



# HOUSE STAFF POLICIES AND PROCEDURES

2010 – 2011

## TABLE OF CONTENTS

<a href="#">Administration</a>	2	<a href="#">Institutional Licensure</a>	8
<a href="#">Adverse Actions</a>	12	<a href="#">Institutional Policies</a>	8
<a href="#">Appointment</a>	3	<a href="#">Insurance</a>	4
<a href="#">Basic Postgraduate Resident Permit</a>	7	<a href="#">Lab Coats</a>	19
<a href="#">Benefits</a>	4	<a href="#">Leave</a>	4
<a href="#">Billing Compliance</a>	8	<a href="#">Licensure</a>	6
<a href="#">Campus Information</a>	2	<a href="#">Meals</a>	19
<a href="#">Changing Programs</a>	16	<a href="#">Medical Records</a>	8
<a href="#">Conference Attendance</a>	11	<a href="#">Moonlighting</a>	11
<a href="#">Counseling</a>	16	<a href="#">On-call Quarters</a>	19
<a href="#">Criminal Background Check</a>	3	<a href="#">Parking</a>	19
<a href="#">Disaster Plan</a>	8	<a href="#">Physician Impairment</a>	8
<a href="#">Duty Hours</a>	10	<a href="#">Program Completion</a>	19
<a href="#">Education Program Policies</a>	9	<a href="#">Program Closure or Reduction</a>	19
<a href="#">Elective Rotations</a>	11	<a href="#">Reappointment</a>	15
<a href="#">Email</a>	19	<a href="#">Resident Complaints</a>	16
<a href="#">Evaluations</a>	11	<a href="#">Resident Support</a>	16
<a href="#">Grievance Procedure</a>	17	<a href="#">Salaries</a>	3
<a href="#">House Staff Association</a>	16	<a href="#">Scholarly Activity</a>	9
<a href="#">ID Badges</a>	19	<a href="#">Sexual Harassment</a>	8
<a href="#">Immunization</a>	8	<a href="#">Violence Policy</a>	8

[Back to Top](#)

This update is effective and replaces all previous versions of the TTUHSC House Staff Policies and procedures.

[Back to Top](#)

## GME ADMINISTRATION

Steven Lee Berk, M.D.

Dean

Texas Tech University Health Sciences Center  
School of Medicine

Richard M. Jordan, MD  
Regional Dean  
TTUHSC at [Amarillo](#)

Surendra Varma, MD  
Associate Dean for GME  
and Resident Affairs  
Chair, GME Committee  
TTUHSC at [Lubbock](#)

John C. Jennings, MD  
Regional Dean  
TTUHSC at [Permian Basin](#)

Kristin Stutz, MS, DIO  
Interim Assistant  
Academic Assistant Dean  
TTUHSC at [Amarillo](#)

J.Edward Bates  
Senior Director for GME & DIO  
TTUHSC [Lubbock](#)

Ramona Burdine, MD  
Assistant Dean of Education  
Chair, GME Committee  
TTUHSC at [Permian Basin](#)

[Back to Top](#)

## CAMPUS GME DIRECTORS

[Amarillo](#) Campus  
(806) 354-5417

[Kristin Stutz](#), MS, DIO  
[Janet Abbott](#), Interim Assistant Director

[Lubbock](#) Campus  
(806) 743-2978

[Stacy Martin](#), BS, Associate Director

[Permian Basin](#) Campus  
(432) 335-5265

[Tina Leal](#), MA, Director and DIO

[Back to Top](#)

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER  
GRADUATE MEDICAL EDUCATION

POLICIES AND PROCEDURES

The purpose of Graduate Medical Education (GME) is to provide an organized medical education program with guidance for and supervision of the resident, facilitating the resident's ethical, professional and personal development while ensuring safe and appropriate care for patients.

The following information has been compiled by the Texas Tech University Health Sciences Center (TTUHSC) Office of [Graduate Medical Education](#) (GME) for use by residents, Chairs, Program Directors and administrators at TTUHSC. These policies, regulations, and procedures form an integral part of the "Graduate Medical Education Program Agreement." The term "**resident**" refers to all post-graduate trainees including interns, residents, fellows, and house staff.

**I. APPOINTMENT**

- A. **Post Graduate Year** (PGY) level is assigned to each resident. Post Graduate training at TTUHSC requires that each resident be eligible to be licensed in Texas and to take national board exams for board certification.
- B. Prior to accepting an applicant, the Program Director shall ensure that the applicant has passed [USMLE/COMLEX](#), Step 1, within the number of attempts provided by the [Texas State Board of Medical Examiners](#) (TMB) for Texas licensure.
- C. Criminal Background Check  
In accordance with [HSC OP 10.20](#), "Criminal Background Checks for Students, Trainees, and Residents." Residents entering training on, about, or after July 1, 2006, will not be placed on the payroll nor be assigned any clinical duties until they have undergone a CBC and the results establish that the residents are eligible for clinical training.

[Back to Top](#)

Please reference the following websites for [HSC OP 10.20](#):

- [Attachment A](#) – Notice to students and trainees
- [Attachment B](#) – Consent for Release of Information

TTUHSC does not discriminate based on race, color, national origin, sex, disability, religion, age or veteran status in admission, employment, access to, or treatment in its programs or activities. See State of Texas and [Regents' Rules, Section 03.01.09](#).

- D. Each applicant submitting an [ERAS application](#) shall be required, at the time of the interview, to complete a TTUHSC ERAS Addendum.
- E. Each applicant must be a graduate of a [medical school that is approved](#) by TMB or a medical school whose curriculum is accepted by the Texas Higher Education Coordinating Board as equivalent to that of a Texas medical school. A graduate of the latter must:
1. Possess a valid certificate issued by the [Education Commission for Foreign Medical Graduates](#) (ECFMG); and,
  2. Be eligible for employment at TTUHSC.
- F. Resident appointments are recommended by the department and are subject to review and approval by the TTUHSC GME Office and the Dean of the TTUHSC School of Medicine. No resident may begin, or continue in, a residency without this approval and appointment.

[Back to Top](#)

**II. BENEFITS**

- A. [Salaries](#) are appropriate to the training level of the resident, and are reviewed annually. Residents are paid by TTUHSC on a monthly basis. Payment is inclusive from the first to the last day of the current month, and checks/direct deposits are issued on the first regular business day of the following month. Residents should consult their GME representative regarding distribution of paychecks at each campus. [Forms](#) for direct deposit may be obtained from Human Resources, Payroll, or the GME office. For tax purposes, remuneration to a resident is considered salary by the Internal Revenue Service.

## B. Insurance

1. [Malpractice Coverage](#) for residents is \$100,000 per incident and \$300,000 annual aggregate while participating in TTUHSC-sponsored training. This occurrence coverage covers incidents that occur while the coverage is in force regardless of when the claim is made or reported. This insurance covers any activity that is a part of the resident's training program but **does not** assume liability for activity beyond the scope of the residency training program, including outside remunerative medical activity i.e., "moonlighting". Any resident who suspects the possibility of an "incident" shall immediately notify the Risk Management Office. (PLEASE REFER TO THE SELF-INSURANCE BROCHURES CONCERNING INCIDENTS AND CLAIMS REPORTING.) TTUHSC professional liability coverage is not provided for activity outside the course and scope of the training program.
  2. [Group Health Insurance](#) is provided by TTUHSC for all residents and their eligible dependents. If a resident elects to enroll in a health plan other than the group plan, the entire cost shall be borne by the resident. Residents should not assume that professional courtesy discounts for themselves and family members will be extended. If a resident is on approved leave, premiums will be paid in accordance with state and federal guidelines, not to exceed 12 weeks, e.g., FMLA, parental leave, etc. Upon completion of training or leaving the program before completion, a resident may elect, at his/her expense to continue insurance coverage in accordance with federal COBRA regulations.
- [Back to Top](#)
3. **Medical Services Available** Residents are provided coverage for health, dental, and eye exams. They are able to choose their own providers from lists provided to them at the start of their residency.
  4. [Worker's Compensation](#) coverage is provided for all residents. Any on-the-job injury must be reported to the resident's supervisor as soon as possible, at which time the supervisor shall have the duty to complete applicable paperwork and forward to the TTUHSC Department of Human Resources. Reimbursement for an on-the-job injury cannot be considered unless an appropriate report has been filed with the Health and Safety Office. Each resident shall be provided access to, either by website link or written copy, the **School of Medicine Ambulatory Care Clinic Policy 7.07: Management of Blood and body Fluid Exposures** and shall comply with the respective campus procedure relative to needle sticks.
  5. [Disability Income, Term Life Insurance, Dental and Vision Coverage](#) is provided by TTUHSC for all residents and their eligible dependents.

- C. **Leave** Leave is integrally conditioned upon each program's participation requirements for board eligibility in terms of minimum time spent in the program. TTUHSC provides leave benefits as outlined below; however, board requirements shall take precedence, discretion resting with the Program Director in the context of departmental policy. For these benefits, a working day is based on a traditional employment workweek, i.e., five working days per week.

Residents should be aware that an extended period of leave, regardless of the type of leave, may necessitate an extension of their training program in order for the resident to meet the minimum training requirements of their professional board, in order to qualify to sit for their board examination. Residents are strongly encouraged to discuss this matter with their Program Director to ensure they will be able to utilize their leave and still complete the program as anticipated, or to be aware of and plan for an extension of the program in their particular situation so that they have met all specialty board training requirements.

[Back to Top](#)

1. **Vacation** is approved for not more than 15 working days for PGY levels 1-2 and not more than 20 working days for PGY-3 level and above, subject to residency program requirements. Any variance from this policy must be justified by the Program Director/Chair, recommended by the GME Chair, and approved in advance by the Dean. Timing and scheduling of vacations is at the discretion of the individual department. Vacation benefits do not carry forward from year to year and must be taken within the current contract agreement year.  
**Unused vacation benefits are not paid upon completion or termination of the agreement.**
2. **Sick Leave** entitlement may be approved for up to 12 working days per year and may be carried forward from one contract year to another, if applicable. Residents will not be compensated for accumulated sick leave. A part-time resident accrues sick leave on a pro rata basis of the percentage of time worked. Sick leave with pay may be taken when sickness, injury, or pregnancy prevents the resident from performing his/her duty or when a member of his/her immediate family (spouse, child, or parent) is actually ill and requires the resident's attention. The

use of sick leave is strictly limited to the time necessary to provide care and assistance as a direct result of a documented medical condition. A resident who must be absent from duty because of illness shall notify the Program Director at the earliest practicable time. To be eligible for accumulated sick leave with pay during a continuous period of more than three working days, residents must provide to their Program Director a doctor's certificate or other written statement that is acceptable to the Program Director concerning the illness. Time taken for illness on days either side of vacation requires a physician's statement. Otherwise, the leave will be counted as vacation or leave without pay if all vacation leave has been exhausted.

3. **Family and Medical Leave Act (FMLA)** requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Residents are eligible if they have worked at TTUHSC at least 12 months and a minimum of 1,250 hours over the previous 12 months. Copies of the FMLA policies ([HSC OP 70.32](#)) may be obtained from the [GME Office](#) or the [Human Resources Office](#). [Back to Top](#)
4. **Parental Leave of Absence**, not to exceed 12 weeks, is available for residents with less than one year of service or who have worked less than 1,250 hours in the 12-month period immediately preceding the commencement of leave. This leave is available only after the resident has utilized all available paid vacation and sick leave. Additional information may be obtained from the [GME Office](#) or the [Human Resources Office](#). This parental leave of absence is limited to, and begins with the date of the birth of a natural child or the adoption or foster care placement, of a child under three years of age.
5. **Leave of Absence**. A Leave of Absence is defined as the interval when all accumulated vacation and/or sick leave time has been exhausted. The Campus GME Committee must approve a leave longer than 30 days, exclusive of FMLA. Leave of Absence with or without pay, is to be reported by the Program Director to the GME Office. Leave without pay may necessitate payment by the resident for medical insurance coverage during that stipulated period. Issues related to minimum training time required by specialty certification boards will be resolved by the resident and the Program Director. Available sick and/or vacation days must be utilized prior to taking leave without pay. **(See above, Sec. C, 2 for definition of sick leave entitlement.)**

An extended leave of absence may require termination of the leave, resignation of the resident, reapplication to the training program and reappointment, if applicable. Granting of the leave of absence is at the discretion of the Program Director, as is any reappointment, if, applicable.

6. **Educational Leave** must be approved by the resident's Program Director and an official travel form, if applicable, must be executed by the department's administrative officer. Failure to do so may jeopardize certain dependent and other benefits, which may be forfeited if the resident is not on official leave of absence. Subject to residency program requirements and approval, educational leave is granted with pay and not charged to vacation time.
7. **Funeral Leave** may be granted with pay upon the death of an immediate family member or immediate family member of spouse. The total time allowed shall normally not exceed three days.
8. **Court Leave** When a resident receives either a summons to serve as a juror or a subpoena to appear as a witness, the attendance of the individual is required. A judge may, at his discretion, excuse a resident called to serve as a juror by virtue of the resident's being a physician "in training," but since the resident receives a salary, the judge may determine no exemption is allowed. Unless the judge grants an exemption, a resident is required to perform jury duty and must be released from the department to respond to the summons. [Back to Top](#)
9. **Military Leave** requires immediate notice to the Program Director, accompanied by means of verification of applicable military orders. A resident who is a member of the National Guard or a member of any non-activated reserve units of the Armed Forces will be entitled to a leave of absence from duties without loss of vacation time or salary on all days ordered by proper authority to duty with troops on field exercise or for instruction, not to exceed 15 work days per academic year.
10. **Compensation:** Residents shall not be entitled to pay or other compensation for holidays, unused vacation, or sick leave.

### III. MEDICAL LICENSURE

Residents shall timely provide copies of all medical licensure information to the GME Office. A resident having either a current or a former license from any state must provide a copy(ies) to the GME Office prior to beginning of the residency. If any license has been canceled, limited, or removed for any reason, copies of that information must be provided in

advance of appointment to establish eligibility for appointment. When discovery of licensure problems is made after appointment, failure to provide this information as outlined above constitutes failure to comply with terms of the GME Program Agreement, renders the agreement void and results in immediate termination of the resident's appointment. No resident or fellow will be allowed to participate in clinical (patient care) duties unless a current valid Texas Physician License or a Basic Postgraduate Resident Permit is on file in the Campus GME Office and the residency program department.

[Back to Top](#)

A. **Licensure** is the personal and financial responsibility of each resident. The TTUHSC requirement for passing the licensure exam is as follows:

1. Prior to Commencement of training by an applicant in a resident position, the Program Director shall verify the applicant has passed [USMLE](#), Step 1, or its equivalent within the number of attempts permitted for Texas licensure. Prior to commencement of training by an applicant who would be transferring into a residency training program at TTUHSC, and who would be entering at the PGY 3 level or higher, the Program Director will verify the applicant has passed all three steps of [USMLE](#) or [COMLEX](#), within the number of attempts permitted by TMB for a physician to be licensed in Texas. If the applicant has not fulfilled this requirement, the applicant will not be eligible to begin a TTUHSC graduate medical education program. In the case of fellowship applicants, or residents applying to enter a program at the PGY 3 level or above, prior to commencement of training, the Program Director shall verify the applicant has passed all three (3) steps of the [USMLE](#) or [COMLEX](#), within the number of attempts permitted for Texas Licensure. (3 or less on Step I, 3 or less on Step II for the CS and CK (3 each section) and 3 or less on Step III of the [USMLE](#) or [COMLEX](#)). Such fellowship/residency applicants who have not met this requirement will not be eligible to begin training.
2. No later than June 30 of their PGY 1 year for those residents beginning their residency July 1, 2010 and thereafter, all PGY 1 residents must present written proof to their Program Director and the GME Office of having taken [USMLE](#), Step III and having taken and passed [USMLE](#), Step II CK and CS, or their equivalents. No later than March I of the PGY 2 year, or 4 months before the end of a resident's PGY 2, year, all residents shall be required to present proof to the GME Office and Program Director, of passing Step III of [USMLE](#), or its equivalent, within the number of attempts permitted for Texas licensure.
3. If a resident does not pass Steps II and III of the [USMLE](#) no later than March 1, or 4 months before the end of their PGY 2 year, a new TTUHSC GME Program Agreement will **NOT** be offered to the resident. However, the resident will be required to complete the current agreement, i.e. serve until June 30<sup>th</sup> of that year unless other facts/conditions apply.
4. If a resident passes Step III of [USMLE](#) subsequent to March 1 of the PGY 2 year, but prior to June 30 of that year, or before the end of their PGY 2 year, a new TTUHSC GME Program Agreement may, at the discretion of the Program Director, be offered, if the program has not already filled the position.
5. A resident who does not receive a new TTUHSC GME Program Agreement for any portion of the time it would normally take to successfully complete the program in the minimum amount of time may appeal the decision to not offer such agreement. Should the resident elect to appeal this decision, the same procedure for appealing a dismissal, within the House Staff Policies and Procedures will be used.

[Back to Top](#)

B. **Texas License:** Subject to program requirements, eligible residents may be required to obtain a Texas license after the first year of training. If this is not a departmental requirement, the basic postgraduate resident permit, formerly referred to as institutional permit is renewed as applicable in accordance with current TMB rules. Expiration of license or postgraduate permit will result in suspension of privileges by the affiliated hospital and/or dismissal from the residency program.

[Back to Top](#)

C. **A Basic Postgraduate Resident Permit** is required for any resident not licensed as an independent practitioner in the State of Texas. The permit, obtained from TMB, **does not** allow a resident to practice clinical activity outside his/her training program. Notification from TMB that the resident's application for a basic postgraduate resident permit (institutional permit) is denied will void the GME Program Agreement and any applicable provisions. TMB requires Program Directors to report the following occurrences to the Board:

1. The director of each approved postgraduate training program shall report in writing to the executive director of the board the following events within seven days of their occurrence:

[Back to Top](#)

- a. If an applicant did not begin the training program due to failure to graduate from medical school as scheduled or for any other reason(s);
  - b. If a permit holder has been terminated or has resigned from the program and the reasons(s) why;
  - c. If a permit holder has been or will be absent from the program for more than twenty-one (21) consecutive days (excluding vacation, family, or military leave) and the reason(s) why;
  - d. If the program has information that a permit holder has been arrested after the permit holder begins training in the program; and/or,
  - e. If the program has information that a permit holder, while in postgraduate training:
    - i. Engaged in alcohol or chemical substance abuse, dependency or addiction;
    - ii. Engaged in sexual contact with a patient, or sexually inappropriate behavior or comments directed towards a patient;
    - iii. Behaved in a disruptive manner toward physicians, hospital personnel, other medical personnel, patients, patient's family members or others that interferes with patient care or could be reasonably expected to adversely impact the quality of care rendered to a patient; is known or suspected to have a medical disorder and has exhibited behavior that is likely to have resulted from the disorder and that could reasonably be expected to adversely affect the quality of care rendered to patients;
    - iv. Is known or suspected to have a sexual disorder, including but not limited to pedophilia, exhibitionism, voyeurism, frotteurism, or sexual sadism;
    - v. Was named in a professional liability claim or suit in which the permit holder was named that involved death or serious bodily injury and in which funds were paid on behalf of the permit holder; or,
    - vi. Failed to practice medicine in an acceptable professional manner consistent with public health and welfare where such failure indicates the permit holder is unable to practice medicine in a competent manner and the permit holder has been unable to correct his or her deficiencies through the remedial measures, if any, offered by the program.
2. If the program has determined that a permit holder has committed unprofessional or dishonorable conduct within the meaning of the Act or as defined under [190.8. Violation Guidelines](#) of this title relating to and the reason(s) why;
3. If the program has, in relation to academic or non-academic reasons, made a final determination and taken disciplinary or adverse action to include:
- a. Limited, reduced, suspended, revoked or denied privileges;
  - b. Formally warned, censured, reprimanded, or admonished in writing;
  - c. Monitored admissions and/or treatment plans in a manner that exceeds standard educational practices.
  - d. Placed the permit holder on academic or disciplinary probation;
  - e. Requested termination or terminated the permit holder from the program, requested or accepted withdrawal of the permit holder from the program, or requested or accepted resignation of the permit holder from the program; or,
  - f. Any such similar action and the reason(s) why.

[Back to Top](#)

[Back to Top](#)

[Back to Top](#)

[Back to Top](#)

#### D. Department of Public Safety (DPS) & Drug Enforcement Administration (DEA) Numbers

1. **Institutional Drug Enforcement Administration (DEA) Numbers** are assigned by the GME Office or affiliated hospital. The institutional DEA number allows prescription-writing privileges for only those activities that are a part of the training program. Institutional DEA numbers are not valid for outside remunerative employment, i.e., "moonlighting."
2. **Individual [Department of Public Safety \(DPS\)](#) & [Drug Enforcement Administration \(DEA\) Numbers](#).** Once the resident obtains a full, unrestricted Texas medical license, institutional DEA numbers are invalid for use by the resident, who must then obtain individual DPS and DEA numbers. All eligible residents are responsible for obtaining their individual DPS and DEA numbers and must keep the GME Office informed of their status.

#### IV. INSTITUTIONAL POLICIES

- A. **[Billing Compliance](#)**. Within the first 30 days of beginning residency training at TTUHSC, each resident will undergo **[Billing Compliance](#)** training, and then annually thereafter.
- B. **Medical Records**. Dictation, timely completion of charts, signing patient orders and compliance with the rules and regulations of the Medical Records Departments of TTUHSC and affiliated hospitals are considered integral to graduate medical education and professional development. Residents shall complete all medical records assignments in a timely manner, and each resident shall be responsible for familiarizing himself/herself with hospital medical records policies. Failure to complete medical records, as prescribed by applicable hospital bylaws, rules and regulations, clinic rules and regulations, and/or departmental policy, will result in corrective action, which may include, but not be limited to, disciplinary action or loss of benefits at the department/campus level. A Certificate of Completion or Verification of Training letter will not be issued until all medical records are completed.
- C. **Disaster Plans** of respective hospitals vary. Each resident should receive an assignment to a disaster station and must be familiar with his/her applicable role and responsibilities.
- D. **Sexual Harassment** is a violation of state and federal law. The TTUHSC Graduate Medical Education program prohibits sexual harassment. Each resident will be provided access to [TTUHSC OP 70.14](#), "Sexual Harassment" and be responsible for understanding its contents and complying with this policy. This policy is available in the Department of Human Resources at each campus and in each GME office. In addition, each resident is responsible for attending and participating in any training programs required by TTUHSC.
- E. **Violence and Workplace Threats**, found in [TTUHSC OP 76.08](#), prohibits violent threatening or intimidating conduct by TTUHSC personnel, including residents. A copy of this policy is provided at orientation and is available in the Department of Human Resources and in each GME office.
- F. **Immunization**. TTUHSC provides immunization at no cost to residents. Each resident is responsible for knowing and complying with the TTUHSC Immunization Policy, which is distributed at orientation and is available in the GME Office.
- G. **Physician Impairment**. Each resident is responsible for knowing the contents of and complying with the TTUHSC Policy for Impaired Physicians which is distributed at orientation and is available in the GME Office and at the end of this document in [See Appendix A](#) for Evaluation and Treatment of Impaired Physicians or House Staff.

[Back to Top](#)

[Back to Top](#)

#### V. EDUCATION PROGRAM POLICIES

The Program Director, with the assistance of the faculty, is responsible for developing in written form and implementing the academic and clinical program that includes, but is not limited to, a statement of educational goals of the program with respect to the knowledge, skills, and other attributes of residents for each major assignment and each level of the program. The statement is distributed to residents and reviewed with residents prior to the assignment.

- A. **Appointment** to a residency program requires residents to develop competencies in the six areas below to the level expected of a beginning practitioner.

[Back to Top](#)

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health;
2. **Medical Knowledge** of established and evolving biomedical, clinical, and cognate, e.g. epidemiological and social-behavioral sciences and the application of this knowledge to patient care;
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care;
4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals;
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population; and,
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.

## B. **Scholarly Activities**

1. The responsibility for establishing and maintaining an environment of inquiry and scholarship rests with the faculty, and requires that an active research component be included within each program. Both faculty and residents must participate actively in scholarly activity. Scholarship is defined as any of the following:
  - a. The scholarship of discovery, as evidenced by peer-reviewed funding or publication of original research in peer-reviewed journals.
  - b. The scholarship of dissemination, as evidenced by review of articles or chapters in textbooks.
  - c. The scholarship of application, as evidenced by the publication or presentation at local, regional, or national professional and scientific society meetings, for example, case reports or clinical series.
  - d. Active participation of the teaching staff in clinical discussions, rounds, journal club, and research conferences in a manner that promotes a spirit of inquiry and scholarship; offering of guidance and technical support, e.g., research design, statistical analysis, for residents involved in research; and provision of support for resident participation, as appropriate, in scholarly activities.
2. Resources for scholarly activities for faculty and residents are available, e.g., laboratory space, equipment, computer services for data analysis, and statistical consultation services.

## C. **Resident Duty Hours and the Working Environment**

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

### 1. **Supervision of Residents**

- a. All patient care must be supervised by qualified faculty. The Program Director shall direct, manage and document supervision of residents. Residents must be provided with prompt, reliable systems for communicating with supervising faculty.
- b. Faculty schedules must be structured to provide residents with continuous supervision and consultation.
- c. Faculty and residents must be educated to recognize the signs of fatigue. Individual departments shall adopt and implement policies to prevent and counteract the potential negative effects of fatigue.

## 2. Duty Hours

- a. Duty hours are defined as the time spent in all clinical and academic activities related to the residency program, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.
- b. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities.
- c. Residents must be provided one (1) day in seven (7) free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. One (1) day is defined as one continuous 24-hour period free from all clinical, educational, and administrative activities.
- d. Adequate time for rest and personal activities must be provided such that a continuous ten (10)-hour time period is to be provided between all daily duty periods and after in-house call

## 3. **On-Call Activities**

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

- a. In-house call must be assigned no more frequently than every third night, averaged over a four-week period.
- b. Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 6 (six) additional hours in order to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care unless further limited by the relevant Program Requirements.
- c. New patients may not be assigned or accepted after 24 continuous hours on duty. A new patient is defined as any patient for whom the resident has not previously provided care unless otherwise defined in the relevant Program Requirements.

[Back to Top](#)

- d. At-home call (pager call) is defined as call taken from outside the assigned institution.
  - i. The frequency of at-home call is not subject to the every third-night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable, personal time for each resident. Residents taking at-home call must be provided with one (1) day in seven (7) completely free from all educational and clinical responsibilities averaged over a 4-week period.
  - ii. When residents are called into the hospital from home, the hours residents spend in-house are counted toward the 80-hour weekly limit.
  - iii. The Program Director and the faculty must monitor the demands of at-home call in their programs and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

[Back to Top](#)

## 4. **Moonlighting**

- a. Moonlighting is defined as participating in any medical activity beyond the scope of the residency program, including outside remunerative activity. TTUHSC does not provide professional liability insurance coverage for moonlighting. Because residency education is a full-time endeavor, moonlighting is, in general, discouraged for TTUHSC residents. However, in the event any moonlighting does occur it shall not interfere with the obligation and ability of the resident to fulfill the goals and objectives of the educational program and must be approved in writing by the Program Director. This approval will become part of the resident's file. **Anyone holding a J-1 Visa will not moonlight under any circumstances.**

- b. "Internal moonlighting" is defined as activity within the resident's TTUHSC program, an affiliated hospital, and/or a non-hospital primary clinical site(s). Internal moonlighting must be counted toward the 80-hour weekly limit on duty hours.
- c. No resident may be required to perform moonlighting or internal moonlighting.
- d. A moonlighting resident's performance will be monitored for the effects of moonlighting and any adverse affects may lead to withdrawal of permission.

[Back to Top](#)

## 5. Oversight

- a. Each program must have written policies and procedures consistent with the Institutional and Program Requirements for resident duty hours and the working environment. These policies must be distributed to the residents and the faculty. Monitoring of duty hours is required with frequency sufficient to ensure an appropriate balance between education and service.
- b. Back-up support systems must be provided when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care.

## 6. Conferences

All housestaff are expected to attend house staff meetings and participate in required core curriculum activities.

## 7. Elective Rotations

- a. Any proposal for a resident's elective/rotation must be presented in writing by the Program Director on behalf of the resident to the Graduate Medical Education Committee for approval, along with the Program Director's recommendation. If the Program Director cannot endorse the request, the Program Director should not approve the request at the Program Director level.
- b. The proposal must include goals and objectives, length of the elective/rotation, qualifications of the preceptor, and educational values of the elective/rotation. The source of funding, including salary for the period of such absence, shall be identified by the program.

[Back to Top](#)

## 8. Evaluations

- a. **Residents** -The Program Director, in participation with members of the teaching staff shall at minimum, semi-annually evaluate the knowledge, skills, and professional progress of the resident. The written evaluation should describe the strengths and weaknesses of the resident's performance. Residents shall be notified of any deficiencies at the earliest possible date, and plans for improvement must be timely provided to the resident in writing. Evaluation forms on each resident should be maintained in the program file. Annual and final written evaluations are retained in the GME files. The evaluation process, and any action taken, regarding a resident's status in the program including, but not limited to, probation, suspension and termination is performed as "medical peer review," as that term is defined under Texas state law. The Program Director must provide a final written evaluation for each resident who completes the program. The evaluation must include a review of the resident's performance during the final period of education and shall verify whether the resident has demonstrated sufficient professional ability to practice competently and independently. The final evaluation must be part of the resident's permanent record maintained by the institution.
- b. **Faculty** -Residents shall participate at least annually in regular evaluation of teaching faculty.
- c. **Program** -Residents shall participate at least annually in regular evaluation of their residency program.

[Back to Top](#)

## 9. Adverse Actions

It is expected that residents who qualify for training programs are able to progress satisfactorily through the program. However, when performance and/or progress are not satisfactory, actions of an adverse or disciplinary nature are taken. Those include observation, probation, suspension, and/or dismissal. When implementing disciplinary action against a resident, each Program Director shall complete a **Disciplinary Action Form** and a TMB [Program Director's Report of Certain Types of Conduct](#) and forward to the GME Office. (See [Section III.C](#) of this document for TMB reporting requirements).

### a. Observation

Observation is a measure that is generally utilized prior to probation, but is not required when probation or other disciplinary measures are appropriate. It is the duty of the Program Director of each residency program to establish a mechanism for evaluating the performance of the residents, including written progress reports. In the event a resident's clinical or educational performance is found to be unsatisfactory, the Program Director should meet with the resident at the earliest possible date, outline in writing the deficiencies, specify how they are to be corrected, and indicate the period in which correction or remediation is to occur. If after a specified amount of time progress has not been demonstrated, the resident may be placed on probation. Observation status is not a prerequisite to probation. Neither observation nor probation may be appealed.

### b. Probation

Where a resident's performance fails to meet the standards set by the department, the resident may be placed on probation by the Program Director. Probation occurs when a resident is notified that his/her progress or professional development or conduct is such that continuation in the program is at risk.

- i. The Program Director shall, in writing notify the resident regarding the probation outline the reasons for the action, provide a specific remedial plan, establish a time frame for the probation and conduct a follow-up probation evaluation at the designated time, or sooner, if necessary. The notice will be delivered by certified mail, Return Receipt Requested, to the resident at his/her last known address or hand-delivered with written acknowledgement of delivery to the resident. Unless precluded from doing so, the Program Director must also discuss the probation with the resident.
- ii. As a general rule, sixty (60) calendar days will be allowed for the resident to correct or remediate the identified deficiency or conduct. However, some probationary periods may be for a shorter period of time. If, at the end of or during the probationary period the Program Director determines that the resident has not corrected or remediated the identified deficiency or conduct, the resident may be dismissed from the program. If at the end of or during the probationary period the Program Director elects to dismiss the resident, the dismissal procedures in [Section V.,C.,9.,d.](#) shall be utilized.
- iii. If the Program Director is satisfied that the resident has corrected or remediated the identified deficiency or conduct and any other deficiency that may have arisen during the probationary period, the resident will then be notified in writing that the probationary status has been lifted.
- iv. The decision to place the resident on probation may not be appealed. If the resident is dismissed at the end of the probationary period, the dismissal may be appealed in accordance with the procedures outlined in [Section V.,C.,9.,d.,ii.,aa.](#) If a resident is placed on probation or suspended, after notice that a new Program Agreement has been/will be extended but prior to beginning a new year of training, the offer for appointment shall be automatically deemed abated until all requirements relating to the disciplinary actions are fully resolved. At the discretion of the Program Director, the Program Agreement abated during this referenced disciplinary period may be declared null and void.
- v. A resident may be placed on probation at any time without first having been placed on observation. The decision regarding whether or not to extend a new Program Agreement to a resident that is on probation or suspension may be deferred, at the discretion of the Program Director, until the end of the disciplinary period.

c. **Suspension**

- i. The Program Director may suspend a resident with or without pay, depending on the circumstances which may include, but not be limited to, any situation where a serious charge is brought against the resident or there is concern that the resident's performance of his/her duties is seriously compromised or may constitute a danger to patients, others or self. An investigation will be initiated within seven (7) calendar days from the date of the suspension and shall be completed within 30 days. The resident may not appeal suspension with pay. However, suspension without pay is subject to appeal.
- ii. The resident will be notified of his/her suspension by certified mail, Return Receipt Requested, to his/her last known address or hand delivered with written acknowledgement of delivery. At the conclusion of the investigation the Program Director shall confer with the resident regarding the suspension as soon as practicable, but in no event later than 30 days from date of suspension, except as referenced immediately hereinabove.
- iii. Suspension will be lifted when the investigation is completed. Upon completion of the investigation a decision will be made as to the proper course of action, based upon the investigation findings. Such action will be communicated in writing to the resident. Suspension must be reported to TMB.

d. **Dismissal**

**The authority to dismiss a resident resides solely with the Dean of the School of Medicine.**

- i. A resident may be recommended for dismissal by the Program Director during the term of his/her annual contract for unsatisfactory performance or conduct. Examples include, but are not limited to the following:
  - aa. Performance that presents a serious compromise to acceptable standards of patient care or jeopardizes patient welfare;
  - bb. Failure to progress satisfactorily in fund of knowledge, skill acquisition and/or professional development;
  - cc. Unethical conduct;
  - dd. Excessive tardiness and/or absenteeism;
  - ee. Illegal conduct;
  - ff. Unprofessional conduct;
  - gg. Job abandonment.
- ii. The recommendation for dismissal shall be made by utilizing the **Disciplinary Action Form** and appending any related documentation. The Program Director shall specify in writing the areas deemed unsatisfactory and state the reasons for the dismissal. Dismissal in these situations implies poor performance, unprofessional conduct, or malfeasance and is subject to appeal. Job abandonment, defined as three (3) days unexcused absence from the program without notice to the Program Director, is tantamount to resignation. The **Disciplinary Action Form** should be forwarded to those individuals listed on the form and finally to the Associate Dean for Educational Programs on the Lubbock Campus. A copy of this recommendation should be provided to the resident about whom it pertains.
  - aa. Upon receipt of the written recommendation for dismissal/**Disciplinary Action Form**, the resident may initiate the appeal process by submitting to the Chair of the campus Graduate Medical Education Committee (GMEC) within five (5) business days, a written notice of appeal. In the event the resident elects to not appeal the decision, or the resident fails to appeal within the prescribed five (5) business days, the resident will be deemed to have waived the option to appeal. Upon receipt of the findings of the ad hoc Appeals Committee or after time has expired to appeal or, the Regional Dean/Associate Dean for Educational Programs will then submit in writing to the Dean a final recommendation for action. The Dean will then review the recommendation and render a decision, which shall be communicated in writing to the

[Back to Top](#)

Educational Programs, and Program Director.

[Back to Top](#)

- bb. The resident shall have no clinical duties during this process, but the resident will be provided salary and insurance benefits during the process (provided the resident has not exhausted sick and/or vacation leave time) not to exceed forty-five (45) calendar days from the receipt of the request for consideration. The Program Director may assign duties to the resident, other than clinical, during the review period, if applicable.
- cc. Upon receipt of the notice of appeal from the resident, the Chair of the Campus GMEC shall appoint an *ad hoc* Appeal Review Subcommittee consisting of two (2) faculty members of that Committee, a Chief Resident, and a House Staff officer. Membership of this subcommittee shall exclude faculty and housestaff from the department of the appealing resident. The subcommittee shall be charged to review the recommendation of dismissal.
- dd. At least five (5) days prior to the hearing, the resident and the Program Director shall provide to each other and the Review Subcommittee all relevant documents that will be used in the appeal process to include, but not be limited to, the written request for appeal, all reports, evaluations and recommendations related to the action taken and his/her file as maintained by the Office of Graduate Medical Education. All documents submitted to the Review Subcommittee shall be deemed confidential and returned to the GME Office after a decision is rendered.

At least five (5) days prior to the hearing the resident and Program Director shall, provide to each other and the Review Subcommittee the names of witnesses to be available for the hearing proceedings. The resident and Program Director shall each be responsible for arranging the participation of their respective witnesses for and during the hearing proceedings.

- ee. At the hearing by the Appeal Review Subcommittee, the resident shall have the right to appear in person and may be accompanied by legal counsel retained by the resident. If legal counsel is to accompany him/her the resident shall in writing notify the subcommittee at least five (5) days in advance. The legal counsel may serve only in an advisory capacity to the resident and may not participate in the hearing. In the event the resident is accompanied by legal counsel at the hearing, a representative from the **Office of the Vice Chancellor and General Counsel (OVCGC)** shall attend on behalf of the university.
- ff. The resident shall have the right to address the subcommittee, but may not be required to do so, and may introduce evidence considered to be relevant and material to the case. This material should be provided to the appeals committee chair and Program Director no later than five (5) days prior to the hearing. (The Assistant Dean of the GME may be utilized to disseminate the documents to the committee and Program Director) All evidence offered must be reasonably related to the facts and statements concerning the reasons for dismissal and the resident's appeal.
- gg. Failure of the resident to appear at the hearing results in automatic dismissal of the resident's request for consideration and any and all other rights of appeal. The Review Subcommittee shall submit a report and recommendation to the campus GME Committee no later than seven (7) calendar days from the conclusion of the hearing.
- hh. If the resident believes procedural due process has not been followed up to and/or during the hearing, he/she must notify the Chair of the campus GME Committee in writing within five (5) calendar days after receipt of the Review Subcommittee's recommendations. Only in cases where the Campus GME Committee determines that the procedural due process concerns materially affected the outcome will a new subcommittee be appointed to re-hear the resident's request for consideration of the dismissal.
- ii. The campus GME Committee shall review the findings and recommendations of the Review Subcommittee at a regular or called meeting that shall be held within seven (7) calendar days after receipt of report from the Review Subcommittee. The recommendation of the campus GME Committee will be forwarded to the Regional Dean/Associate Dean for Educational Programs for review and recommendation, who in turn, will forward his/her recommendation to the Dean of the School of Medicine. The Dean of the School of Medicine shall then review the recommendation and make a decision, which shall be

[Back to Top](#)

communicated in writing to the resident, the Regional Dean, Program Director, and Chair of the GME Committee. The communication to the resident shall be by Certified Mail Return Receipt Requested or hand delivered with acknowledgment of delivery.

- jj. A final determination by the Dean of the School of Medicine to dismiss the resident shall nullify or terminate any previous agreement appointing the resident to a subsequent year of training.
- kk. Unless required and where a deadline for reporting exists, no specialty or sub-specialty certifying board or national, state, or local medical organization, exclusive of a licensing agency, shall be notified of a pending disciplinary action until a final determination has been made by the Dean of the School of Medicine.
- ll. Remedies and procedures contained herein must be exhausted in their entirety prior to the resident's resorting to any other forum.
- mm. Periods listed herein are guidelines and may be extended only by the Dean of the School of Medicine where justified. For the purpose of determining any deadline herein, the first business day following any event shall count as the first day.

[Back to Top](#)

[Back to Top](#)

#### 10. Agreement for Continued Training

- a. The issuance of an agreement for continued training is conditioned upon successful completion of the current year.
- b. No agreement shall be for a period greater than twelve (12) months. Acceptance into a residency program does not constitute a multi-year agreement.
  - i. A resident who does not plan to continue in the succeeding year(s) of his/her training program must notify the Program Director in writing four (4) months prior to the ending date of the current agreement.
  - ii. If a resident is not to be issued an agreement for the next year of training, he/she must receive written notice (by certified mail, Return Receipt Requested, or hand delivery with written acknowledgement of receipt/delivery) from the Program Director four (4) months prior to the ending date of the current agreement. The institutional dismissal appeals process ([Section V., C., 9., d., ii., aa.](#)) of the Houses Staff Policies and Procedures is available to the resident if the resident elects to appeal the decision.
  - iii. A leave of absence is defined as the interval when all accumulated vacation and/or sick leave time has been exhausted or when the resident voluntarily leaves a program. Extended leaves of absence may necessitate resignation of the resident and application for a new appointment when and if the resident wishes to return to training (excluding pregnancy). Granting of the leave and issuance of a new contract for continued training thereafter is at the discretion of the Program Director.

[Back to Top](#)

If a leave of absence is requested or occurs during the interval after appointment to a new year of training but before the new training year begins, any issuance of a contract for continued training is invalid, and any requirements relating to the leave of absence must be met prior to the resident's return to training.

- iv. If a resident is placed on probation or is suspended, after issuance of a new contract for continued training and prior to beginning a new year of training, the decision to issue such contract may be deemed continued or abated, at the discretion of the Program Director, until all requirements relating to the probation or suspension are resolved.

- v. A Program Director may decide to not advance a resident to the next PGY level at the end of their Graduate Medical Education Agreement period. This decision may be based upon the resident's failure to have met the requirements to be advanced to the next PGY level or other similar circumstances. Should this occur, the resident may be offered a Graduate Medical Education Agreement for less than the twelve-month period. This period of time is generally used by the Program Director to assess whether the resident can correct any identified deficiencies. The decision to not advance a resident may not be appealed. The decision to not renew a resident's contract may be appealed under the section titled [Dismissal](#) of the House Staff Policies and Procedures.

[Back to Top](#)

## B. Changing Programs

1. When a resident in a TTUHSC residency program wishes to pursue the possibility of changing to another residency within TTUHSC, the following steps must be followed:
  - a. The resident must inform his/her current Program Director that he/she is seeking another residency position at the same institution.
  - b. The Program Director of the residency to which a change is sought should inform the Program Director of the current program regarding possible recruitment.
  - c. Both residency Program Directors should be in agreement regarding the change.
  - d. Any unresolved dispute regarding change to a new program should be referred to the campus Graduate Medical Education Committee.
  - e. When a resident in a TTUHSC residency program transfers to another program outside TTUHSC, the Program Director will, if requested by the program of transfer, and with the written acknowledgment of the resident, provide the Program Director of transfer a written statement of verification of the previous educational experiences and a statement regarding the performance evaluation of the transferring resident.
  - f. By federal statute, persons on a J-1 visa are permitted to change programs once only.

[Back to Top](#)

## VI. RESIDENT SUPPORT

- A. **House Staff Association** is a resident's support system organized to promote social and professional relationships among the residents. Information pertaining to the Housestaff Association may be obtained through the GME Office.
- B. **Counseling Services** are provided by the institution and vary from campus to campus. Information pertaining to available support and counseling services may be obtained from the GME Office.
- C. **Resident Complaints** Current residents are provided a process by which to resolve complaints and grievances related to the work environment or issues related to the program or faculty. Complaints that are covered by a TTUHSC Operating Policy, such as sexual harassment, violence in the workplace, and others, shall be referred to the appropriate office for consideration. A resident grievance of an academic action such as the non-issuance of a contract for continued training or dismissal shall be addressed under the appropriate section of these Housestaff Policies and Procedures.

[Back to Top](#)

### 1. Early Resolution

Prior to filing a request for a hearing, the resident must attempt to resolve the issue through a meeting with the individual(s) involved.

- a. If the complaint involves a specific incident or clearly defined matters, the complaint must be initially communicated to the Program Director at this initial step within seven (7) business days.
- b. For complaints based on a continuing series of less clearly defined matters, the complaint must be communicated to the Program Director at this initial step no later than twenty (20) business days following the onset of the issue(s) of complaint.
- c. If the issue(s) is not resolved at this initial step, the resident shall promptly attempt resolution by proceeding through the next step(s).

[Back to Top](#)

2. If the complaint is against a faculty member, the resident should contact the Program Director. If not against a faculty member, the resident should contact the Chief Resident. In each case, the resident will clearly present his/her concerns and suggestions for resolution of those concerns. The Chief Resident shall make every effort to facilitate resolution of the issue(s), and shall inform the resident in writing of his/her response and reasons for that response within four (4) business days.
3. If resolution has not been achieved in after meeting with individual(s) involved, the resident should meet with the Residency Program Director to seek resolution. The Program Director shall make a determination within four (4) business days.
4. If resolution is not achieved as a result of the above, or the complaint involves the Program Director, the resident may then contact the department Chair regarding the complaint within four (4) business days from the Program Director's decision.
5. The resident will present a formal written complaint to the department Chair including a summary of specific events, describe prior attempts to resolve the complaint, and state the remedy sought. The formal complaint cannot be changed after submission without approval of all persons concerned. The department Chair will investigate the complaint, attempt to reconcile differences and propose a solution. The department Chair will provide a written statement of his/her recommendation to all parties within four (4) business days from receipt of the complaint.
6. If the complaint is against the department Chair, the resident should present the complaint to the Chair of the campus GME Committee (GMEC).

[Back to Top](#)

#### D. **Hearing Request**

If the resolution recommended by the department Chair or the Chair of the campus GMEC is rejected by either the resident or the person against whom the complaint was filed, each may, within four (4) business days, request a hearing by submitting a written request to the Chair of the Campus GME Committee. The hearing request must include the original written complaint and remedy sought, the basis of disagreement with the proposed resolution and a copy of the Department Chair's written recommended resolution.

#### E. **Hearing Procedure**

Upon receipt of a written request for a hearing, the Chair of the campus GMEC, having gained assurance that the complaint does not fall under the purview of another dispute forum, will, within four (4) business days, initiate the process for establishing a Resident Hearing Panel according to the following procedure:

[Back to Top](#)

1. The panel shall consist of a faculty member from the campus GMEC appointed by the Chair of the GMEC to serve as chairperson. The Chair of the Faculty Grievance Committee will appoint an additional faculty member who will be a full-time physician from a clinical department and may, but is not necessarily required to be, a member of the Faculty Grievance Committee. The Chair of the GMEC will appoint an additional faculty member who will be a clinician involved in graduate medical education, but may not be a member of the GMEC. The fourth member of the panel will be a housestaff officer. The fifth member of the panel will be a resident appointed by the President of the House Staff. The appointed panel members shall not be from the resident's department or from the department of the party made the subject of the complaint. No panel member shall have a conflict of interest in this matter. The Chair of the campus GMEC shall immediately notify both parties of the composition of the panel. Each party has the right to request replacement of any of the proposed members of the panel based on conflict of interest. This request must be submitted in writing to the Chair of the Campus GMEC in writing within three (3) business days of notification of the panel composition. The decision of the Chair of the campus GMEC will be final.
2. Within four (4) business days, the Panel will coordinate and set a date for the hearing. If the resident plans to have an attorney present, he/she shall notify the Chair of the panel not later than five (5) days before the hearing date. The party(s) against whom the complaint is made may also have an attorney present only in an advisory capacity. An attorney from the Office of General Counsel may attend in an advisory capacity as well.
3. Within five (5) business days, the parties will submit copies of the original written complaint/response,

[Back to Top](#)

copies of documentation and a list of the witnesses to be presented at the hearing, and the Chair of the panel will distribute these to the opposing party and the panel members. Each party will then have three (3) business days to submit additional documentation or add to the list of witnesses in rebuttal. The hearing shall be held within five (5) business days after receipt of this additional material.

4. The Chair of the panel shall present both parties with the Agenda for the Hearing which may include opening statements, presentation by the resident, presentation by the person against whom the complaint is made and summary or closing statements. Each party shall have the opportunity to question the other party and all witnesses appearing. The responsibility of establishing the validity of the complaint rests with the resident who filed the complaint.
  5. The Hearing Panel Chair shall make an audio record of the hearing, which shall include date, time and location of the hearing and names of those present. Evidence, (e.g., records, written testimony, duplicated materials, etc.), introduced will be noted. A copy of the audiotape of the proceedings will be provided to both parties upon written request. The original will be retained in the GME office for a period of one year.
  6. All materials presented to the panel shall be treated as confidential, and upon completion of the hearing, all materials shall be returned to the appropriate party or destroyed together with any notes taken during the process, except for a copy, which is forwarded to the Chair of the GMEC with the panel's recommendation.
  7. After completion of the hearing, the Resident Hearing Panel shall meet in closed session and prepare written findings and recommendations. Within four (4) business days of ending deliberations, the Chair of the panel shall forward the panel's findings and recommendations to the Chair of the GMEC. [Back to Top](#)
  8. The Chair of the GMEC shall present the findings and recommendations to the GMEC, which shall review the panel's recommendations, provide written results of the GMEC's review and then forward the committee's findings and recommendation and the panel's recommendation to the Regional Dean of their respective campuses and for the Lubbock campus, the Dean, SOM for review and comment to be made within four (4) business days of receipt of the recommendations.
  9. The Regional Dean of the resident's respective campus (Amarillo and Permian Basin) may also provide a position regarding the findings and recommendations and shall forward the recommendations, comments and other appropriate documentation to the Dean, SOM (Lubbock) who shall make the final decision within four (4) business days of receipt of the materials.
  10. Both parties shall have the right of appeal of any final decision but only on procedural grounds. The appealing party must provide written notice of appeal to the opposing party and the Regional Dean, and the grounds for the appeal must be submitted to the Dean within three (3) business days. Within three (3) business days, the Dean, whose decision is final, will notify all parties in writing of his decision regarding the appeal. [Back to Top](#)
  11. The Chair of the GMEC must approve any departures from these procedural guidelines, including established time frames, and only for cause.
- E. **ID Badges/Tags** are provided to the resident and *must* always be worn in patient care areas. Lost or damaged ID badges should be reported to the department Residency Program Coordinator.
- F. **Parking** for residents is subject to the parking rules of TTUHSC as well as the hospital to which each is assigned. Parking and auto registration information may be obtained from each campus GME Office.
- G. **Lab Coats** are provided by departments and/or hospitals. Information about laundry services is available within the departments.
- H. **Meals** provided to residents vary from campus to campus. Information is available within individual departments.
- I. **On-Call Quarters** are provided. Specific information is available within each department.
- J. **[Institutional E-Mail addresses](#)** are provided for residents. Residents are held accountable for information sent to their TTUHSC e-mail addresses. Residents should check their e-mail on a regular basis.
- K. As physicians, all TTUHSC residents are subject to the School of Medicine policies addressing impairment of peers, (see [Appendix A](#)), which may include intervention, drug testing, medical evaluation, treatment, rehabilitation, etc.

## **VII. PROGRAM COMPLETION**

[Back to Top](#)

A post-graduate education program is not considered completed by a resident until the total training time specified by program requirements has been satisfactorily fulfilled. Failure to satisfactorily complete this requirement may jeopardize a resident's eligibility for Specialty Board Examination, the discretion and responsibility resting with the Program Director.

Upon recommendation of the Program Director, a certificate of completion is awarded to a resident who satisfactorily completes the residency training requirements for board certification eligibility. All exit protocols are appropriately completed and Verification of Training letters are provided at the request of the resident who satisfactorily ends a period of training but does not complete the training requirements for board eligibility. Advance verification by the Department and approval by the GME Office are required prior to issuance of a certificate or verification of training letter.

## **VII. PROGRAM CLOSURE OR REDUCTION**

In the event TTUHSC intends to reduce the size of an ACGME accredited program or close such program or close the sponsoring institution (TTUHSC), TTUHSC will inform the DIO, the GMEC, and the affected residents at the earliest possible date.

In the event of such reduction or closure, TTUHSC will either allow residents already in the program to complete their education or assist the resident in enrolling in an ACGME accredited program in which they can continue their education.

[Back to Top](#)

## APPENDIX A

### **POLICY FOR EVALUATION AND TREATMENT OF IMPAIRED PHYSICIANS OR HOUSE STAFF**

#### **I. PREAMBLE**

The Texas Tech University Health Sciences Center (TTUHSC) recognizes that its *Physicians* and *House Staff* (resident physicians) who are impaired are individuals who need professional help. Additionally, the medical staff realizes that an impaired physician can prevent the University from meeting its commitments to provide for high quality patient care in a safe environment. The University's employees and trainees at all campuses are expected to conduct their activities in this highly complex healthcare environment in full control of their manual dexterity and skills, mental faculties, and judgment.

#### **II. POLICY**

TTUHSC regards the misuse or abuse of drugs or alcohol by a physician as conduct subject to disciplinary action, which may include the immediate suspension of all or any portion of the clinical privileges granted to a member of the medical staff and eventual termination of employment. In addition, other neuropsychiatric and general medical illnesses may produce impairment covered under this policy. Actions taken under this policy shall be in accordance with the discipline policies established by the TTUHSC [Board of Regents](#), the Professional Staff Bylaws and Rules and Regs, the [TTUHSC SOM Faculty Handbook](#), and the House Staff Guidelines, and state laws and regulations including V.T.C.A. Article 4495b, [Medical Practice Act](#). Referrals to an appropriate treatment program and follow-up in a supervised rehabilitation program are among the ways physicians may be assisted in returning to professional activities.

This policy applies to all *Physicians* and *House Staff* employed, appointed, affiliated, or under contract with TTUHSC. *Physicians* and *House Staff* become subject to this policy if, and when, there is a reason to conclude that the individual is impaired or is exhibiting a behavior pattern suggestive of impairment. The direct observation of chemical substance abuse or observations of aberrations in job performance and/or behavior may be cause for this conclusion.

[Back to Top](#)

#### **III. DEFINITIONS**

The following are definitions, explanations, qualifications, or stipulations regarding certain terms used in this policy:

- ***Physician(s)*** as used throughout this policy includes medical doctors, doctors of osteopathy, *and doctors of dentistry* who have completed training and are licensed to practice in the state of Texas, and includes physicians providing services in correctional facilities.
- ***House Staff (Resident Physicians)*** as used throughout this policy includes medical school graduates who participate in a residency training or fellowship program at TTUHSC, which has been approved by the Accreditation Council for Graduate Medical Education.
- ***Chemical substance abuse*** is the personal use of any chemical substance that is specifically proscribed by law or by regulation pursuant to legal authority (e.g., Schedule 1 drugs); the personal misuse of any legally controlled substance; or the personal misuse of any normally legal chemical substance (e.g., alcohol) in a manner that produces the likelihood of the development of impairment.
- ***Chemical substance misuse*** is the self administration of any chemical substance for any reason other than its intended use.
- ***Emergency situation*** is one in which there may be an imminent or potential adverse effect on a TTUHSC patient, employee, student, or other persons.

[Back to Top](#)

- ***Impairment by substance abuse or misuse*** refers to any condition, resulting from substance abuse that interferes with the individual's ability to function at work as normally expected.
- ***Impairment for other neuropsychiatric illnesses or medical reasons*** refers to any other categories of impairment including major debilitating illnesses, depression, dementia, or other psychopathology or disruptive behavior that may interfere with the individual's ability to function at work as normally expected.
- ***Symptoms of impairment*** may also include declining work performance as manifested by unavailability, missed appointments, lapses in judgment, incomplete medical records, poorly communicated nocturnal phone orders, mood swings, unexplained absences, embarrassing behavior, signs of intoxication or self-medication, and/or withdrawal from hospital or other professional activities. Family problems and change in character or personality are further accompaniments of impairment.
- ***TTUHSC Physician Health and Rehabilitation Committee (PHR Committee)*** is a medical peer review committee, as defined in the Texas Medical Practice Act, Article 4495b, V.A.C.S., or as may be amended, to assist physicians with physical impairments, chemical or substance abuse problems, or mental and emotional difficulties that may affect clinical skill and judgment.
  - i. The **PHR Committee** shall be a standing subcommittee of the MPIP Policy Committee at each campus.
  - ii. The **PHR Committee** members shall be appointed by each Regional Policy Committee pursuant to the MPIP Bylaws, Article 3.
  - iii. Each campus PHR Committee shall consist of five (5) members, one of which shall be a psychiatrist or psychologist, and one of whom shall be House Staff. The House Staff member shall be an officer, or elected by the House Staff Association. The **PHR Committee** shall exclude participation of the House Staff member in a faculty impairment situation.
  - iv. Each member's term shall be a minimum of three years, with the exception of the House Staff member whose term shall be for one year. Original start-up appointments may be staggered for shorter periods of time. No member may serve more than three (3) consecutive three-year terms.
  - v. Each campus committee shall adopt bylaws consistent with other campuses to guide the fulfillment of duties under this policy.

• [Back to Top](#)

#### **IV. REPORTING REQUIREMENTS**

It is the responsibility of all TTUHSC employees, or other persons to contemporaneously report observations of impairment to at least one of the following:

- immediate supervisor of the ***Physician*** or ***House Staff***,
- immediate supervisor of the work area where the Physician or House Staff is providing health care services,
- the **PHR Committee**,
- the Associate Dean-Clinical Practice at Lubbock or Regional Dean at Amarillo, El Paso or Odessa, or,
- the Medical Director Managed Health Care.

Reports of impairment shall be based on "reasonable suspicion" defined as a good faith belief, based on specific, contemporaneous, and articulable observations.

The ***Physician*** or ***House Staff*** are also encouraged to self-report and shall have an opportunity to voluntarily relinquish duties and privileges that cannot safely be performed and cooperate in the development of activity restrictions which may be imposed. This policy does not preclude a ***Physician*** or ***House Staff*** from self-reporting to TMB to obtain a protective Board order, or obtaining support through the TTUHSC Employee Assistance Program (EAP) services.

[Back to Top](#)

Behaviors or actions, which are illegal or improper, shall also be referred for resolution under appropriate policies such as the Sexual Harassment policy or Affirmative Action/Equal Employment Opportunity policy, or other applicable laws or regulation.

In situations in which an employee's performance has deteriorated for other than identifiable job-related circumstances, a supervisor may also implement the steps for supervisory referral to the Employee Assistance Program. ([TTUHSC OP 70.38](#) or as may be amended.)

## V. DOCUMENTATION

Written documentation of the report of impairment or behavior suggestive of impairment, medical and psychiatric evaluation reports, and other correspondence pertaining to these events and the treatment and rehabilitation of any Physician or House Staff will be treated as confidential.

All such documentation shall be labeled **"CONFIDENTIAL – PEER REVIEW."**

Documentation is the responsibility of and is under the control of the **PHR Committee** and shall be maintained in a secure location as the **PHR Committee** may designate.

The contents of the file will be released by TTUHSC only upon written authorization of the affected *Physician* or *House Staff*, except as required by state and federal law.

Activity restrictions imposed as a result of actions under this policy will be communicated to individuals or entities (e.g., residency program director, hospital quality assurance or similar committee, liability risk manager, other supervisory personnel) ONLY on a need-to-know basis, commensurate with the level of risk. The overriding consideration will be the safety of patients, any other employees, or persons at TTUHSC, and the affected *Physician* or *House Staff*.

[Back to Top](#)

## VI. AUTHORITY

TTUHSC's authority over *Physicians* who are employed, appointed, affiliated, or under contract with TTUHSC extends to termination of relationship, as well as to the appointment and retention of faculty status and clinical privileges at TTUHSC.

TTUHSC's authority over *House Staff* extends to restricting residents' access to patients and, if necessary, discharging residents from the training program, and reporting the individual to the Texas State board of Medical Examiners (TMB) for endangering the lives of patients and posing a continuing threat to the public welfare. Other action may include reporting the restriction and the reasons for it to the Graduate Medical Education office at each campus. The resident physician may be prohibited from participating in any clinical activities at TTUHSC if found to be impaired and not already subject to an ongoing monitored rehabilitation program.

The [Texas State Board of Medical Examiners](#) (TMB) is authorized under the laws of Texas to refuse to admit persons to examination and to refuse to issue licenses or to renew licenses to practice medicine to physicians who are considered a continuing threat to the public welfare as a result of their impaired status or of the intemperate use of alcohol or drugs that could endanger the lives of patients. This also includes those who are unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of drugs, narcotics, chemicals, or any other type of material or impairment.

A person, healthcare entity, or medical peer review committee that, without malice, furnishes records, information, or assistance to a medical peer review committee or to the TMB regarding any physician who is a continuing threat to the public welfare is immune from any civil liability arising from such an act. (Title 71, Article 4495b, 1.03(3), 3.08(16), and 5.06(m), Vernon's Ann. Civ. St., Medical Practice Act)

*Physicians* or *House Staff* who assist in evaluation of an impaired *Physician* or *House Staff* under this policy will be considered agents of the **PHR Committee**, a peer review committee. If there is a conflict in obligation, the responsibility to the Institution takes precedence over the responsibility to the impaired employee.

[Back to Top](#)

## VII. ROLES AND RESPONSIBILITIES

TTUHSC is responsible for the health and safety of its patients, employees or other persons present. TTUHSC, through its administration, must act upon personal observations of or reports of symptoms of impairment about a *Physician* or *House Staff* that may endanger the life of a patient or may increase the likelihood of immediate injury or damage to health or safety.

### A.

#### Associate Dean - Clinical Practice, Lubbock Regional Deans, Amarillo, El Paso, Odessa

If a report of impairment is received by the Associate Dean-Clinical Practice or Regional Deans, he/she may consult with the clinical department chair, and may direct the matter to the **PHR Committee** for resolution. Recommendations from the TTUHSC Credentials Committee and the department Chair or Regional Chair to which the affected *Physician* or *House Staff* reports may be considered in resolving an impairment situation.

If the affected *Physician* is a department Chair, the Associate Dean-Clinical Practice or Regional Dean shall identify a physician within that department who shall act in place of the Chair for purposes of this policy.

Actions MAY include the following:

[Back to Top](#)

- Arrange for immediate medical leave for evaluation and treatment if needed.
- Immediately suspend all or any portion of clinical privileges or require an immediate withdrawal from any and all clinical duties. [NOTE: Actions that adversely affect clinical privileges for more than 30 days are reportable to state and national regulatory bodies.]
- Immediately notify the affected *Physician* or *House Staff* of the medical leave or suspension, with confirmation by certified, return receipt requested.
- Immediately notify the Chair of the Credentials Committee.
- Immediately notify the appropriate department chair of the medical leave or suspension so that patient care responsibilities may be reassigned for those patients whose treatment has been interrupted by the action.
- In the case of *House Staff*, notify the Graduate Medical Education office and Residency Director within two working days of action taken.
- Reporting the individual to the Board of Medical Examiners.

### B.

#### Chair, Regional Chair and/or Program Director

If a report of impairment is received by the Chair, Regional Chair, and/or Program Director, he/she may consult with the Associate Dean-Clinical Practice, the Regional Dean, and may direct the matter to the **PHR Committee** for resolution. Actions taken MAY include those listed above as well as the following:

- Initial verification of the accuracy of the observations suggesting impairment.  
Explain to the individual in question that these observations have been made.
- Report to the Associate Dean-Clinical Practice or Regional Dean (or his/her designee) any *Physician* or *House Staff* conduct that requires that immediate action be taken to protect the life of a patient or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee, or other person in the hospital.

[Back to Top](#)

- Take steps to have the **Physician** or **House Staff** escorted directly to nearest Emergency Room (ER) to be seen for medical evaluation by the Medical Director or staff physician on duty, including a request for laboratory testing for the presence of illegal drugs or alcohol in body fluids. In addition, a psychiatric evaluation by the staff psychiatrist may also be sought, particularly if there appears to be a need for immediate intervention or for the personal safety of the impaired person. In such instances, an Emergency Detention or Order of Protective Custody may be considered. Testing for drugs or alcohol is voluntary. In the event that the ER staff physician or on-call staff psychiatrist is unavailable, the Associate Dean-Clinical Practice or Regional Dean, or his/her designee, will assign a physician to medically evaluate the fitness for duty of the reported **Physician** or **House Staff**.

The **Physician** or **House Staff** shall be advised that communications during the above evaluations may not be confidential and may be used to determine whether the Physician or House Staff has impairment to the extent that he/she cannot safely engage in providing health care.

- Arrange for any **Physician** or **House Staff** deemed to be impaired by drugs or alcohol or impairment for other reasons to be evaluated by the Employee Assistance Program personnel through a supervisory referral and/or escorted to a treatment facility or his/her residence. In this instance, input from the **PHR Committee** should be obtained if possible. If the **Physician** or **House Staff** refuses assistance, the TTUHSC Police Department must be contacted to prevent the individual in question from operating a motor vehicle while in an impaired condition.

[Back to Top](#)

### C.

#### Emergency Room - Medical Director

Upon the arrival of the **Physician** or **House Staff** at the Emergency Room (ER), the Medical Director or the staff physician on duty will perform a fitness-for-duty evaluation of the person alleged to be impaired, and may also request the on-call staff psychiatrist to perform a psychiatric evaluation. The evaluations shall be accomplished within one hour of arrival or as expeditiously as possible.

If the evaluations present significant information about a **Physician** or **House Staff** regarding neuropsychiatric impairment, the ER Medical Director or staff physician on duty will inform the Associate Dean-Clinical Practice or Regional Dean, and the appropriate Chair or Regional Chair.

In an emergency situation, the Medical Director of the Emergency Room, the **PHR Committee**, the department Chair or Regional Chair, in conjunction with the on-call staff psychiatrist, may temporarily remove the **Physician** or **House Staff** from work assignments pending a medical evaluation and consultation with the Associate Dean-Clinical Practice or Regional Dean.

### D.

#### TTUHSC Physician Health and Rehabilitation Committee (PHR Committee)

Anyone with knowledge of or reason to believe that a **Physician** or **House Staff** is impaired may contact any member of the **PHR Committee** to refer the individual for committee action, in lieu of an initial referral to the department Chair, Regional Chair, Regional Dean, or Associate Dean-Clinical Practice.

The **PHR Committee** will investigate all cases referred to it with the strictest confidentiality possible. If the **PHR Committee** determines that there is conduct that requires immediate action to protect the life of any patient or to reduce the substantial likelihood or immediate injury or damage to the health or safety of any patient, employee, or other person, the **PHR Committee** may take any of the actions previously outlined in this policy with involvement of appropriate administrative authority as needed. If immediate action is deemed to be unnecessary, the **PHR Committee** may, with the approval of the department Chair, Regional Chair, Regional Dean, or Associate Dean-Clinical Practice, pursue intervention through the Employee Assistance Program's Supervisory Referral and/or the local Texas Medical Association (TMA) Committee for Physician Health and Rehabilitation.

[Back to Top](#)

E.

**Medical Director - Managed Health Care (Correctional Health)**

Anyone with knowledge of or reason to believe that a *Physician*, who is employed by or under contract to TTUHSC to provide health care services at correctional institutions and/or under the supervision of Managed Health Care, is impaired shall report the information to the Medical Director-Managed Health Care (or his designee who shall be a medical doctor). The information may also be reported to the Associate Dean-Clinical Practice or Regional Deans, who shall refer it to the Medical Director-Managed Health Care.

The Medical Director-Managed Health Care will investigate all cases referred with the strictest confidentiality possible. If the Medical Director-Managed Health Care determines that there is conduct that requires immediate action to protect the life of any patient or to reduce the substantial likelihood or immediate injury or damage to the health or safety of any patient, employee, or other person, the Medical Director-Managed Health Care may take any of the actions previously outlined in this policy with involvement of appropriate administrative authority as needed.

If evaluation in an Emergency Room is not available or feasible, the Medical Director-Managed Health Care may arrange for an evaluation at the most appropriate site according to his or her best judgment.

**VIII. TESTING GUIDELINES**

**Testing for drugs and alcohol**

Any *Physician* or *House Staff* being evaluated for a reported condition or impairment may be asked to undergo voluntary laboratory testing for the presence of illegal drugs or alcohol in body fluids or breath as a part of the medical evaluation for fitness for duty.

If the *Physician* or *House Staff* refuses testing, this information will be communicated immediately to the Associate Dean-Clinical Practice, Regional Dean, or the Medical Director-Managed Health Care.

**NOTICE:** Although testing for alcohol or drugs is voluntary, refusal of recommended testing may result in severe disciplinary measures including suspension from duties pending evaluation and investigation of the conduct of comprising the report of symptoms of impairment.

To the extent feasible, requests for laboratory tests shall be sent to a laboratory independent of TTUHSC and affiliated hospitals. A National Institute of Drug Abuse (NIDA) approved laboratory may be considered.

A screening test positive for chemical substances will be confirmed by the best currently available laboratory techniques. If the accuracy of a positive confirmatory test is disputed by the individual, the confirmatory test on a different aliquot of the same sample will be repeated in a qualified laboratory, which may be chosen by the individual with observation of proper chain of custody procedures. If the test result is not disputed or if the additional confirmatory test is positive, the result will be taken as definitive evidence of chemical substance abuse in the case of illegal chemical substance. The entirety of the available evidence will be used to determine the presence or absence of chemical substance abuse if the substance involved is one for which a bona fide medical indication exists.

The cost of chemical substance testing undertaken in the course of investigation for substance abuse and/or impairment will be borne by TTUHSC.

The cost of chemical substance testing performed as part of a treatment program, including maintenance monitoring, will be considered to be part of the cost of the program and will be the responsibility of the affected individual.

### **Testing for other than drugs or alcohol**

Any *Physician* or *House Staff* being evaluated for a reported condition of impairment other than from chemical or substance abuse may be asked to undergo physical or psychiatric evaluation as a part of the medical evaluation for fitness for duty.

If the *Physician* or *House Staff* refuses testing, this information will be communicated immediately to the Associate Dean-Clinical Practice, Regional Deans, or the Medical Director-Managed Health Care.

The testing required will be specifically tailored to each case, and the information sought will be specified.

The cost of such testing undertaken in the course of investigation for other than substance or chemical abuse impairment will be borne by TTUHSC.

The cost of future testing or treatment involved with the rehabilitation of an impaired physician will be borne by the affected individual.

### **IX. RESOLUTION OF REPORTED IMPAIRMENT**

A report of impairment shall be verified, investigated, and evaluated. Resolution may include a recommendation for any of the following:

- corrective action in accordance with Professional Staff Bylaws adopted at each campus, action under the House Staff Guidelines,
- action under TTUHSC Operating Policy and Procedures for non-faculty personnel,
- a Plan for treatment for those impairments subject to rehabilitation, and such Plan shall be the responsibility of the **PHR Committee**.

[Back to Top](#)

If the **PHR Committee** recommends a Plan for treatment, each Plan:

- C. shall be prepared on a case-by-case basis by the **PHR Committee** with input from the following as may be appropriate from receipt of the initial report of impairment: Chair, Regional Chair, and/or Program Director, Associate Dean-Clinical Practice, Lubbock, and Regional Deans, Amarillo, El Paso, and Odessa.
- D. shall be completed within 30 days of receipt of a recommendation.
- E. shall contain:
  - standards, work duty restrictions and/or reassignments,
  - supervision or any other requirements necessary to accomplish rehabilitation,
  - time deadlines for completion of the intervention steps periodic reviews with Physician to assess progress,
  - on-going, random drug-testing and health evaluation as necessary, other requirements for return to unrestricted practice, and
  - consequences if the Plan is not followed.
- F. Physicians or House Staff shall provide written consent for the PHR Committee to contact any treating physician while monitoring a Plan, including a personal physician.
  - Physicians or House Staff who self-report shall have input into the Plan. The PHR Committee may consider input from Physicians or House Staff who are the subject of a report of impairment.
  - The Physician or House Staff shall sign the Plan, and his/her immediate supervisor shall also acknowledge the Plan by signature.

### **X. FAILURE TO COOPERATE OR REPORT**

Failure of a *Physician* or *House Staff* to cooperate with an investigation or report for or follow-through with specified rehabilitation steps shall be deemed to be misconduct under TTUHSC policies and may result in disciplinary action without regard to results obtained from investigation under this policy.

[Back to Top](#)