requirements may include, but are not limited to, criminal background checks, substance abuse testing, health screenings, providing additional paperwork/information, etc.
16. Adhere to the policies defined in the UCSDMC document entitled, Guidelines for Managing Impaired Residents and the UCSD House Officer Policy and Procedure Document.
17. Adhere to UCSD Office of Graduate Medical Education Resident Use of Email Policy, and the UCSD Electronic Communications Policy and Procedures.

ELIGIBILITY – SELECTION – NONDISCRIMINATION

Eligibility Criteria

Applicants for appointment to the graduate medical education training programs sponsored by UCSD must meet the following criteria:

- Graduate of a medical school located in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME); or
- Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or
- Graduate of an international medical school located outside of the United States and Canada who meets the following qualifications:
  - Holds a current, valid certificate issued by the Educational Commission for Foreign Medical Graduates; and
  - Holds a full and unrestricted license in the State of California to practice medicine or has received written notification from the Medical Board of California of approval to commence training in an accredited program in this State; or
- Graduate of a medical school located outside of the United States who has completed a Fifth Pathway program provided by an LCME - accredited medical school, and who provides evidence of compliance with the licensure laws of the State of California or holds a full and unrestricted license from the State of California.
- All applicants hired by UCSD will be required to provide and undergo the following procedures:
  - Provide proof of United States citizenship or eligibility/authorization to work in the United States;
  - Complete a full verification and criminal background screen.

Selection

Programs should select from among eligible applicants on the basis of their preparedness and ability to benefit from the program in which they are appointed. Aptitude, academic credentials, personal characteristics and ability to communicate should be considered in the selection.

Non - Discrimination

The University of California prohibits discrimination against or harassment of any person employed by or seeking employment with the University on the basis of race, color, national origin, religion, sex, gender, gender identity, gender expression, pregnancy, physical or mental disability, medical condition (cancer - related or genetic characteristics), genetic information (including family medical history), ancestry, marital status, age, sexual orientation, citizenship, or service in the uniformed services (as defined by the Uniformed Service Employment and Reemployment Rights Act of 1994).

University policy also prohibits retaliation against any employee or person seeking employment for bringing a complaint of discrimination or harassment pursuant to this policy, or against a person who assists someone with a complaint of discrimination or harassment, or who participates in any manner in an investigation or resolution of a complaint of discrimination or harassment. The University of California is an affirmative action/equal opportunity employer. The University undertakes affirmative action to assure equal employment opportunity to minorities and women, for persons with disabilities, and for covered veterans.

Sexual Harassment Policy

The University of California is committed to creating and maintaining a community in which all persons who participate in University programs and activities can work together in an atmosphere free of all forms of harassment, exploitation or intimidation, including sexual. Specifically, every member of the University community should be aware that the University is strongly opposed to sexual harassment and that such behavior is prohibited both by law and by University policy. It is the intention of the University to take whatever action may be needed to prevent, correct and, if necessary, discipline behavior which violates this policy. This statement is abstracted from the UCSD Sexual Harassment and Complaint Policy PPM Section 200 - 10. The policy may be obtained from the Office of Sexual Harassment Prevention and Policy or from the Office of Graduate Medical Education.

TITLES AND LEVELS

Initial appointment

Each House Officer is appointed to a Resident Physician title with a duration period of not more than one (1) year. Titles for House Officer Appointments are Resident Physician I through IX and Chief Resident Physician.

Appointments to the Resident Physician Series are made by the Associate Dean for Graduate Medical Education upon nomination by the Program Director based on the number of years of training accepted by the board in the particular specialty or subspecialty. House Officers must be graduates in medicine or osteopathic medicine or hold an equivalent degree, and must be licensed to practice medicine in the State of California by the end of their first 24 months of postdoctoral training, or as otherwise prescribed by law. Individual appointments are made on an annual basis.

Typically, a first - year resident enters at level one and progresses a step on each anniversary of appointment until the conclusion of the training program. Credit for previous training (i.e., advanced standing) is a matter for discussion between the House Officer, the Program Director and the Specialty Board. A stipend for service as Chief Resident is afforded in addition to the salary when so indicated by the Program Director.

Reappointment/Promotion

Reappointment to a Resident Physician position for subsequent year is not automatic and is subject to annual review and contingent upon mutual agreement, funding availability, and satisfactory performance. Reappointment shall be recommended by the Training Program Director and approved by the Associate Dean of Graduate Medical Education.

Reappointment to a subsequent year shall be for one - year term.

Chief Residents

Appointments are made for not more than one year by the Associate Dean for Graduate Medical Education after nomination by the Program Director. Chief residents must be graduates in medicine, osteopathic medicine or hold an equivalent degree with service of one or more years in the graduate medical education program in an approved hospital or equivalent training, and must hold a medical license in the State of California. This does not apply to Chiefs in Internal Medicine or Pediatrics.

Salary - Rates

The basic salary scales for House Officers are established by the University Office of the President. At UCSD Medical Center salaries for represented House Officer are collectively bargained by UCSD and the San Diego House Officer Association.

DUTY HOURS

Duty hours are defined as all clinical and academic activities related to the training program, i.e., patient care, 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, journal clubs, etc. Duty hours do not include reading and preparation time spent away from the duty site. Each program shall adopt the duty hour policies for their specialty as defined in the ACGME Institutional and Program Requirements. In the absence of more stringent ACGME - RRC requirements, the following specific duty hours for House Officers in ACGME programs shall be maintained unless exceptions have been granted in accordance with established.

UCSD assures an educational environment in which House Officers may raise and resolve issues without fear of intimidation or retaliation by administration, faculty or staff. (Refer to Section in the HOPPD entitled, Educational Environment Conducive to Open Exchange of Issues.)

Duty Hours

Duty hours shall be limited to 80 hours per week, averaged over a four - week period, inclusive of all in - House call activities. When a House Officer on - call from home or off - site must return to the hospital, such time in the hospital shall be included in the 80 hour limit. All moonlighting hours (both internal and external) are included in the 80 hour limit.

Each House Officer shall be scheduled for a minimum of one day free of all duty every week when averaged over four weeks. One day free of all duty is defined as one continuous 24 - hour period free from all clinical, educational, and administrative activities. Particular attention should be paid to individual Residency Review Committee program requirements in the event the “one day in seven” is to be averaged over a shorter period, such as 1 week.

A. Maximum Duty Period Length

1. Duty periods for PGY1 residents (interns) must not exceed 16 hours in duration.
2. Duty periods of PGY2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. Programs must encourage residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 p.m. and 8:00 a.m., is strongly suggested.
    a. Residents may be allowed to remain on - site in order to accomplish transitions in care and to participate in didactic activities; however, this period of time must be no longer than an additional four hours.
    b. Residents must not be assigned any additional clinical responsibilities after 24 hours of continuous in - house duty.
    c. Each program must consult with their individual RRC because further limitations may be imposed.
    d. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. Under those circumstances, the resident must:
        (1) Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
        (2) Document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director. The program director must review each submission of additional service, and track both individual resident and program - wide episodes of additional duty.

B. Minimum Time Off Between Scheduled Duty Periods

1. Each House Officer shall have an adequate time for rest and personal activities.
2. PGY1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
3. Intermediate - level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in - house duty.
4. Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.
    a. Circumstances of return - to - hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director.

C. Maximum Frequency of In - House Call/Night Float/At Home Call

1. Residents must not be scheduled for more than six consecutive nights of night float.
2. PGY2 residents and above must be scheduled for in - house call no more frequently than every third night, when averaged over a four - week period.
3. At - home call (pager call) is defined as call taken from outside the assigned institution.
    a. 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. House Officers taking at - home call must be provided with 1 day in 7 completely free from all educational and clinical responsibilities averaged over 4 - weeks.
    b. When House Officers are called into the hospital from home, these hours must be counted toward the 80 - hour limit.
    c. Residents are permitted to return to the hospital while on at - home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80 - hour weekly maximum, will not initiate a new “off - duty period”.
    d. The training program director must monitor the demands of at - home call and make scheduling adjustments as necessary to mitigate excessive service demands or fatigue.

D. Extra Work for Extra Pay/Moonlighting

1. As identified by the ACGME, residency education is a full - time endeavor. As such, each 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. Please refer to GME 005 policy on Extra Work for Extra Pay.
2. Residents and Fellows may be given the opportunity to provide extra service for additional compensation at UCSD. This service that occurs within the training program sponsoring institution, termed, “Extra Work for Extra Pay,” or Internal Moonlighting, shall be counted toward the 80 hour weekly limit on duty hours averaged over 4 weeks. In addition, any external moonlighting hours shall also be counted toward the 80 hour weekly limit.
3. PGY1 residents (interns) are not permitted to moonlight.

E. Supervisory Back - up

Appropriate faculty or supervisory resident backup will be provided for every House Officer for consultation, education and supervision. Please refer to GME 001 Supervision Policy.

F. House Officer Alertness Management/Fatigue Mitigation

1. The program must educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation.
2. Faculty members and residents must be educated in alertness management and fatigue mitigation processes; and,
3. Adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning, such as naps or back - up call schedules.
4. Each program must have a process to ensure continuity of patient care in the event that a resident may be unable to perform his/her patient care duties.
5. The sponsoring institution must provide adequate sleep facilities or safe transportation options for residents who may be too fatigued to safely return home**.**

GRIEVANCE

A. Each program's policies and procedures shall include grievance procedures in relation to duty hours within the program.

B. Overall, House Officers may bring forward issues regarding duty hours to their training program director, chief resident, department chair, the Associate Dean for Graduate Medical Education and the Chair of Graduate Medical Education Committee.

C. Additionally, any trainee may bring his/her concerns regarding duty hour implementation directly to the Campus Ombudsperson, UCSD Office of the Ombuds, who can be reached at (858) 534 - 0777. Such interaction is held in strict confidence. The Campus Ombudsperson will report to the Chair, GMEC who will investigate the circumstances and initiate an appropriate resolution.

D. Represented House Officers may refer to the Resident Duty Hours section of the SDHSA Memorandum of Understanding.

WORKING ENVIRONMENT

A. In - House sleep and rest space and bathroom facilities shall provide security and privacy. The Office of Graduate Medical Education will work closely with the House Officer to identify and address, as appropriate, personal service issues.

B. Continuing efforts shall be made to upgrade ancillary support services and, in particular, to minimize the provision of services by House Officers that could be provided with no diminution in quality by other personnel.

C. Representative House Officers may refer to the Working Environment section of the SDHSA Memorandum of Understanding.

HOLIDAYS

The University holidays are as follows:

- New Year's Day
- Third Monday in January
- Third Monday in February
- Last Monday in May
- Independence Day
- Labor Day
- November 11 (Veteran's Day)
- Thanksgiving Day
- Friday following Thanksgiving Day
- December 24 (or announced equivalent)
- December 25
- December 31 (or announced equivalent)

Unless an alternate date is designated by the President, a holiday that falls on a Saturday is observed on the preceding Friday and a holiday that falls on a Sunday is observed on the following Monday.

- A House Officer may observe a special or religious holiday, provided that the work schedule permits and provided that the time off is charged to vacation or is without pay.
- Holiday call shall be distributed by the Training Program Director, or designee, equitably among House Officers at the same postgraduate level. The Program Director or designee may consider the following factors when scheduling holiday call: continuity of patient care, opportunity for unique educational experience, supervision or education of others or other special requirements of the House Officer's particular level of training.
- House Officers receive holiday pay pursuant to University policies.
- Represented House Officers may refer to the Holidays section of the SDHSA Memorandum of Understanding.

LEAVE POLICY

VACATION

House Officers accrue vacation at the official rate of 13.33 hours per month. This provides a total of 20 vacation "working days" per year. Due to the complexities of rotation schedules for House Officers in various training programs, 28 calendar days or one calendar month will be given as leave depending upon the mode of scheduling of a given service. A part - time House Officer receives the proportionate amount, based on the percent and duration of the appointment.

- Vacation leave shall be requested by the House Officer in writing and scheduled with the agreement of the Program Director or his/her designee.
- Vacation may be scheduled in full or may be split depending upon the requirements of the training program and the written requests of the House Officer.
- To the extent allowed by the training requirements of the program, vacation leave will be granted in accordance with House Officers requests.
- Changes in the leave schedule may be initiated by the Program Director when required by department activities. The Program Director shall endeavor to give advance notice of any change.
- House Officers wishing to make a change in the posted leave schedule must submit a written request. Approval of such requests is subject to the staffing requirements of the training program and the discretion of the Program Director or his/her designee.
- Leave must be taken during the period of appointment unless an exemption is granted to the department by the Associate Dean for Graduate Medical Education.

PROFESSIONAL LEAVE

With the approval of the Training Program Director, House Officers may be granted up to five work days of leave with pay, per academic year, to pursue scholarly activities pursuant to their educational curriculum.

- Time not taken may not be carried over from one academic year to the next and will be forfeited.

SICK LEAVE

House Officers shall accrue sick leave at the rate of 8 hours (one working day) per month, which is the equivalent of 12 working days per year. A part - time House Officer receives the proportionate amount, based on the percent and duration of the appointment.

- Each House Officer shall immediately notify his/her Training Program Director of any illness and, if requested by the Program Director, shall provide physician records to document illnesses lasting three or more days.

- Sick leave is not to be used as additional vacation.
- Sick leave that remains unused at the end of an appointment year will carry over to the following appointment year if the House Officer is reappointed. In the event the House Officer is not reappointed, unused sick leave will be forfeited.
- Sick leave not used beyond the predetermined date for separation is forfeited.

SICK LEAVE - FAMILY ILLNESS AND BEREAVEMENT

Family Illness

A House Officer shall be permitted to use not more than 30 days of sick leave in any calendar year when required to be in attendance or to provide care because of the illness of the House Officer's spouse, parent, child, sibling, grandparent or grandchild. In - laws and step - relatives in the relationships listed also are covered. This provision also covers other related persons residing in the House Officer's Household.

Family Bereavement

A House Officer shall be permitted to use not more than 5 days of sick leave when the House Officer's absence is required due to death of the House Officer's spouse, parent, child, sibling, grandparent or grandchild. In - laws and step - relatives in the relationships listed also are covered. This provision also covers other related persons residing in the House Officer's Household. In addition the House Officer shall be permitted to use not more than 5 days of sick leave in any calendar year for bereavement or funeral attendance due to the death of any other person. The House Officer shall provide prior notice to the Training Program Director as to the need for and likely length of any such absence.

PERSONAL LEAVE OF ABSENCE

A House Officer may be granted a personal leave without pay when other leave balances have been exhausted, for the House Officer's convenience, but in granting the leave, the best interests of the training program shall be considered.

- Personal leaves may be granted for personal needs not otherwise specifically provided for by this policy.
- The Training Program Director may approve a personal leave for a period not in excess of six months. The Associate Dean for Graduate Medical Education may grant individual exceptions to the six - month limit.

PREGNANCY/CHILDBEARING DISABILITY LEAVE

A House Officer disabled due to pregnancy, childbirth or related medical conditions shall be granted a medical leave of absence of up to four months, but not to exceed the period of verified disability.

- Pregnancy disability leave may consist of leave without pay or paid leave such as accrued sick leave and accrued or advanced vacation leave.
- If a House Officer on an approved pregnancy disability leave is also eligible for family and medical leave, (noted below under Family and Medical Leave), up to 12 workweeks of pregnancy disability leave shall run concurrently with family and medical leave under Federal law.
- Upon termination of a pregnancy disability leave that runs concurrently with Federal family and medical leave, an eligible House Officer is also entitled to up to 12 workweeks of State family and medical leave.
- A pregnant House Officer enrolled in the House Officer disability plan should contact the House Officer disability plan coordinator to discuss eligibility for coverage and the procedure to follow to obtain the disability benefit.
- For House Officers disabled by pregnancy, childbearing or other related medical conditions who meet the eligibility requirements of the Family and Medical Leave Act, the University shall continue its contribution for the House Officer's health insurance benefits for the length of such disability, up to four months.
- As an alternative to or in addition to Pregnancy Disability Leave, the University will temporarily modify the job duties of a pregnant House Officer or transfer the House Officer to a less strenuous or hazardous position, if requested by the House Officer and medically advisable according to the House Officer's health care

provider, provided that the temporary transfer or modification of duties can be reasonably accommodated by the University. Such a temporary modification of duties or transfer will not be counted by the University toward a House Officer's entitlement to up to four (4) months of Pregnancy Disability Leave. At the conclusion of the Pregnancy Disability Leave (or earlier upon the House Officer's request if that request is consistent with the advice of the House Officer's health care provider), the House Officer will be returned to her original position or duties.

PARENTAL LEAVE

Parental Leave is a form of Family Care/Medical Leave to care for the House Officer's newborn or a child placed with the House Officer for adoption or foster care. Such leave must be initiated and concluded within one year of the birth or placement of the child. The University shall grant a Parental leave subject to the provisions of Family and Medical Leave Act (FMLA) or the California Family Rights Act (CFRA), as applicable. If requested and taken immediately following a Pregnancy Disability Leave, a House Officer eligible for FMLA/CFRA at the beginning of her Pregnancy Disability leave shall be granted the unused portion of FMLA/CFRA leave for Parental Leave purposes, up to a maximum of 12 workweeks. The amount available for use is determined by the amount which the House Officer has previously used under FMLA/CFRA in the leave year.

- Parental Leave must be initiated and concluded within one year of the birth or placement of the child.
- Parental Leave alone shall not exceed 12 workweeks within the calendar year. However, when Parental Leave is combined with a leave for pregnancy - related or childbearing disability only, the total Family Care/Parental Leave shall not exceed seven months in the calendar year.
- Leave granted for bonding purposes shall be concluded within 12 months following the child's birth or placement for adoption or foster care.

FAMILY AND MEDICAL LEAVE

Family and Medical Leave is provided for an eligible House Officer's serious health condition, or the serious health condition of the House Officer's child, spouse or parent in accordance with applicable federal or state law, including the FMLA and the CFRA.

- A House Officer is entitled to up to 12 workweeks of Family and Medical Leave during the calendar year, provided that:
  - The House Officer has at least 12 cumulative months of University service (all prior University service shall be used to calculate the 12 - month service requirement); and
  - The House Officer has worked at least 1,250 actual hours during the 12 months immediately preceding the commencement date of the leave.
  - Family and Medical Leave is unpaid leave, except under the following circumstances:
    - Accrued/advanced vacation (for the specific academic year) may be used at the House Officer's option before taking leave without pay.
    - In addition, up to 30 days of accrued sick leave per year may be used as salary replacement for family illness leave.
    - All paid time off used for Family and Medical Leave shall be deducted from the 12 workweek Family and Medical Leave maximum.

Advance Notice and Certification

- Whenever possible, the House Officer shall provide at least 30 days advance notice. If 30 days notice is not practicable because of a medical emergency, for example, notice shall be given as soon as practicable. Failure to comply with these notice requirements may result in postponement of family and medical leave.
- A House Officer who requests Family and Medical Leave shall be required to present medical certification

prior to taking the leave and prior to returning to the training program.

Leave Related to a Family Member's Military Service

Eligible employees are entitled to leave in accordance with the FMLA for purposes related to a covered family member's military service. An unpaid FMLA leave may be taken for any one, or for a combination, of the following reasons:

- A "**qualifying exigency**" arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty or call to active duty status as a member of the National Guard or Reserves in support of a contingency operation; or,
- To care for a covered family member (including a spouse, son, daughter, parent, or next of kin) who is a current member of the Armed Forces or veteran and has serious injury or illness incurred or aggravated in the line of duty and who is currently getting medical treatment.

When a requested leave is due to a "qualified exigency", an eligible employee may take up to 12 workweeks of leave during any 12 - month period.

When requested leave is taken to care for an injured or ill service member or veteran, an eligible employee may take up to 26 workweeks of leave during a single 12 month period to care for the service member. Leave care for an injured or ill service member or veteran, when combined with other FMLA - qualifying leave, may not exceed 26 weeks in a single 12 month period.

Effect on Benefits

A House Officer on family and medical leave shall be entitled to continue participation in health plan coverage (medical, dental and optical) as if on pay status for a period of up to 12 workweeks in a 12 - month period. Contribution toward premium cost shall remain as it was prior to the onset of family and medical leave for a period of up to 12 workweeks in a calendar year.

LEAVE FOR WORK-INCURRED DISABILITY

A House Officer who is off pay status and receiving temporary disability payments under the Workers' Compensation Act shall be granted a leave without pay for all or part of the period during which temporary disability payments are received, except that any leave without pay that is granted shall not extend beyond a predetermined date of separation.

- Periods of leave for work-incurred disability run concurrently with Family and Medical Leave for a House Officer who is eligible for Family and Medical Leave.

MILITARY LEAVE

A House Officer granted temporary military leave for active - duty training or extended military leave is entitled to receive the House Officer's regular University pay for the first 30 calendar days of such leave in any one fiscal year, provided that the House Officer has completed 12 months of continuous University service immediately prior to the granting of the leave (all prior full - time military service shall be included in calculating this University service requirement) and provided that the aggregate of payments for temporary military leave, extended military leave and military leave for physical examination do not exceed 30 calendar days' pay in any one fiscal year.

A House Officer granted military leave with pay shall receive all benefits related to employment that are granted when a House Officer is on pay status.

JURY DUTY

A House Officer who is summoned and serves on jury duty shall be granted leave with pay for the time spent on jury service and in related travel.

- Deferment or excused absence from jury service can only be granted by the court pursuant to the procedure outlined in the Jury Summons Notice.
- Make - up time may be required to meet the educational objectives and certification requirements of the training program or the American Specialty Board.

POLICY ON EFFECT OF LEAVE ON COMPLETION OF THE TRAINING PROGRAM

Make - up time may be required to meet the educational objectives and certification requirements of the training program or the American Specialty Board when a House Officer is required to utilize leave time as described herein.

- The House Officer should discuss this issue with his/her Training program Director, if possible, prior to taking extended leave.
- If extended leave results in the requirement for additional training in order to satisfy the program or American Specialty Board requirements, the pay status for the additional training time will be determined by the Training Program Director and the Associate Dean for Graduate Medical Education, if possible, prior to the approval of the leave.

BENEFITS AND DEDUCTIONS

INSURANCE PACKAGE

House Officers are eligible for enrollment in the UCSD House Officer health, dental, vision, life and disability insurance plans. The House Officer's spouse, dependent children or domestic same or opposite sex partner are also eligible for enrollment in the health, dental and visions plans.

There is no premium charge to the house officer for the cost of enrollment in health, dental and vision plans either for him/herself, for a spouse, dependent children or domestic same or opposite sex partner. There is no premium charge to the house officer for enrollment in either the life or disability plans.

Benefit coverage is not automatic. An enrollment process must be followed within the timeframes established by the carriers. Following the enrollment process, coverage is effective the date of the House Officer's appointment to UCSDMC. Subsequently, new dependents may be enrolled provided enrollment occurs within 30 days after a qualifying event such as marriage, birth, or adoption.

Open enrollment for the House Officer health plans (health, dental, vision and life) occurs on an annual basis during the month of June. At that time the House Officer will have the opportunity to change their medical plan coverage from one carrier to another or to enroll with a plan for the first time.

Health Coverage

Two plans are available:

A. Fee for Service - PPO Plan

- 3 - tier fee - for - service indemnity plan
- Insured may seek treatment anywhere from provider of choice
- Services at UCSDMC and CHHC (tier 1), are generally covered 100% with no deductible and no co - insurance
- Services obtained away from UCSDMC, within the PPO Network (tier 2), are generally covered at 80%, after satisfaction of a deductible amount
- Services obtained outside of the PPO Network (tier 3), are generally covered at 60%, after satisfaction of a deductible amount
- Co - pays are required at all participating providers including UCSDMC for Routine Exam, Emergency Room (unless admitted) and for Prescription Drugs.
- Maximum annual out - of - pocket cost $1,000/PPO provider and $2,000/non - PPO provider (individual) and $2,000/PPO provider and $4,000/non - PPO (family)

B. Managed Care - HMO Plan

- Insured must select a primary care provider who will manage the care.
- No deductibles
- Co - pays are required for Routine Exam, Outpatient Psychiatric Care, Prescription Drugs, Home Health Care, Emergency Room (unless admitted)

Dental Coverage

The dental plan provides comprehensive coverage for preventive, basic, major and orthodontic services. The insured may utilize the services of either a dentist participating in the plan - PPO or a dentist who does not participate in the plan - PPO. The greatest benefit will be paid when the insured utilizes the services within the PPO network.

Vision Coverage

The vision plan provides coverage for eye exams, lenses, frames, medically necessary contacts and cosmetic contacts. There is a deductible amount for services rendered. The plan requires that the insured uses specific participating providers in order to receive full benefits.

Cobra Health Continuation Coverage

House Officers' and their insured dependents have the option of continuing medical, dental and vision plan benefits, at their own expense, upon termination of their plan coverage for any of the following reasons:

House Officer

- Reduction in hours of appointment
- Termination of appointment (for reasons other than gross misconduct)
- The plan terminated

Spouse/Domestic Partner

- Death of a spouse/domestic partner
- Termination of a spouse/domestic partner's appointment (for reasons other than gross misconduct) or reduction in hours of appointment
- Divorce or legal separation

Dependent Child of an Appointee Covered by UCSDMC Health Plan

- Death of a parent
- Termination of a parent's appointment (for reasons other than gross misconduct) or reduction in hours of appointment
- Parent's divorce or legal separation
- Dependent ceases to be a "dependent child" under the UCSDMC sponsored health plans
- COBRA coverage is not automatic. An enrollment process must be followed within the timeframes established by Federal law.

Life Insurance Plan, D - AD&D

In the event of the death of the covered House Officer, the plan will pay $50,000. If the death is accidental, the plan will pay $100,000. The proceeds will be placed in an interest bearing checking account for the beneficiary.

Disability Insurance

Group long term disability insurance is provided to members of the House Officer at no cost to the House Officer.

Worker's Compensation Insurance

If a House Officer sustains a work - related injury or illness, he/she is eligible to receive benefits under the Workers' Compensation Laws. This program is designed to guarantee complete medical attention for the injury or illness and to insure regular monetary benefits as a means of financial support while the House Officer is medically unable to return to work. The premiums for this program are paid entirely by the University. There is no cost to the House Officer for the coverage nor is there a cost for necessary medical care for diagnosis and treatment.

When the injury occurs, the House Officer must immediately notify his/her supervisor of the incident to ensure that proper procedures are followed. If the supervisor is not immediately available, the House Officer must contact the Injury Prevention Disability Management Program (858) 534-3660 and leave information, as instructed, identifying the injury/exposure. If immediate attention is required, the House Officer should go to either the UCSD Hillcrest or Thornton Emergency Department.

For occupational exposures to blood or body fluids, the House Officer should immediately contact the Center for Occupational and Environmental Medicine. If urgent screening is required following a needle stick or blood exposure, the House Officer should immediately go to the UCSD Hillcrest or Thornton Emergency Department.

PROFFESINAL LIABILITY COVERAGE

TYPE OF COVERAGE:	LIMITS:
UC Self - insured Retention (Fully Funded)	$1,000,000 each occurrence
Tail Coverage is produced by virtue of the fact that th coverage is "per occurrence"	$3,000,000 aggregate
	Additional excess insurance available if needed

The UC Self Insurance Program will defend and indemnify house officers and medical students against professional or general liability or malpractice claim arising out of the house officer's or medical student's acts or omissions that are within the course and scope of his/her University duties, for work completed during the training period. The UC Self Insurance Program does not cover: (1) acts/omissions that are not within the course and scope of the house officer's University duties, (2) acts or omissions resulting from fraud, corruption, malice or criminal negligence.

UC Self Insurance Program coverage for house officers and part - time, volunteer clinical faculty is limited to specific assignments in specific locations. Work at affiliated or associated hospitals or elsewhere is covered when it falls within the course or scope of the house officer's University appointment. However, "moonlighting" is not part of the residency program and is not covered under the UC Self Insurance Program.

Questions regarding legal issues, including subpoenas should be addressed to the UCSDMC Office of Risk Management.

DEDUCTIONS

Deductions for State and Federal taxes as well as Medicare will automatically be made from House Officer earnings. Social Security (FICA) withholding will not be made, but in lieu of this, 7.5% of the House Officer's pre - tax pay is directed to the Safe Harbor University of California Defined Contribution Plan. These non - voluntary contributions may be directed to one of the several University of California managed funds or to any one of over 100 Fidelity Investments funds.

House Officers may make voluntary contributions to the University of California 403 (b) Plan and 457 plans. Contributions come from pre - tax pay and may be made within certain limits.

When a House Officer leaves the University, monies from the Safe Harbor Defined Contribution Plan and the voluntary 403 (b) and 457 (b) plans may be handled as follows:

- May either be rolled over into a new employer's retirement fund, or into an IRA; or
- May be left on deposit if the account has a minimum of $2,000 in the Plans; or
- Contributions and earnings may be paid to the House Officer, although the distribution is subject to penalties if the recipient is under the age of 59 ½, and the distribution is subject to taxation.

House Officers who are paid from funding sources that mandate a stipend payment in lieu of salary may not be eligible for one or more of the previously described features.

Check Disposition

In most cases, the House Officer's paycheck will be issued by the University of California at San Diego Payroll Office. House Officers are paid on a monthly basis in arrears (e.g., the August 1 paycheck represents July earnings). Checks may be directed to Surepay direct bank deposit, or the House Officer's campus or home address.

ON CALL QUARTERS

On call sleeping space is assigned to the clinical services. The sleeping space is clean, quiet and safe. On call quarters shall be serviced by the Housekeeping department on a daily basis. The Office of Graduate Medical Education will work closely with House Officers to address personal service issues.

Represented House Officers may refer to the Working Environment section of the SDHSA Memorandum of Understanding.

UNIFORM AND UNIFORM LAUNDERING

Three sets of uniforms (lab coats) are provided to the House Officers at the time of initial appointment. The lab coats will be laundered by UCSDMC at no charge to the House Officer. Uniforms that deteriorate through normal wear and tear shall be replaced by the Medical Center.

Represented House Officers may refer to the Uniform section of the SDHSA Memorandum of Understanding.

RESIDENT USE OF EMAIL

The special nature of residency programs requires ongoing communication between the residents, the training programs, administrators and others at UCSD Medical Center and affiliated institutions.

The policy of the Office of Graduate Medical Education requires that House Officers be available by email. House Officers are required to have and use a UCSD Medical Center email account that is provided at no cost. House Officers are expected to check their email at reasonably frequent intervals unless they are on approved leave. House Officers must comply with UCSD policies and state and federal laws that apply to email.

RECORDS POLICY

The University maintains as confidential the records of each House Officer, and the consent of the individual is required before access to records is allowed except where permitted or required by law, or where directly or routinely required in the administration of the training program. A House Officer may inspect his/her records in accordance with current privacy legislation and University policy.

GRADUATE MEDICAL EDUCATION ACADEMIC DUE PROCESS & LEAVE GUIDELINES

I. INTRODUCTION

A. DEFINITIONS

Academic Deficiency: The terms “Academic Deficiency” or “Deficiencies” mean unacceptable conduct or performance in the professional or academic judgment of the Program Director, Chair, or Associate Dean for GME including failure to achieve, progress or maintain good standing in the Training Program, or achieve or maintain professional standards of conduct as stated below.

Associate Dean: The term “Associate Dean” means the Associate Dean for Graduate Medical Education.

Chair: The term “Chair” means the Chair of the Trainee’s specialty or subspecialty department, or his/her designee.

Clinical Competence Committee: The term “Clinical Competence Committee” means a committee of a School of Medicine department or division, or a committee specially selected by the Associate Dean for Graduate Medical Education in conjunction with the Chair, Graduate Medical Education Committee, that reviews the academic performance of Trainees.

Days: The term “days” means calendar days.

OGME Training Program: The terms “graduate medical education training program” or “GME training program” refer to the second stage of medical education during which medical school graduates are prepared for independent practice in a medical specialty. The foremost responsibility of the GME training program is to provide an organized education program with guidance and supervision of the Trainee, facilitating the Trainee’s professional and personal development while ensuring safe and appropriate care

for patients. Graduate medical education involves the development of clinical skills and professional competencies, including the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies, developmental milestones, and the acquisition of detailed factual knowledge in a medical specialty. These professional standards of conduct include, but are not limited to, professionalism, honesty, punctuality, attendance, timeliness, proper hygiene, compliance with all applicable ethical standards and UCSD policies and procedures (including but not limited to the UCSD Medical Center Medical Staff Code of Conduct Policy), an ability to work cooperatively and collegially with staff and other health care professionals, and appropriate and professional interactions with patients and their families.

A Trainee, as part of his or her GME Training Program, may be in a hospital, other clinical setting or research area. All such appointments, either initial or continuing, are dependent upon the Trainee maintaining good standing in a GME training program. Dismissal from a GME training program will result in the Trainee's automatic dismissal from any and all related appointments such as medical staff membership.

Medical Disciplinary Cause or Reason: The term "medical disciplinary cause or reason" applies to a GME Trainee who holds a license from the State Medical Board of California, or the Osteopathic Board of California, and means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care in accordance with Business and Professions Code section 805.

Program Director: The term "Program Director" means the Training Program Director for the Trainee's specialty or subspecialty, or designee.

Trainee: The term "Trainee" includes all individuals appointed by UCSD's School of Medicine to the titles of Resident Physician I - IX (title codes 2709, 2723, 2708, 2724), Chief Resident Physician (title code 2725, 2738), Resident Physician/Subspecialist IV - IX (title code 2726), Other Post M.D. Trainee II - IX (title code 2732), where specified by UCSD guidelines, or any other GME title assigned by UCSD.

Vice Chancellor: The term "Vice Chancellor" means UCSD Vice Chancellor Health Sciences or his/her Designee.

B. PREAMBLE

The procedures set forth below are designed to provide the University of California San Diego ("UCSD"), UCSD resident physicians and other post - M.D. trainees (collectively referred to as "Trainees") an orderly means of resolving differences. These Guidelines apply to UCSD sponsored programs of Graduate Medical Education ("Training Programs"). These Guidelines shall be the exclusive remedy for appealing reviewable academic actions. Deviation from these procedures that does not result in material prejudice to the Trainee will not be grounds for invalidating the action taken.

Additional time for remediation, either within the Training Program appointment or beyond the expiration of the Trainee's current appointment, may be required to meet the educational objectives and certification requirements of the department or specialty. The Trainee will be notified in writing of any requirements for additional time. Funding for additional time extending beyond the original period of appointment will be permitted only at the discretion of the Associate Dean and upon written confirmation by the Associate Dean and the Program Director or Chair. Academic credit will be given only for full participation in the regular program unless otherwise approved by the Program Director or Chair.

At UCSD, the primary responsibility for remedial academic actions relating to Trainees and Training Programs resides within the departments and the individual training programs. Therefore, academic and performance standards and methods of training and evaluation are to be determined by each department or program at UCSD School of Medicine and UCSD Medical Center. There may be variances in these standards among the various departments and Training Programs.

Trainees and their supervisors are encouraged to discuss their concerns with one another and, if there are any disagreements or disputes, Trainees and their supervisors should make efforts to resolve them. The action(s) taken should be those that in the professional or academic judgment of the Program

Director or Chair best address the deficiencies and needs of the Trainee or the Training Program. These actions are at the discretion of UCSD and need not be progressive. UCSD may select those action(s) described below that it deems appropriate.

A Trainee may request a correction or deletion of his/her academic file under this policy by submitting a written request to the Program Director. Within thirty (30) days of receipt of a written request to amend or delete a record, the Program Director will either make the amendment or deletion or inform the individual in writing that the request has been denied. If the Program Director refuses to amend or delete the record, the Trainee may enter into the record a statement setting forth the reasons for the Trainee's disagreement with the record. Removal of documentation of action(s) from the Trainee's file does not preclude the University from relying on the removed documentation should any subsequent academic action be taken or from communicating the information as required by law, upon receipt of a release from the Trainee, or to any appropriate third party such as a hospital, hospital medical staff or professional licensing board when such communication is intended to aid in the evaluation of the qualifications, fitness, character or insurability of the Trainee.

II. ACADEMIC ACTIONS – NON-DISMISSAL

A. ADMINISTRATIVE ACTIONS

1. Non Appealable Suspension

The Trainee may be suspended from the Training Program for any of the following reasons:

a. failure to complete and maintain medical records as required by the medical center or site in accordance with the center's/site's medical staff bylaws or rules and regulations;

b. failure to comply with state licensing requirements of the California State Medical Board, or Osteopathic Board;

c. failure to obtain or maintain proper visa status;

d. unexcused absence from Training Program for three or more days;

e. the inability to complete a rotation at an Affiliate Institution that is deemed essential to meeting the requirements of the Training Program; or

f. immediately prior to initiation of dismissal procedures under section III.B if it is determined in the sole discretion of the Chair, Program Director, or Associate Dean for GME that it would be in the best interests of patients, the program or the Trainee.

g. The period of suspension should not exceed fourteen (14) days; however, other forms of academic action may follow the period of suspension.

The Chair or Program Director will promptly notify the Trainee of his/her suspension. In addition, for subsections b, c, d and e above, the Trainee will be provided the documentation upon which the suspension is based and a written notice of the intent to consider the Trainee to have automatically resigned at the end of the suspension period (see Part II.A.2. below). The Trainee may utilize the suspension period to rectify (a) or to respond to the notice of intent under (b), (c), (d) or (e) which can include correcting the problem identified in (b), (c) or (e). If the Trainee is suspended under (a) and does not complete the medical records as required within the 14 day suspension period, other academic action may be instituted.

The Trainee will not receive any academic credit during the period of suspension. Unless prohibited by law, the Trainee's stipend will continue to be paid while on this non - appealable suspension status.

2. Automatic Resignation

Automatic resignation from the Training Program will not entitle the Trainee to the Due Process procedures contained in Part III.B. of these Guidelines. Reasons for automatic resignation include:

a. Failure to Provide Visa or License Verification

Absent a written extension granted by a governmental or licensing organization, failure of the Trainee to provide verification of an appropriate and currently valid visa or verification of current compliance with state medical licensing requirements during the 14 day suspension period will result in the Trainee's automatic resignation from the Training Program.

b. Loss of Rotation Privileges to an Affiliate Institution

Failure of trainee to achieve reversal of Affiliate's decision to revoke the Trainee's privilege to rotate to the Affiliate Institution during the 14 day suspension period may result in the Trainee's automatic resignation or dismissal from the Training Program if the rotation at the Affiliate is deemed essential by the Program to meeting the requirements of the Training Program.

c. Absence without Granted Leave

Trainees are expected to communicate directly with the Program Director in the event he or she is unable to participate in the Training Program. The Program Director may grant a leave in times of exceptional circumstances. If a Trainee is absent without leave for three (3) days or more, he or she may be considered to have resigned voluntarily from the program unless he or she submits a written explanation of any absence taken without granted leave. This explanation must be received by the Program Director within five (5) days of the first day of absence without leave.

The Program Director and Chair will review the explanation and any supporting documentation submitted by the Trainee regarding the absence without leave and notifies the Trainee of their decision within five (5) days. Failure to adequately explain or document the unexcused absence to the satisfaction of the Program Director and Chair will result in the Trainee's automatic resignation from the Training Program.

3. Leaves

Administrative leave and conditional leave of absence are not intended to replace any leaves that a Trainee may otherwise be entitled to under state or federal law or University policy.

a. Administrative Leave

A Chair or Program Director may place a Trainee on administrative leave in order to review or investigate allegations involving the Trainee. These may include deficiencies or circumstances where the Trainee may pose a threat to the health or safety of the public, patients or staff, situations where the Trainee's own health or safety may be compromised, or other circumstances that may represent a breach in professionalism by the Trainee. The leave will be confirmed in writing, stating the reason(s) for and the expected duration of the leave. The circumstances should be of a nature that might warrant removing the Trainee from the Training Program. The Chair or Program Director should, as soon as practicable, conclude the review and either return the Trainee to the program or initiate action under these Guidelines. The Trainee will be paid for the period of administrative leave.

b. Conditional Leave

A conditional leave of absence from the Training Program may be provided only under exceptional circumstances, at the Chair's discretion and upon the Trainee's request. At the end of the conditional leave, the Chair will determine whether to re - admit the Trainee conditionally, unconditionally, on probation or to seek the Trainee's dismissal pursuant to the procedures contained in these Guidelines. The Trainee will not be paid a stipend for the period of the conditional leave.

B. NON - REVIEWABLE ACADEMIC ACTIONS

The following actions are non - reviewable and may or may not be used sequentially or in tandem with one another:

- Counseling Letter
- Notice of Concern
- Probation

1. Counseling Letter

A counseling letter may be issued by the Program Director or Chair to a Trainee to address an academic or professional deficiency that needs to be remedied or improved. The purpose of a counseling letter is to describe a single instance of problematic behavior and to recommend actions to rectify the behavior. The Program Director will review the counseling letter with the Trainee. Failure to achieve immediate or sustained improvement or a repetition of the conduct may lead to other disciplinary actions. These actions are determined by the professional and academic judgment of the Program Director or the Chair and need not be sequential. For the purposes of this policy and for responses to any inquiries, a counseling letter does not constitute a disciplinary action.

2. Notice of Concern

A notice of concern may be issued by the Program Director or Chair to a Trainee who is not performing satisfactorily. Notices of concern should be in writing and should describe the nature of the deficiency(ies) and any remedial actions required on the part of the Trainee. A Letter of Concern is typically used when a pattern of problems emerges. The Program Director or Chair will review the notice with the Trainee. Failure to achieve immediate or sustained improvement, failure to meet any requirement(s) set forth in the letter, or repetition of the conduct may lead to additional actions. This action need not follow a counseling letter nor precede other academic actions described later in these guidelines. A notice of concern does not constitute disciplinary action for purposes of these guidelines or for responses to inquiries.

3. Probation

Trainees who are in jeopardy of not successfully completing the requirements of the Training Program or who are not performing satisfactorily may be placed on probation by the Chair or Program Director. Probation will be communicated to the Trainee in writing and should include: a description of the reasons for the probation, any required remedial activity, and the expected time frame for the required remedial activity. Failure to correct the deficiency(ies) within the specified period of time may lead to an extension of the probationary period or to other actions. Probation need not follow a counseling letter or Notice of Concern, nor precede other academic actions described later in these guidelines.

C. ACADEMIC ACTIONS APPEALABLE TO THE CLINICAL COMPETENCE COMMITTEE

Trainees may appeal the following actions to the Clinical Competence Committee:

- Suspension
- Adverse Annual Evaluation
- Non - renewal of appointment before four months prior to the end of the Trainee's current appointment
- Repetition of an academic year
- Denial of a UCSD Certificate of Completion of Training

1. Suspension

The Chair or Program Director may suspend the Trainee from part or all of the Trainee's usual and regular assignments in the Training Program, including clinical or didactic duties, for unprofessional or ethical behavior, for failing to comply with state law, federal law, or UC policies and procedures, or when the removal of the Trainee from the clinical service is required for the best interests of the Trainee, patients, staff or the Training Program. The suspension will be confirmed in writing, stating the reason(s) for the suspension and its expected duration. Suspension generally should not exceed s i x t y (60) days. Suspension may be coupled with or followed by other academic actions and will continue unless and until overturned by the Clinical Competency Committee after an appeal. A suspension under this section may be paid or unpaid.

2. Adverse Annual Evaluation

Trainees will only be entitled to a review by the Clinical Competence Committee for annual evaluations that are adverse (overall unsatisfactory or marginal) ("Adverse Annual Evaluation"). Trainees will be notified by the Program Director of any Adverse Annual Evaluation.

3. Non - Renewal of Appointment Before Four Months Prior to End of Appointment

The Trainee's appointment is for a one - year duration, which is normally renewed annually. Due to the increasing level of responsibilities and increasing complexity of clinical care over the course of the Trainee's training, satisfactory completion of prior academic year(s) or rotation(s) does not ensure satisfactory proficiency in subsequent years or rotations. A Trainee may have his/her appointment not renewed at any time there is a demonstrated failure to meet programmatic standards.

The Program Director should provide each Trainee with a written evaluation at least twice per year. The first evaluation should occur no later than sixth months following the beginning of the appointment term. If the Program Director with the approval of the Chair concludes that the Trainee's appointment should not be renewed for the following year, the Program Director will notify the Trainee of such. The Trainee will be permitted to conclude the remainder of the current academic year unless further academic action is taken.

A Trainee who is notified of the non - renewal of his/her appointment for the following year, before the four months prior to the end of his/her current appointment, will be entitled only to the procedures contained in this Part II.D. of these Guidelines. (A Trainee who is notified of the non - renewal of his/her appointment for the following year after this time will be entitled to the procedures contained in Part III.B. of these Guidelines. See Part III.B.2.)

4. Requirement that Trainee Must Repeat an Academic Year

A Trainee may be required to repeat an academic year in lieu of dismissal from the Training Program due to unsatisfactory progress or other deficiencies at the discretion of the Program Director and Department Chair provided there are sufficient funds. Funds for the additional year must be identified with written confirmation by the Program Director or Chair to the Associate Dean.

5. Denial of University Certificate of Completion

If the Program Director, in consultation with the Chair, decides not to award the Trainee a University Certificate, the Program Director will notify the Trainee as soon as reasonably practicable of this intent.

D. CLINICAL COMPETENCE COMMITTEE APPEAL PROCEDURES

The Trainee will be notified as soon as reasonably possible that he/she has been suspended, received an Adverse Annual Evaluation, that his/her appointment will not be renewed (notice given more than four months before the end of his/her appointment), that he/she will be required to repeat the current academic year, or that s/he will not be granted a UCSD Certificate of Completion of Training.

In order to appeal, the Trainee must, within ten (10) calendar days from the date of the notification, provide the Associate Dean with a written statement detailing the reasons he/she believes he/she should not have been suspended, should not have received an Adverse Annual Evaluation, should have had his/her appointment renewed (for the Trainee notified of non - renewal before four months prior to the end of his/her appointment), not be required to repeat the academic year, or should not be granted a UCSD Certificate of Completion of Training. As soon as practical, the Associate Dean will appoint a Clinical Competence Committee (CCC) to review the appeal. The CCC will meet to review the Trainee's statement within twenty (20) calendar days of the committee's formation unless within 20 days the Chair of the CCC determines that an extension of this time period is necessary. If this occurs, the Chair of the CCC will inform the involved parties of the extension in writing. The committee will review the decision to impose the academic action being appealed to determine whether it was arbitrary and capricious. The CCC, at its discretion, may permit or request the personal attendance of the Trainee. While the Trainee has no right to representation by an attorney at the CCC meeting, another person of his/her choice may accompany the Trainee. There may be circumstances that require further information or review by the Committee. If the Committee cannot reach a decision within 20 calendar days, the Trainee will be notified in writing and be provided a new timetable.

The CCC will orally notify the Trainee of its decision within five (5) calendar days of reaching a final decision, and provide the Trainee a written decision within ten (10) calendar days of the oral notification.

The decision of the CCC will be final. Failure by the Trainee to timely request a review before the CCC will be deemed an acceptance by the Trainee of the academic action.

III. ACADEMIC ACTIONS ~ NON-RENEWAL OF APPOINTMENT WITHIN FOUR MONTHS OF END OF CURRENT APPOINTMENT OR DISMISSAL

A. GROUNDS FOR ACTION

The following actions, if appealed, are reviewable by the Vice Chancellor:

- Dismissal from the Training Program;
- Non - renewal of appointment within four months of the end of the current appointment

1. Dismissal from Training Program

Based on the Program Director's discretion as approved by the Chair, a Trainee may be dismissed from the Training Program for academic deficiencies, including any of the following reasons:

a. Failure to achieve or maintain programmatic standards in the Training Program;

b. Serious or repeated act or omission compromising acceptable standards of patient care, including an act which constitutes a medical disciplinary cause or reason;

c. Unprofessional, unethical or other behavior that is otherwise considered unacceptable by the Training Program;

d. Material omission or falsification of Training Program application, medical record or other University document, including billing records;

e. Confirmations of findings from a criminal background check, law enforcement agency, regulatory body, or UC San Diego Agency (including the Physician Well Being Committee), that could be considered a potential risk to patients or other individuals or considered unprofessional or unethical.

2. Non-Renewal of Appointment Within Four Months of End of Current Appointment

See Section II, C.3 of these guidelines for discussion of non - renewal of appointment.

B. PROCEDURES

The Ad Hoc Formal Review Committee, see below, will handle all procedural matters during the actual hearing. At all other times, before and after the actual hearing, including up to the Vice Chancellor's final decision (if appealed to that level), the Associate Dean will make all such decisions.

1. Level One - Informal Review

When the Program Director, with the approval of the Chair, determines that grounds exist to dismiss a Trainee or to not renew his/her appointment (notice given within four months of the end of the appointment date), the Program Director will provide the Trainee with written notice of the intent to dismiss or not reappoint. This notice will include a statement of the reason(s) for the intended dismissal or non-reappointment, a copy of the materials upon which the intended dismissal or non - renewal is based, and a statement that the Trainee has a right to respond in writing to the Chair within ten (10) calendar days of receipt of the notice. If the Trainee does not respond, the intended action shall become final eleven (11) calendar days after receipt of the notice or as otherwise noted by the Program Director. If the Trainee submits a written response within the ten - day period, the Chair will review it. The Chair will decide whether non reappointment or dismissal is appropriate. Within 15 calendar days thereafter or as soon as reasonably possible, with the agreement of both parties, the Chair will notify the Trainee of the Chair's decision by letter, which shall also be copied to the Program Director and Associate Dean. If the decision is to uphold the intended non - renewal or dismissal, the letter should include the reasons for upholding the proposed action, provide the effective date of the dismissal and include a copy of, or a link to, these guidelines. Attempts at informal resolution do not extend the time limits for filing a formal appeal unless the Trainee and the Program Director so agree in writing, or upon the written approval of the Associate Dean. The Trainee will continue to receive regular stipends until the effective date of the dismissal or appointment end date.

2. *Level Two - Formal Review*

If the Trainee wishes to appeal the Chair's decision to dismiss or not reappoint, the Trainee must send a written appeal to the Associate Dean no later than thirty (30) calendar days after the Trainee receives the Chair's decision. The written appeal should concisely explain why the Trainee believes the Chair's decision was arbitrary and capricious and should address the specific reasons for the dismissal or non - reappointment set forth in the Program Director's notice of intent to dismiss or to not reappoint.

The Trainee may be assisted or represented by another person at his or her own expense. UCSD may also be represented. If the Trainee is represented by an attorney, he/she shall notify the Associate Dean within fifteen (15) calendar days of initiating the appeal. The University will not be represented by an attorney if the Trainee is not so represented. The Trainee must appear in person at the hearing, even when represented. The failure of the Trainee to appear in person for the full duration of the hearing will be deemed a voluntary dismissal of his/her appeal.

Within fifteen (15) calendar days of receipt of the appeal, or as soon thereafter as is practicable, the Associate Dean will appoint an Ad Hoc Formal Review Committee to hear the appeal. The Committee will consist of three members, at least one of which shall be a member of the full - time faculty, one senior trainee (PGYIII or higher), and one faculty member of the Graduate Medical Education Committee. The Associate Dean will designate one of the Committee members to be the Committee Chair. The Chair is empowered to impose reasonable limits on all proceedings of the Ad Hoc Committee. If possible, one of the Committee members should be from the same department as the Trainee; however, individuals who were substantially involved in any earlier review of the issues raised in the appeal, or who were substantially involved in any incident underlying the appeal generally should not sit as a member of the Committee. The Associate Dean may, at its discretion, request that an attorney from the Office of the General Counsel be appointed to provide independent legal counsel to the Committee. This attorney shall not vote in the Committee's deliberation process. Until the appointment of a Committee Chair, the Associate Dean will resolve all issues related to these procedures.

The Hearing will ordinarily be held within sixty (60) calendar days of receipt of the appeal by the Associate Dean. Unless otherwise agreed by the Parties and the Chair, the Trainee and his/her advocate, if any, will meet at least fifteen (15) days prior to the Hearing at a pre - hearing conference with the Committee Chair, the University representative and the University advocate (if any) to agree upon the specific issues to be decided by the Committee. If the parties are unable to reach an agreement on the issues to be decided, the Committee Chair will determine the issues to be reviewed. Issues that were not raised in the notice of intent to dismiss or to not reappoint, the Trainee's written and timely response thereto, or the notice of the Chair's decision, may not be raised in the Hearing absent a showing of good cause. At this conference, the parties may raise other procedural and substantive issues for decision by the Chair.

At least ten (10) calendar days prior to the Hearing, or at another date agreed to by the Parties and the Chair, all documents to be introduced as evidence at the hearing and names of all witnesses shall be exchanged. With the exception of rebuttal witnesses and documents used in rebuttal, any witnesses not named and documents not exchanged ten (10) calendar days before the hearing may, at the Committee Chair's discretion, be excluded from the Hearing.

The Hearing will provide an opportunity for each party to present evidence and question witnesses. The Committee Chair has broad discretion regarding the admissibility and weight of evidence and is not bound by federal or state rules of evidence. If requested by either party, the Committee will take judicial notice of (i.e., recognize as a fact the existence of) any University policies. The Committee Chair will rule on all questions of procedure and evidence. The hearing will be recorded on audio tape by the University unless both parties agree to share the cost of a court reporter, or one party elects to pay the entire cost for the reporter in order to have a transcript for its own use, in which case the other

side may purchase a copy of the transcript for half the cost of the court reporter and transcription plus any copy costs. The Trainee may listen to any audio tape and may purchase a copy of the audio tape. The Associate Dean will be the custodian of the audio tape and any written record, and will retain the recording for five (5) years from the time the Ad Hoc Committee's or Vice Chancellor's decision becomes final.

Unless both the Trainee and the University agree to an open hearing, the hearing will be closed. All materials, reports and other evidence introduced and recorded during the course of a closed proceeding may not be disclosed until the final resolution of the appeal under these procedures except as may be required by applicable law. At the request of either party or the Committee Chair, only the witness testifying may be present and other potential witnesses will be excluded. However, the Trainee, his/her advocate and the University's representative and its advocate will at all times have the right to attend the hearing.

The Trainee has the responsibility of establishing that the dismissal or non - renewal was arbitrary and capricious. The University will initially come forward with evidence in support of the Chair's decision. Thereafter, the Trainee will present his/her evidence. The parties shall have the opportunity to present rebuttal evidence. The Committee Chair has the right to limit rebuttal evidence at his/her discretion. Following the presentation of the evidence at the Hearing, the Committee Chair will determine whether each party will be given an opportunity to present a closing statement. The Committee Chair will also determine the applicable time limits for any such closing statements.

At the discretion of the Committee Chair, each party may submit a brief following the Hearing. The maximum length of such a brief, if any are allowed, will be determined by the Committee Chair. The Committee Chair will also determine the appropriate briefing schedule. Following the close of the Hearing, the Committee will present its written recommendation(s) to the Trainee, the Chair, Program Director and Associate Dean. This recommendation(s) should occur, absent unusual circumstances, within fifteen (15) calendar days of the Hearing's conclusion.

The Committee will evaluate the evidence presented and prepare a recommended decision that shall contain written findings of fact and conclusions. The decision of the Chair will be upheld if the Committee finds that the Trainee has not met his/her burden to establish by a preponderance of the evidence that the Chair's decision was arbitrary and capricious. The recommended decision shall become final after fifteen (15) calendar days unless an appeal is filed pursuant to III.C.

C. DECISION BY VICE CHANCELLOR

Within fifteen (15) calendar days of receipt of the Committee's recommendation(s), the non- prevailing party may submit, to the Vice Chancellor, a final written appeal to the Committee's recommendation(s). A copy of any such appeal must also be provided to the other party. Any appeal submitted to the Vice Chancellor must be limited to:

(a) Whether the record presented to the Committee contained sufficient evidence to support the Committee's recommendation(s); or

(b) Whether there is new evidence that could not reasonably have been introduced at the Hearing and would be likely to change the result.

In the event that a party submits a timely appeal to the Vice Chancellor, the other party shall have fifteen (15) calendar days following its receipt of the appeal to submit its own response, if any.

After receipt of the Committee's recommendation, the parties' written responses (if any), and the record, the Vice Chancellor within sixty (60) calendar days, or as soon as reasonable thereafter, will take any action deemed appropriate, including upholding the Committee's Recommended Decision, rejecting the Committee's recommendation or remanding the matter back to the Committee with instruction for further review and recommendation. The Vice Chancellor's ultimate decision will be final and will be in writing and sent to the Program Director, the Chair, the Trainee, the Associate Dean and the Ad Hoc Formal Review Hearing Committee Chair.

D. REMEDY

If the Trainee successfully appeals his/her non-renewal or dismissal and the Committee's decision is upheld under III.C or becomes final pursuant to the last paragraph of III.B, the remedy will not exceed restoring the Trainee's stipend payment from the date of dismissal or non-renewal, benefits or any rights lost as a result of the action, less any mitigating income earned from other sources.

SPECIAL REQUIREMENTS FOR HOUSE OFFICERS

CALIFORNIA MEDICAL LICENSE

UCSD Medical Center encourages House Officers to apply for their medical license in California within 60 days of reaching eligibility for licensure. Once licensed, House Officers must maintain a full and unrestricted license in order to continue their appointment. Initial appointments will not be made for any House Officer who is on probation from the Medical Board or Osteopathic Board. Should a UCSD House Officer's license be placed on probation during training, the Program Director may request, and be granted, an exception to policy from the Associate Dean for Graduate Medical Education in order for the House Officer to continue in the training program. The Associate Dean for Graduate Medical Education will convene an Ad Hoc License Evaluation Committee and follow the established probationary license guidelines for existing UCSD House Officers.

The California Medical Practice Act permits medical and osteopathic school graduates to practice medicine within the scope of their ACGME approved training program without a license in this State while they are fully registered with the Medical Board of California as follows:

GRADUATES OF MEDICAL SCHOOLS IN THE US, PUERTO RICO AND CANADA

- May train for the first year following graduation from medical school at the intern/PGY1 level for a period not to exceed 12 months from the commencement of the PGY1 year of training; and
- May continue for a second year of training in this State at the PGY2 level for a period not to exceed 12 months from the commencement of the PGY2 year of training. At the conclusion of the PGY2 year, the House Officer must be licensed in order to continue in training in this State; or
- US, Puerto Rican and Canadian medical school graduates must hold a full and unrestricted license to practice medicine in this State upon completion of 24 months of approved postgraduate medical education.

GRADUATES OF INTERNATIONAL MEDICAL SCHOOLS

- An international medical school graduate must be registered with the Medical Board of California prior to commencement of training in an ACGME approved training program in this State.
- To qualify for licensure the physician must meet one of the following requirements:
  - Completion of a minimum of two years of ACGME postgraduate training; or
  - Completion of 12 months of ACGME postgraduate training and current certification by a member board of the American Board of Medical Specialties or a specialty board approved by the MBC - Division of Licensing; or
  - Completion of 12 months of ACGME postgraduate training and successful completion of the computerized clinical competency exam (SPEX) in the State of California.
- The international medical school graduate must hold a full and unrestricted license to practice medicine in this State upon completion of 36 months of ACGME approved postgraduate medical education in the United States.
- House Officers who have not obtained a license within the prescribed time frames will not be allowed further patient contact and may be terminated from their training program. For the duration of training, a full and unrestricted California medical license must be continually maintained as a prerequisite for continued appointment.

CRIMINAL BACKGROUND CHECK (CBC) POLICY: HOUSE OFFICER

Completion of a satisfactory CBC will be a requirement for all newly appointed physicians in training sponsored by UCSD School of Medicine/UCSD Healthcare, effective 6/23/08. During training, once licensure is required, the ability to obtain and maintain licensure will serve as evidence of an ongoing satisfactory CBC.

Procedures

1. Contracts sent by the Office of Graduate Medical Education will include a statement about the requirement of a satisfactory CBC and completion of an attestation questionnaire as a condition of employment.
2. CBC's will be performed by reputable company through the usual business contracting arrangements.
3. Matched physicians - in - training and current House Officer will be asked to provide appropriate authorization, with the pertinent identifying information necessary to initiate the check.
4. Those undergoing the CBC will have an opportunity before any information is released to UCSD to review the data for accuracy.
5. The following databases would be searched:
   a. Social Security Number Validation
   b. Analyzed Social Security Number Search
   c. County Criminal Records Search
   d. National Criminal File Search
   e. National Sexual Offender Database Search
   f. Sanctions Base Search
   g. Motor Vehicle Records/Driving Records Search
6. CBC reports for new physicians - in - training will be reviewed by the DIO/Associate Dean for Graduate Medical Education, the Chair of the Graduate Medical Education Committee and the physician - in - training's Program Director, in consultation with the Department's Education Committee, who will make a decision about entry into the program. There is no appeal to this decision.
7. CBC reports for current physicians in training will be reviewed by the DIO/Associate Dean for Graduate Medical Education, the Chair of the Graduate Medical Education Committee and the physician - in - training's Program Director, in consultation with the Department's Education Committee, who will make a decision about continuation in the program. Should a decision of termination be made, the appeal mechanism specified in UCSD's House Officer Policy and Procedure Document will apply.

NARCOTIC REGISTRATION

A House Officer who is licensed in the State of California may apply for a Drug Enforcement Administration number by completing DEA Form #224 online. This form can be found on the DEA's website, http://www.deadiversion.ucdoj.gov

There is no charge for the DEA registration (the fee will be exempt) if the House Officer uses the UCSD business address on the application, and identifies the Director, Office of Graduate Medical Education, as the certifying official.

House Officers can use the UCSDMC Institution DEA number (by very clearly noting their 5 digit UCSDMC provider number) when they write inpatient prescriptions that are to be filled at UCSDMC, Hillcrest and Thornton sites. House Officers may not write prescriptions for controlled substances for discharged patients or outpatients without a personal DEA number even if the prescription is to be filled at UCSD Medical Center.

TRAINING AT AFFILIATED GME TRAINING SITES

Additional screening and procedural requirements may be mandated by affiliated institutions while trainees are rotating through those sites as a part of their GME training program at UCSD.

TRAINING IN ACLS AND PALS

House Officers who are in training programs involved with responding to code blue are required to be certified in a training program approved by UCSD Medical Center. Trainees in other programs are encouraged as well to become certified.

EDUCATIONAL ENVIRONMENT CONDUCIVE TO OPEN EXCHANGE OF IDEAS

UCSD assures an educational environment in which House Officers may raise and resolve issues without fear of intimidation or retaliation by administration, faculty or staff through the following organizational system:

Members of the House Officer may bring forward issues regarding their working environment and their educational programs in a confidential and protected manner at any time to the Associate Dean for Graduate Medical Education, to the Chair of the Graduate Medical Education Committee who represents the GMEC and to the Director, Office of Graduate Medical Education. House Officers may also bring issues to the attention of the Graduate Medical Education Committee through their membership on that committee.

House Officers are also encouraged to discuss issues that require attention or resolution regarding their educational experience with their Chief Residents, Training Program Directors and with their Department Chair/Division Chief.

The approved UCSD Graduate Medical Education Academic Due Process and Leave Guidelines document ensures the house officer fair policy and procedure for academic or other disciplinary actions which may be taken against house officer.

HOPPD REVIEW/APPROVAL

The House Officer Policy and Procedure Document will be reviewed on an annual basis, or as otherwise needed, by the Graduate Medical Education committee and by the Associate Dean for Graduate Medical Education, the Director, UCSD Medical Center and by the Dean, School of Medicine. Revised documentation will be forwarded to all House Officers.

Approved:

Sherry Huang, MD
Chair, Graduate Medical Education Committee

9/17/2012
Date

Stephen R. Hayden, MD
Associate Dean for Graduate Medical Education and DIO

9/17/12
Date

Paul S. Viviano
CEO UC San Diego Health System

10/1/12
Date

Maria C. Savoia, MD
Dean for Medical Education

9/25/12
Date