RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
GRADUATE MEDICAL EDUCATION POLICY & PROCEDURE MANUAL

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SECTION ONE

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I. 1
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: SELECTION OF HOUSESTAFF

I. PURPOSE

To establish guidelines for eligibility, selection, evaluation, promotion and dismissal of housestaff in all residency programs sponsored by RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL and /or core teaching hospitals.

II. SCOPE

This policy will apply to all of the postgraduate training programs at RUTGERS Robert Wood Johnson Medical School.

III. DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Policy:

1. Eligibility for Admissions to RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL Residency Programs

   Educational Requirements:

   a. In order to be admitted to graduate medical education programs, a candidate must have satisfied the educational requirements for registration as a resident in the State of New Jersey under the regulations promulgated by the New Jersey Board of Medical Examiners. Every medical school attended must be accredited by the Liaison Committee on Medical Education (LCME), or the American Osteopathic Association (AOA) or recognized and listed in the World Health Organization Directory of Medical Schools. The applicant from a non-LCME/non-AOA accredited school must have completed his/her didactic training (first two years of basic science education) in the jurisdiction where the school is authorized to confer a medical degree.

(1.) For admission to the first postgraduate year (PGY1), the applicant must qualify for registration with the Board of Medical Examiners as defined in Board of Medical Examiners Regulation.

(2.) For admission to PGY2 and subsequent years, the applicant must qualify for a permit issued by the Board of Medical Examiners as defined in Board of Medical Examiners Regulation 13:35-1.5(1),(m).

(3.) For admission to PGY3 and subsequent years, the applicant must have passed USMLE Step 3, NBOME Part III or COMLEX Level III.

(4.) For admission to any postgraduate year after the applicant has used up his or her five years of eligibility for registration/permit in the State of New Jersey, the applicant is required by State Law to have a New Jersey license (NJSA 45:9-21(d) regardless of where they have completed their training. This requirement also applies to all current trainees after the fifth year of graduate training. ***As this is a State Law, and not a programmatic requirement, affected applicants/trainees are responsible for the payment of all applicable New Jersey licensing fees and renewal costs.***

b. International Medical Graduates (IMG's) must be U.S. citizens, U.S. permanent residents or holders of J-1 Exchange Visitor visas issued by the Educational Commission on Foreign Medical Graduates (ECFMG) in order to be eligible for admission to a position in any of the University's graduate medical education programs. An eligible IMG must hold a currently valid ECFMG certificate.

c. Must satisfy the conditions for appointment/reappointment as stated in University Policy #00-01-20-87:00 and University Policy #00-01-10-08:00. See Section IV.D. Housestaff Contracts portion of this policy for details.

B. <u>Procedure:</u>

1. The following credentials will be collected for each candidate for a housestaff position.

a. Application blank, completed and signed (except for ERAS applications)
b. Dean's letter

c. Medical school transcript
d. Copy of medical school diploma or verification of graduation from the medical school. (PGY I appointments may be made prior to graduation but it is the Program Director's responsibility to verify graduation and file documentation in the intern's file.)
e. Two letters of reference from faculty familiar with the individual's performance. If a candidate is applying for PGY II or above, one letter must be from the candidate's former Chief of Service or Program Director.
f. An ECFMG Certificate or ECFMG letter which must be verified in writing by the Program Director.

All candidates should interview with the Program Director or a designee. PGY I year positions may be filled through the National Resident Matching Program.

Contracts are prepared by the Program Director and forwarded to the Office of Graduate Medical Education with credentials check list (See Attachment 1) signed by the Chair, Program Director and accompanied by all credentials and documentation of the interview. If any of the required credentials are missing, contracts should be amended to include a clause that states "this contract should be amended with a cover memo". The Office of Graduate Medical Education and staff will review the contracts and supporting documents for completion and compliance and then forward them to the Associate Dean for Graduate Medical Education for approval. Contracts for mailing and all original credentials will be returned to the Program Director through the Office of Graduate Medical Education.

C. Housestaff Selection

Residency programs should select from among eligible applicants on the basis of their preparedness, aptitude, academic credentials, personal characteristics and ability to communicate. It is the policy of the University to recruit, hire, train, and promote without regard to age, ethnicity, disability, marital status, national origin, race, religion, sex, sexual orientation, or veteran status unless otherwise prohibited by applicable law.

D. Housestaff Contracts

The contract for each house officer in a graduate medical program shall:

1. Specify the specialty and sub-specialty, where applicable, and the level or Postgraduate Year (PGY), e.g., Internal Medicine PGY 1, 2, 3, or Internal Medicine-Cardiology PGY 4, 5,etc., and the term of the contract;

2. Have an attachment describing assigned duties including patient care and teaching, and the program's overall work schedules;

3. Specify that registration/permit/licensure requirements of the New Jersey Board of Medical Examiners must have been met as a precondition of the contract;

4. Contain an attachment defining scope of practice of registration or permit holders as per regulations of the New Jersey Board of Medical Examiners;

5. Describe benefits including vacations, professional and/or sick leave, family leave, liability insurance, health insurance and other insurance for residents and their families, and meals and laundry or their equivalent, consistent with hospital or University policies or the collective bargaining agreement between the Committee of Interns and Residents (CIR) and the University, where applicable;

6. Specify whether or not extramural employment (moonlighting) is permissible; and, where moonlighting is permissible, specify that malpractice coverage is not provided by the University for moonlighting and additionally specify that the house officer must (a) have approval of the Program Director and (b) must give assurance that this activity will not interfere with the responsibilities to the residency program.

7. Have as attachments required copies of University policies.

8. Specify that compliance with the University's Housestaff Immunizations and Health policy is required as a condition of the contract.

9. Specify conditions for appointment/reappointment as stated in RUTGERS Robert Wood Johnson Medical School Policy on

9. Specify the conditions for appointment/reappointment as stated in RUTGERS Robert Wood Johnson Medical School Policy on Graduate Medical, Dental & Podiatry Education, University Policy # 00-01-20-87:00; Excluded Individuals & Entities, University Policy #00-01-10-08:00 and Section I.2 of this Policy Manual.

Policy #00-01-10-08:00 - “RUTGERS Robert Wood Johnson Medical School will not employ or enter into contracts with any individual or entity who is currently excluded by the Office of Inspector General (OIG) and/or the General Service the event that during the course of appointment, an individual becomes excluded by the OIG or GSA from participation in Federal Health Care Programs, the individual’s employment and/or contractual relationship shall be terminated.

Policy #00-01-20-87:00 - The Housestaff agrees that this Contract is contingent upon completion of the Criminal Record Search document and Housestaff Disclosure and Authorization Form and the receipt by RUTGERS Robert Wood Johnson Medical School of a consumer or investigative report, as those terms are defined in the Federal Credit Reporting Act, deemed favorable by RUTGERS Robert Wood Johnson Medical School .

ATTACHMENT 1

APPLICANT: _____
LAST FIRST M.I.

CREDENTIALS CHECKLIST FOR HOUSESTAFF APPOINTMENT

(This form is to be attached to the front of each applicant's folder. It shall accompany the credentials and contract being submitted for signature).

U.S. Graduates	Received	Foreign Medical Graduates	**Received
Application	_____	Application	_____
Deans Letter	_____	Dean's Letter*	_____
Medical School Transcript	_____	Medical School Transcript Translation* See policy I.1 Section IV.A.1.a. for additional requirements	_____
Letters of Recommend. (2)	_____	Letters of Recommend (2)	_____
USMLE Scores (Step 1 and 2 or equivalent)	_____	USMLE Scores (Step 1 and 2 or equivalent)	_____
Diploma	_____	Diploma	_____
PGY-II & Above, Letter From Yr. 1 Program Director or Chief	_____	PGY-II & Above, Letter From Yr. 1 Program Director Or Chief	_____
PGY-III & Above USMLE Step 3 Scores	_____	ECFMG Certificate or ECFMG Letter	_____
Interview	_____	Interview	_____

* Not required for subspecialty residents (fellows).
** If documents are not in English, they need to be accompanied by English translation.

Credentials Complete:

_____
Chief/Program Director Date

_____
Administrative Director of Medical Education Date

Before hire:
1. All recent graduates need to provide a certified copy of their diploma.
2. All non-US citizens must provide proof of legal visa status.

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I.2
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: TRANSFERRING RESIDENTS

I. PURPOSE

To establish guidelines for required documentation for housestaff transferring into and out of a RUTGERS Robert Wood Johnson Medical School residency/fellowship program.

II. SCOPE

This policy will apply to all the postgraduate training programs at the RUTGERS Robert Wood Johnson Medical School

III. DEFINITIONS

A. Housestaff – refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

B. Transferring – Moving from one program to another within the same or different sponsoring institution or when entering a PGY II program requiring a preliminary year, even if the resident was simultaneously accepted into the prelim PGY I program and the PGY II program as part of the match (e.g., accepted to both programs right out of medical school). This term DOES NOT apply to a resident who has successfully completed a residency and then is accepted into a subsequent residency or fellowship program.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Before accepting a resident who is transferring from another program, in addition to adherence to GME Policy #I.1 Selection of Housestaff, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

B. A program director must provide timely verification of residency education and summative performance evaluations for residents who leave the program prior to completion. Verification includes the following:

1. evaluations,
2. rotations completed,
3. procedural/operative experience, and
4. a summative competency-based performance evaluation.

Approved by the GMEC 11/13/07

ATTACHMENT I

RUTGERS
Robert Wood Johnson
Medical School

Date _____

Dear Program Director,

Subsequent to our telephone conversation on _____ regarding the performance of _____, MD / DO, and your willingness to release this trainee as of _____, our selection committee intends to offer a PGY ____ position to him / her effective _____.

New ACGME regulations require verification of prior training to include evaluations, rotations completed, procedural/operative experience and a summative competency-based performance evaluation. Kindly document the trainee's experience in your program by completing the enclosed form and attaching copies of all evaluation forms completed during his/her training. Any additional comments or feedback would be welcome.

Please feel free to contact me if you have any questions. Thank you very much for your time.

Sincerely yours,

(Name)
Program Director
(Program)
RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
(Program Director email)
(phone)
(fax)

TRAINEE TRANSFER RELEASE & EVALUATION FORM

Trainee Name _____ **Current Level of Training** _____

Anticipated date of release from current program _____

	Unsatisfactory	Marginal	Satisfactory	superior
MEDICAL KNOWLEDGE **knowledge-base and application to patient care and education of others**				
PATIENT CARE **Engages in compassionate, timely and effective care encompassing disease prevention, health promotion, treatment and care at the end of life**				
PROFESSIONALISM **Displays behaviors reflecting continuous professional development, ethical practice, cultural sensitivity, responsibility toward patients, our profession and society**				
INTERPERSONAL & COMMUNICATION SKILLS **Demonstrates appropriate written & verbal skills with patients, family members, consultants and other professionals**				
PRACTICE-BASED LEARNING AND IMPROVEMENT **Ability to evaluate evidence to improve care, engages in periodic self-assessment**				
SYSTEMS-BASED PRACTICE **Understands contexts and system of health care delivery, and resource utilization.**				

Undecided
This candidate is eligible for contract renewal at our institution: □ **Yes** □ **No** □

The following rotations were completed while at our institution:

JUL 2____	AUG 2____	SEP 2____
OCT 2____	NOV 2____	DEC 2____

Page 2 of attachment
Trainee Transfer Evaluation & Release Form
Trainee_____

APR 2____	MAY 2____	JUN 2____

The trainee has had the following procedural/operative experience.

Comments:_____

_____

_____

_____

_____

_____

_____

_____

Signature of Program Director / Date

_____

Name of Program

_____

Telephone Number

Attachments: Resident Evaluations

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I. 3
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: PROMOTION OF HOUSESTAFF

I. PURPOSE

To provide a guideline for housestaff reappointment to the next level of postgraduate training in accordance with the agreement between the University and the Committee of Interns and Residents (CIR).

II. SCOPE

This procedure applies to all housestaff.

III. DEFINITION

Housestaff-refers to all interns, residents and subspecialty residents (fellows) enrolled in any RUTGERS Robert Wood Johnson Medical School postgraduate training programs. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Criteria for promotion in each residency program shall be specified, maintained current, documented and communicated to residents at the beginning of each academic year.

B. In general, postgraduate levels are determined by the Program Director, the Department Chair and the Dean on the basis of previous training and experience.

C. In addition to fulfilling the requirement of satisfactory academic progress, residents must satisfy the following requirements with regard to registrations, permits, and licenses.

1. For promotion to PGY2 and above, the resident must obtain and maintain a permit issued by the Board of Medical Examiners as defined in Board of Medical Examiners Regulation 13:35-1.5; a house officer who does not obtain or make application for such a permit shall automatically be terminated at the conclusion of PGY1; a resident who fails to maintain such permits shall be terminated upon the loss of the permit; a New Jersey medical license shall satisfy these permit requirements;

2. For promotion to PGY3, the resident must have passed USMLE Step 3, or COMLEX Level III; a house officer who has taken the exam prior to June 30th and has not received exam scores will be promoted to PGY3

with the understanding that passing scores must be provided to the program director within six weeks of the exam date or the PGY3 contract will be terminated;

3. For promotion to any postgraduate year after a house officer has used up the 5-year limit for registration/permit eligibility as specified in NJSA 45:9-21d, the house officer must have a New Jersey license; a house officer whose eligibility for a permit has expired and who has not obtained a New Jersey license shall automatically be terminated at the conclusion of the last academic year of eligibility for a permit; and

4. Residency programs have the option of requiring housestaff to obtain New Jersey licensure as a condition of promotion to PGY3 if eligible at that time, or to any succeeding postgraduate year; however, if it is a requirement of the Program, the Program will pay NJ State Licensing fees and renewal costs for New Jersey licensure of any House Staff Officer employed at the University. This does not cover USMLE Step III or COMLEX.

D. The decision to offer a promotion to a house officer will be conveyed to the house officer by the Program Director after a review of his/her faculty evaluations, in-training exam performance and the personal observations of the Program Director.

E. Written notification shall be given to the house officer for non-renewal of contracts. Housestaff who have July 1st appointments will be notified, in writing, by December 15th of the first year of service and not later than November 15th of the second year of service and thereafter, if their services are not to be renewed for the next year of a given residency training program. In the event that a house officer commences work on a date other than July 1st, the last date for non-renewal shall be five and one half months (5 ½) or four and one half (4 ½) months, respectively, following the date on which such work commences. When possible, earlier notice of non-renewal will be given to such house officer. Non-renewal of contracts may be appealed through an Ad Hoc Non-Renewal Committee. (See GME Policy I.6 Resident appeal of non-renewal of contract)

F. In the event a house officer's performance is not satisfactory, the Program Director will inform the house officer in writing. The outline or plan for remedial training requirements must be provided to the house officer in writing. This shall include the time period for remedial training and subsequent re-evaluation of the house officer's suitability for promotion. A timely written non renewal notification will be given which can be reversed if on re-evaluation the house officer is felt to be qualified for promotion.

Approved at 2/23/99 GMEC meeting
Amended at the GMEC Meetings on 5/11/04, 09/13/05, 10/11/05, 09/12/06, 05/13/08

POLICY#: I. 4
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: PERFORMANCE EVALUATION

I. PURPOSE

To establish a general guideline within which each program can provide a house officer with periodic evaluations as required by the ACGME, University, CIR or RRC specific to each Program.

II. SCOPE

This applies to all housestaff in all postgraduate training programs.

III. DEFINITIONS

Housestaff-refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual housestaff member may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Each house officer shall be continuously evaluated for his/her academic performance as follows:

1. Formative Evaluation

The faculty must evaluate in a timely manner the residents whom they supervise. In addition, the residency program must demonstrate that it has an effective mechanism for assessing resident performance throughout the program, and for utilizing the results to improve resident performance.

a) Assessment should include the use of methods that produce an accurate assessment of residents' competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

b) Assessment should include the regular and timely performance feedback to residents, particularly with regard to any deficiencies noted. Evaluations must be given to housestaff semi-annually, or as specified by each Program's RRC and at the completion of training. Such evaluations are to be communicated to each resident in a timely manner, and maintained in a record that is accessible to each resident.

c) Assessment should include the use of assessment results, including evaluation by faculty, patients, peers, self, and other professional staff, to achieve progressive improvements in residents' competence and performance.

2. Final Evaluation

The program director must provide a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of education, and should verify that the resident has "*demonstrated sufficient competence to enter practice without direct supervision".* The final evaluation must be part of the resident's permanent record maintained by the institution.

3. Other measures of performance to be considered in assessing academic growth include but are not limited to the following:

a. Standardized examinations
b. Required certifications, such as ACLS
c. In-service examinations
d. Quality of research, presentations, publications, etc.
e. Success in achieving assigned goals, including remediation goals.

4. Personal communications between program director and faculty or other persons in a supervisory role. (In order for such communications to be used meaningfully in evaluation, oral communications must be documented, with a copy placed in the house officer's file and another copy provided to the house officer. However, documentation of such communication may occur for the first time when an evaluation form is completed).

5. Periodic review of each house officer's progress in the program by the program director in which all of the above performance measures will be discussed.

B. Each residency program must have in place a system of evaluation used to assess the academic performance of housestaff on a continuing basis; this system must be followed uniformly for all housestaff in the program. This serves to enhance the education process and keep trainees apprised of their progress.

C. The Program Director will assume responsibility for establishing the mechanism and frequency of performance evaluations in compliance with the ACGME essentials for the specific program. This is monitored through the GME internal review process.

D. The Program Director will inform the housestaff annually of the departmental procedure and schedule for performance evaluations.

E. Documentation of periodic performance evaluations shall be maintained in the house officer's academic record.

F. In order to continue in a residency program, a housestaff officer must make satisfactory academic progress as determined in accordance with the residency program's evaluation system.

G. All academic matters, including in-training exams should be considered in determining whether a house officer is making satisfactory academic progress. Academic matters include acquisition of knowledge related to the discipline as well as all aspects of the development of clinical and professional skills necessary for effective functioning as a health care professional. Of particular importance as academic issues are areas such as patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice.

Approved by GMEC on 2/23/99
Amended by the GMEC on 5/13/08, 8/11/09

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I. 5
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: ACADEMIC DEFICIENCIES OF HOUSESTAFF AND PROCEDURES FOR APPEALS OF ACADEMIC DECISIONS

I. PURPOSE

To establish procedures for housestaff at the RUTGERS Robert Wood Johnson Medical School to appeal actions regarding academic performance, including dismissal.

II. SCOPE

This policy is directed to all members of the housestaff. These procedures are not intended to be applicable to non- academic matters; procedures for dealing with non-academic discipline are specified in the University's contract with the Committee of Interns and Residents (CIR). However, please note that all matters that are academic in nature shall be addressed via this process even if such matters have both academic and non-academic implications.

III. DEFINITIONS

Housestaff- refers to all interns, residents, and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

Academic matters include acquisition of knowledge related to the discipline as well as all aspects of the development of clinical and professional skills necessary for effective functioning as a health care professional. Of particular importance as academic issues are areas such as patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice. It should also be noted that when particular issues are of concern as both academic and employment-related, they should ordinarily be treated as academic issues. Since the academic development of residents is the paramount reason for the existence of residency programs at RUTGERS, it is incumbent upon residency program administrators and faculty to give the highest priority to and place the strongest emphasis upon the academic significance of difficulties that housestaff may be experiencing.

IV. RESPONSIBILITY/REQUIREMENTS

A. Remediation of Academic Deficiencies. In the event that academic deficiencies are identified:

1. The program director or designee shall counsel the house officer. If counseling is conducted by a designee, the program director shall be informed in writing.

2. When a house officer is asked to attend a personal interview for the purpose of investigating his/her performance or conduct and such interview may reasonably be expected to lead to actions that could be characterized as disciplinary in nature (such as a formal letter of reprimand, a suspension or a dismissal), written or oral notice of the interview shall be given to the associate or assistant dean responsible for graduate medical education and to the CIR. A CIR representative may accompany the house officer to hear the matter being discussed, but may not interfere with the interview or speak. Upon determining in good faith that the matter is academic in nature, the CIR representative should leave.

3. The program director shall outline corrective measures and shall establish criteria and time frames for the correction of the deficiencies.

4. The program director shall document the above interactions with the house officer in writing, with a copy placed in the house officer's file.

5. The program director shall re-evaluate compliance with corrective actions as established earlier.

6. If performance is restored to a satisfactory level, the program director will indicate this orally to the house officer as soon as it has occurred. A written notation of this interaction will also be placed in the house officer's file, with a copy to the house officer.

7. If the house officer fails to correct the identified academic deficiencies to the satisfaction of the program director within the specified time frame, the program director may either extend the remediation period, using the same procedures as for an initial remediation effort, or proceed with termination in accordance with the process described in the following subsection of this document.

8. For severe deficiencies warranting immediate termination, the program director may proceed in accordance with the steps outlined below.

9. Copies of all documentation regarding academic deficiencies of housestaff should be provided to the associate dean responsible for graduate medical education.

B. Termination

1. In the event of severe academic deficiencies or failure to remediate lesser deficiencies, the program director may make the determination that the house officer should be terminated from the program. The program director should consult with a representative group from among the faculty who interact to a significant extent with the house officer.

2. Once the program director has made the decision to terminate a house officer from the program, the director shall notify the house officer in writing of the termination. Copies of this notice shall be provided to the associate dean responsible for graduate medical education and to the CIR. Termination shall ordinarily become effective not less than two weeks after receipt of the written notice. The notification period may be waived at the discretion of the program director if, in the judgment of the program director, continuance of the house officer in the program during the notice period would result in a risk of danger to patients or in a risk of other harm or damage either to the program itself or to other University personnel. The notification shall include the following:

   a. Reasons for dismissal
   b. Effective date of dismissal
   c. Process for appealing the dismissal

C. Appeals Process

1. The house officer has the right to appeal any formal communication from the program director which is to become part of the house officer's permanent file or any adverse academic decision made by the program director. Appeal is to be made to an Ad Hoc Appeal Committee, established as indicated below, or to the residency program's standing Committee on Housestaff Evaluation (or its equivalent). This appeal must be made in writing to the program director within five working days of having received the notification of termination or an adverse action.

2. If the house officer submits a timely notice of appeal, the director shall schedule a meeting of the residency program Committee on Housestaff Evaluation or convene the Ad Hoc Appeals Committee. The Ad Hoc Appeals Committee, if created, should consist of [not fewer than five] faculty members of the division, department or group of departments responsible for the program. The faculty members selected for this purpose shall be experienced faculty in the area of graduate medical

education. The number of members of the Ad Hoc Committee shall be large enough to be representative of the faculty of the division, department or group of departments responsible for the program. The committee considering the house officer's appeal should include at least one house officer.

3. The house officer may request to meet with the Committee in person and be accompanied at the hearing by a faculty member or fellow house officer who may act as an advisor. If a CIR representative has not previously determined that the matter at issue is academic, the house officer may also be accompanied by a representative of the CIR who shall not participate in the proceedings. (The CIR representative's only role in the hearing is to make a determination whether the matter under discussion is a bona fide issue of academic performance.) The program director will also be present at the hearing at which time he or she shall set forth the circumstances leading to the planned adverse action or the reasons for which the house officer has been dismissed. Following the presentation, the house officer and/or their advisor shall be permitted to set forth whatever information the house officer wishes the Committee to consider as reasons to vacate the decision to endorse the adverse action or to dismiss the house officer.

4. Following the hearing before the Committee, the Committee will immediately confer and, following deliberations, advise the Department Chair in writing of its recommendation and the reasons for that recommendation. The Department Chair shall render a decision, and the decision of the Chair shall be final. If the Department Chair is the Program Director, the decision of the Committee shall be final. This decision shall be conveyed to the house officer in writing. The Chair shall provide copies of the notice of adverse action or dismissal to the associate dean responsible for graduate medical education.

Approved by GME Committee, April 13, 1999
Amended 6/13/06, 5/13/08 & 9/9/08

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I. 6
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: TERMINATION OF APPOINTMENT

I. PURPOSE

To provide guidelines and procedure for the voluntary and non-voluntary termination of an appointment prior to the established expiration date of the house officer's contract.

II. SCOPE

This policy is applicable to all members of the housestaff.

III. DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

Termination of a house officer's appointment prior to the established expiration date may be accomplished only for good reason.

A. Voluntary Termination

1. If a house officer desires such a termination due to personal hardship, he or she should write a letter to the Program Director and the Chair of the Department stating the reason for the request.

2. An interview may be requested.

3. Termination may be granted with the concurrence of the Chair and/or Program Director.

B. Non-voluntary Termination (Dismissal)

1. Reasons for a non-voluntary termination of a house officer prior to the established expiration date of contract may include but is not limited to:
   a. Unsatisfactory performance, including failure to remediate deficiencies.

b. Excessive absenteeism which effectively disrupts training.

c. Personal conduct.

2. In accordance with both University policy and the CIR, dismissals for academic cause are not grievable.

C. The Medical School's procedure for due process regarding decisions on academic issues concerning residents is addressed in GME Policy I.5 Academic Deficiencies of Housestaff and Procedures for Appeals of Academic Decisions.

D. Housestaff may be disciplined or discharged for cause, however, these actions shall be grievable, and in the event the involved house officer files a grievance, the burden of proving just cause shall be upon the University.

The University shall give five (5) working days advance notice, in writing, of any intended disciplinary action to the affected house officer and the CIR. The notice shall state the nature and extent of discipline, the specific charges against the house officer and describe the circumstance(s) upon which each charge is based.

Approved by GMEC on 02/23/99
Amended by the GMEC on 05/13/08

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: I. 7
SECTION: SELECTION/PROMOTION PROCESS
SUBJECT: RESIDENT APPEAL OF NON-RENEWAL OF CONTRACT

I. PURPOSE

To establish a grievance procedure for house staff who wish to appeal a notice of non-renewal of the house officer's contract.

II. SCOPE

This procedure applies to all house staff.

III. DEFINITION

House staff refers to all interns, residents and subspecialty residents (fellows) enrolled in any RUTGERS Robert Wood Johnson Medical School postgraduate training programs. An individual member of the housestaff may be referred to as a house officer.

IV. PROCEDURE

A. A house officer may appeal a Program Director's decision not to renew the house officer's contract for the following academic year by submitting a written request to the Department Chair within five (5) working days of receipt of notice of the decision.

B. If the house officer submits timely notice of appeal, the Department Chair shall convene a Non-Renewal Committee to consider the appeal. The Non-Renewal Committee shall be composed of the Department Chair, the Associate Dean for GME, or their designees, and one faculty member designated by the Chair of the GME Committee.

C. The house officer will be invited to meet with and make a personal presentation to the Non-Renewal Committee and may be accompanied by a faculty member or fellow house officer who may act as an advisor. The house officer may also be accompanied by a representative of the CIR, who shall not participate in the proceedings. The Non-Renewal Committee may invite the Program Director and any other witnesses to make presentations. All parties may submit any relevant information to the Non-Renewal Committee prior to or during the hearing.

D. The Non-Renewal Committee shall consider only whether the non-renewal conforms to the following standards:

1. the decision was communicated to the house officer in writing;

2. the decision was communicated in a timely manner, in accordance with RUTGERS Robert Wood Johnson Medical School procedure on non-renewal of house officer contracts; and

3. the non-renewal decision was not based on reasons prohibited by law or RUTGERS Robert Wood Johnson Medical School policy.

If the Non-Renewal Committee determines that the non-renewal decision conforms to these standards, the decision shall be upheld.

E. Following the hearing, the Non-Renewal Committee shall deliberate and render a written decision, which shall be communicated to the house officer and Program Director. The decision of the Non-Renewal Committee will be final and binding.

Approved at the 10/11/05 GMEC meeting.

SECTION TWO

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: II. 1
SECTION: BENEFITS & AMENITIES
SUBJECT: COMPENSATION PLAN AND PROGRAM

I. PURPOSE

To provide a policy concerning compensation of housestaff.

II. SCOPE

This policy applies to the compensation of all housestaff.

III. DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. Policy:

Salaries will be paid in accordance with the appointment/contract letter.

B. Procedure:

Rates are negotiated between the CIR (residents union) and the University and published in Article V of the Agreement. This agreement is renegotiated every three years. All housestaff are required to be members of the bargaining unit.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: II. 2
SECTION: BENEFITS & AMENITIES
SUBJECT: BENEFITS

I. PURPOSE

To identify individual benefits available to housestaff.

II. SCOPE

The benefits apply to all housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. Vacation

1. All housestaff shall be entitled to four (4) weeks of paid vacation to be scheduled in accordance with departmental policy, which shall not preclude scheduling of vacation in two (2) week blocks. Whenever a holiday falls within a vacation period, the individual housestaff shall be entitled to an extra vacation day. Pro-rata earning of vacation is one and two-thirds (1 2/3) days for each full month of employment.

2. Individual house officer shall, on or before September 1 of each year, submit in writing to the Program Director all requests for vacation leave. The Program Director, after review of the needs of the services and rotation schedules, will make reasonable efforts to honor the individual request, granting at least two (2) consecutive weeks off, or in services where scheduling accommodations can be made, more than two (2) weeks of vacation.

3. One week of scheduled vacation is defined as seven (7) consecutive twenty-four (24) hour days off during which there is no assignment of work.

B. Leave

1. Sick Leave
   See Section IV.1 of this policy manual “Medical Leave and Family Leave”.
2. Bereavement Leave
   See Section IV.2 of this policy manual “Bereavement”.
3. Maternity Leave
   See Section IV.1 of this policy manual “Medical Leave and Family Leave”.
4. Family Leave
   See Section IV.1 of this policy manual “Medical Leave and Family Leave”.
5. Disability Leaves
   See Section IV.1 of this policy manual “Medical Leave and Family Leave”.
6. Leave for USMLE
   Housestaff will be permitted to take up to three (3) days paid leave for the purpose of taking the USMLE. This shall not be charged against vacation time and such paid leave shall be permitted only one time.

C. Parking

Parking fees are set forth in the CIR agreement.

D. Meals

At University-operated or other facilities where housestaff are assigned, a meal allotment shall be provided each month to housestaff who will be on overnight shift of six hours or more or an extended shift of twelve or more hours. The allotment of script or cafeteria credit shall be equal to the number of on-calls that the housestaff officer is assigned during that month, multiplied by the amounts set forth in section ‘B’ of the CIR contract.

E. Holidays

1. All RUTGERS Robert Wood Johnson Medical School housestaff, wherever assigned, shall be entitled to all RUTGERS Robert Wood Johnson Medical School holidays. The University shall exercise its best efforts to ensure that housestaff on rotation to an affiliated facility are granted all RUTGERS Robert Wood Johnson Medical School holidays on the day they occur.

2. Effective January 1, 1998, RUTGERS Robert Wood Johnson Medical School holidays are: New Year’s Day, Martin Luther King’s Birthday, Good Friday, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day after Thanksgiving, Christmas and three floating holidays, one of which shall be taken within thirty (30) calendar days of the house officer’s birthday, except as mutually agreed upon between the Program Director and house officer.

F. Professional and General Liability/Self Insurance

The University provides coverage for housestaff activities performed within the scope of University employment, including activities duly authorized as part of the training program to which the resident is appointed. Coverage includes both Professional (Medical Malpractice) and General Liability (allegations of negligent acts or omissions, other than those of professional nature). A claim arising as a result of an insured activity is eligible for coverage whether the claim is actually received by the insured while enrolled in the residency program or the receipt of the actual claim transpires subsequent to active enrollment. Coverage applies to authorized activities performed at RUTGERS Robert Wood Johnson Medical School -owned facilities, at RUTGERS Robert Wood Johnson Medical School affiliated facilities and to certain specially approved activities, such as some approved elective rotations. Coverage does not apply to any acts or omissions that transpire outside the scope of RUTGERS Robert Wood Johnson Medical School employment and/or outside the authorized scope of the RUTGERS Robert Wood Johnson Medical School residency program. For example, moonlighting activities are not covered.

The conditions of this coverage require:

1. That an insured give written notification to RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management (30 Bergen Street, Administration Complex 13, Room 1313, Newark, NJ 07107-3007) within ten days of the of the receipt of any claim, summons and complaint, letter of intent to pursue litigation, etc.

2. That an insured give verbal notification to RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management (973-982-6277; Fax: 973-972-7257) of any covered medical incident, whether occurring on RUTGERS Robert Wood Johnson Medical School premises or at an affiliated facility, which might give rise to claim; such notification must be given as soon as practical. (Note: all insured are to report any medical incident which might give rise to a claim with RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management before discussing or writing to administrative representatives, hospital committee representatives, quality assurance or patient representatives etc, of any facility at which they might be rendering services).

3. That the insured must fully cooperate with RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management and the Attorney General’s office of the State of New Jersey. Any alteration of medical records or intentional misrepresentation or concealment of material facts by the insured may nullify the insured's right to coverage.

4. That all insured agree to attend all Risk Management and Loss Control Programs designated by RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management to be a mandatory part of this insurance program.

5. That the preceding is not intended to represent a full disclosure as to the terms and provisions of coverage under the RUTGERS Robert Wood Johnson Medical School Professional and General Liability Program of Self Insurance; complete information is available through RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management. Should any pertinent questions arise as to coverage; the insured is advised to contact a RUTGERS Robert Wood Johnson Medical School - Risk and Claims Management representative immediately.

G. Group Benefit Programs

1. Health Insurance

a. Housestaff are provided the opportunity to participate in the group benefit programs provided by the University. Such coverage is effective the first day of the month following two full months of employment and is subject to completion of the appropriate forms. Coverage is not automatic.

b. Pursuant to N.J.S.A. 26:2J-1, et seq., employees may opt to receive medical coverage from approved Health Maintenance Organizations, when available, in lieu of the normal coverage under the State Health Benefits Program Eligibility requirements and administrative procedures are governed exclusively by the State Health Benefits Commission.

2. Prescription Drug Plan

Housestaff are provided the State Prescription Drug Benefit Program. The plan provides benefits to all eligible unit employees and their eligible dependents.

3. Dental Care Program

Participation in the Program shall be voluntary with a condition of participation being that each participating housestaff authorize a bi-weekly salary deduction not to exceed fifty (50%) percent of the cost of the type of coverage elected; e.g. individual, husband and wife, parent and child or family coverage.

4. Life Insurance

The University shall provide life insurance to all Housestaff in the amount of three (3) times the annual salary of the housestaff, at no cost to the resident.

5. Temporary Disability Insurance

Housestaff shall be included in the State Temporary Disability Plan, which is a shared cost plan providing payments to employees who are unable to work as the result of non-work connected illness or injury.

6. Hepatitis 'B' Screening and Vaccine

The University will provide one Hepatitis 'B' screening and vaccine series at no cost to housestaff who request them, providing the appropriate medical consent forms have been completed and signed. The vaccine shall be administered by physicians designated by the University or affiliated hospitals.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: II. 3
SECTION: BENEFITS & AMENITIES
SUBJECT: WORKING ENVIRONMENT

I. PURPOSE

To establish guidelines for the provision of adequate working environment for housestaff.

II. SCOPE

This applies to all postgraduate medical education programs.

III. DEFINITIONS

Housestaff - refers to all interns, residents and fellows enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Policy:

The training programs shall provide a working environment that is consistent with proper patient care and the educational needs of housestaff.

1. Housestaff shall be supervised by the teaching staff in accordance with the Program requirements as published in the American Medical Association's Graduate Medical Education Directory.

2. Each training program shall establish policies governing duty hours and working environments that are optimal for housestaff education and the care of patients. They shall meet the special requirements that relate to duty hours and on-call schedules based on educational rationale, patient need, and include continuity of care. This is reviewed as part of the GME internal review of programs. Copies of the policies are maintained by the GME office. Policies shall include the following items:

   a. The goals and objectives of each residency shall not be compromised by excessive reliance on housestaff to fulfill institutional service obligation.

b. Programs should ensure that housestaff are provided backup support when patient care responsibilities are especially difficult or prolonged.

c. Duty hours will be consistent with this policy manual as well as meet the general and special requirements pertaining to each program.

d. Housestaff on duty will be provided adequate sleeping quarters and food services.

e. Training sites will provide effective laboratory, medical records and radiologic services to insure high quality patient care. The GME office maintains a log of JCAHO accreditation letters of all participating institutions.

f. All locations where housestaff are assigned shall provide security, including but not limited to parking facilities, on-call quarters, and hospital departments.

3. Housestaff are expected to participate in a working environment which is free of objectionable and disrespectful conduct and communication of a sexual nature. The Medical School will not tolerate conduct of a sexual nature that interferes with an individual's work performance or creates an intimidating, hostile, or offensive working or learning environment. (Also see University Policy on Sexual Harassment # 00-01-35-25:00.)

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: II. 4
SECTION: BENEFITS & AMENITIES
SUBJECT: FORUM FOR RESIDENT FEEDBACK

I. PURPOSE

To assure a positive educational environment in which housestaff can communicate and exchange information on their working environment and their educational programs.

II. SCOPE

This applies to all postgraduate medical education programs.

III. DEFINITIONS

Housestaff - refers to all interns, residents, and fellows enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Policy:

The training programs shall provide a working environment in which members of the housestaff may raise and resolve issues without fear of intimidation or retaliation. Members of the housestaff must be able to communicate and exchange information on their working environment and their educational programs. There must be a process by which individual house officers can address concerns in a confidential and protected manner.

1. The Associate Dean for Graduate Medical Education; Dr. Parisa Javidian, Associate Professor of Pathology; and the resident members of the GMEC will all function as Ombudsmen to whom house officers can communicate concerns in a confidential manner without fear of intimidation or retaliation.

2. Focus group meetings in which the Associate Dean for Graduate Medical Education meets with housestaff at various hospital sites and in individual programs will be scheduled throughout the year. Comments and concerns raised by housestaff at these meetings may be confidentially reported to the GMEC by the Associate Dean.

Approved by GMEC on February 23, 1999 – Editorial Revision 06/12/08

SECTION THREE

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: III. 1
SECTION: WORK SCHEDULES
SUBJECT: MOONLIGHTING

I. PURPOSE

To establish guidelines as set forth in the University Policy # 00-01-30-10:00 for outside employment while a member of the housestaff.

II. SCOPE

This policy is directed to all members of the housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. The primary work obligation of a full or part-time housestaff of the University is to the University.

B. Full or part-time housestaff must not be required to engage in moonlighting. They may voluntarily engage in outside employment only if the outside employment does not:

1. constitute a conflict of interest (see University policy 00-01-10-05:00, Code of Ethics: General Conduct);

2. occur at a time when the house officer is expected to perform his or her University duty;

3. diminish the house officer's efficiency in performing his or her primary work obligation at the University; or

4. exceed the 80-hour weekly limit on duty hours when combined with regular program work schedules.

C. Notice of regular or continuing outside employment of full or part-time housestaff is required during the regular work year. (Such individuals will complete a Notice of Outside Employment and will follow the submission process as indicated below.) If housestaff plan to engage in outside employment, they are required to receive approval of outside employment from their Program Director, Department Chair and forward the forms for approval and signature to the Associate Dean for Graduate Medical Education. The GME Office will send it to the Office of Ethics and Compliance for final approval. E & C will return the forms to the GME office, who will keep a copy on file and return forms to the Program Director. The resident's performance will be monitored for the effect of these activities upon performance and adverse effects may lead to withdrawal of permission.

D. This policy shall not apply to outside employment undertaken by a house officer during his or her annual leave or vacation periods, except that no such house officer may engage at any time in outside employment that constitutes a conflict of interest.

E. OUTSIDE EMPLOYMENT MUST BE REPORTED AS FOLLOWS:

Each house officer must complete an Outside Employment Declaration Form whether or not he/she plans to engage in outside employment. All outside employment must be approved prior to commencing such activity. The Outside Employment Declaration Form must be forwarded to the Office of Graduate Medical Education and signed by the Program Director, Department Chair and Associate Dean for Graduate Medical Education. The Program Director and Department Chair shall keep copies of housestaff declaration forms on file. The Program Director shall forward the original form to the Office of Graduate Medical Education.

F. Failure of housestaff to comply with this policy shall result in disciplinary action up to and including termination.

G. Outside Employment Declaration Form (Procedure should be followed for newly hired housestaff)

1. Newly hired/appointed housestaff shall receive an Outside Employment Declaration form from his/her Medical Education Office during personnel processing/upon appointment.

2. The Program Director is responsible for indicating whether or not outside employment has been approved by signing the Outside Employment Declaration Forms and submitting the original forms to the appropriate Department Chair. Copies shall also be retained by the Program Director.

3. The Department Chair is responsible for signing the Outside Employment Declaration forms as an indication that he/she agrees with the Program

Director and submitting the originals to the Associate Dean for Graduate Medical Education.

4. The Associate Dean for Graduate Medical Education is responsible for signing the forms as an indication that there is agreement with the Program Director, Department Chair, and GME policies. The GME office will submit completed signed forms to Ethics & Compliance for final approval.

Approved by GMEC on 2/23/99
Amended 5/13/03, 9/9/03 & 11/18/03, 08/11/09, 02/08/11

The University Approval Form for Outside Employment can be found under the "Document" section of this website. When completing the form, please include detailed information regarding the specific hours that will be worked and a statement that affirms compliance with the ACGME work hour limitations. The form must be signed by the resident, program director, departmental chair and Associate Dean for Graduate Medical Education.

EXHIBIT C
RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
DECLARATION/REQUEST FOR APPROVAL OF OUTSIDE EMPLOYMENT

HOUSESTAFF

PLEASE NOTE THAT BEFORE ENGAGING IN OUTSIDE EMPLOYMENT, APPROVAL IS REQUIRED FROM YOUR PROGRAM DIRECTOR, DEPARTMENT CHAIR AND ASSOCIATE DEAN FOR GRADUATE MEDICAL EDUCATION, AS WELL AS COMPLETION OF THE STATE OF NEW JERSEY OUTSIDE ACTIVITY QUESTIONNAIRE WITH APPROVAL FROM THE ETHICS LIAISON OFFICER

Date: _____ Program: _____

Name: _____ PGY Level _____
(please print)

PLEASE CHECK ONE: _____ Yes, I am requesting outside employment. (Complete information requested below.)
_____ No, I do not have outside employment.

NOTE: THERE IS NO MALPRACTICE COVERAGE FROM THE UNIVERSITY FOR OUTSIDE EMPLOYMENT

OUTSIDE EMPLOYMENT INFORMATION

Name of Employer _____ Telephone _____

Address _____

Title _____ Type of Work Performed _____

_____

Days & Hours of Work _____

Period of Outside Employment: From _____ To _____

(Attach additional sheets if necessary.)

I have read and understand the University's policies on Code of Ethics and Outside Employment. I attest that the information provided above is true. I understand that hours

worked during outside employment when combined with hours worked in the program must not exceed ACGME requirements.

_____

Housestaff Signature

I have reviewed this request with the employee and (check one)
_____there is no conflict; _____the conflict has been resolved and documented.

_____

Program Director Date

_____

Department Chair Date

_____ ❑ Approved ❑ Denied

Associate Dean for Graduate Medical Education

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: III. 2
SECTION: WORK SCHEDULES
SUBJECT: DUTY SCHEDULES AND RESIDENT DUTY HOURS

I. PURPOSE

To provide residency programs and housestaff with a policy on the scheduling of housestaff duty assignments which ensure compliance with all applicable ACGME requirements. Faculty members know, honor, and assist in implementing the applicable duty hour limitations. Residents comply with those limitations, accurately report duty hours, and cooperate with duty hour monitoring procedures. All involved identify and report sources of potential duty hour violations, and collaborate to devise appropriate corrective action.

II. SCOPE

This policy applies to all sponsored GME programs at the institution

III. DEFINITIONS

A. Duty hours: all clinical and academic activities related to the program. This includes patient care, administrative duties relative to patient care (including those, if any, conducted from home), provision of transfer of patient care, on-call time spent in-house, and scheduled activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

B. External moonlighting: Voluntary, compensated, medically-related work performed by a resident at a place which is NOT used by the sponsored program for training.

C. Internal moonlighting: Voluntary, compensated, medically-related work performed by a resident at this hospital or at any of the other sites used by the sponsored program for training.

D. Scheduled duty periods: Assigned duty at this hospital or other training site encompassing hours which may be within the normal work day, beyond the normal work day, or a combination of both.

IV. RESPONSIBILITY/REQUIREMENTS

A. Weekly limit: Duty hours are limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting (both external and internal). All moonlighting hours are reported as duty hours.

B. Days off: Residents have one day (24 hour period) every week free of all duty (including at-home call), when averaged over the four weeks of the rotation (unless the RRC for the program does not permit averaging.)

C. Maximum duty period length:

1. Duty periods of PGY-1s must not exceed 16 hours in length.

2. Duty periods of PGY-2 and above residents are limited to 24 hours of continuous duty in the hospital. The resident may remain on-site for transition of care and/or to attend an educational conference when that transition is completed, but may not perform additional clinical duties (including continuity clinic) during those additional 4 hours.

3. After 16 hours of continuous duty, residents are encouraged to engage in strategic napping, especially when the 16 hour mark occurs between 10:00 pm and 8:00 am, applying these procedures:

4. Individual exceptions to maximum duty hour period: In unusual circumstances, a resident may remain beyond their scheduled period of duty to continue to provide care to a single patient. In such a circumstance, these policies apply:

    a. The extension of the duty hour period must be <u>initiated</u> voluntarily by the resident – never assigned, or suggested, by a faculty member or senior resident.

    b. PGY-1s are not permitted to remain beyond their scheduled duty hour period.

    c. Possible justifications for this extension of the duty hour period include those established by each program's respective RRC.

    d. The resident must transfer the care of all other patients to the resident team responsible for their continuing care.

e. The resident will complete such reporting processes as established by the program to record the extended duty hour period.

f. The Program Director will review each submission of additional service.

D Time off between Scheduled Duty Periods:

1. PGY-1 residents should have 10 hours, and must have at least eight hours, free of duty between scheduled duty periods.

2. “Intermediate level residents,” as defined by each sponsored program’s RRC, should have 10 hours, and must have eight hours, free of duty between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

3. “Residents in their final years of education,” as defined by the sponsored program’s respective RRC, have flexibility in their duty hour assignments, which might be irregular
or extended. It is desirable that these residents have eight hours free of duty between scheduled duty hour periods, but there will be circumstances when they must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty. Those circumstances may include those specified by the respective RRC, and or program. Such instances of fewer than eight hours away from the hospital must be reported to, and will be monitored by, the Program Director.

4. In-House Night Float must not be scheduled for more than six consecutive nights.

5. At-Home Call

At home call must satisfy the requirement for one-day-in-seven free of duty, averaged over four weeks. Time spent in the hospital by a resident on at-home call must be reported in, and count toward, the 80 hour maximum weekly hour limit. Return to the hospital for episodic care while on at-home call does not initiate a new “off-duty period.”

E. The GME Office must receive, in advance, individual monthly program rotation schedules to review for compliance and to formulate monthly housestaff billings. The GME office will review individual Program hourly work and on-call schedules for compliance. Scheduled call that is not in compliance with this policy will be returned by the GME Office to the program director to be revised.

F. Oversight

1. 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 compliance with the limits described in this policy.

    a. The Program Director is responsible for duty schedules and, of necessity, must make the ultimate decisions regarding on call duty scheduling

    b. The program must monitor resident duty hours to determine if/that its trainees are in compliance with duty hour limits and must report to the GME office for presentation to the GMEC as required.

    c. .The on-call schedule should meet the residency requirements at set by the ACGME for all programs, as described in the Common Program Requirements, and for each training program as determined by its Residency Review Committee.

2. Each participating site where residents take call should have on call rooms and rooms for naps. Any problem or concern should be reported to the DIO

G. 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.

H. Duty Hours Exception

An RRC may grant exceptions for up to 10 % of the 80-hour limit, to individual programs based on a sound educational rationale. However, prior permission of the institution's GMEC is required.

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: III. 3
SECTION: WORK SCHEDULES
SUBJECT: DUTY HOUR EXCEPTION

I. PURPOSE

To provide a policy for granting exceptions to the 80 hours per week limit.

II. SCOPE

This policy is directed to all residency and fellowship program directors.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

The Program Director is responsible for complying with the 80 hours per week work schedule as defined in Policy III.2, and must comply with the following procedures as outlined below when requesting any expansion beyond the 80 hour maximum.

A. APPROVAL PROCESS

1. Program Director must submit in writing a formal request to the GMEC to expand the work hour schedule beyond the 80 hour maximum. This request to increase the housestaff work hours is limited to a maximum of 10 percent. The program director must specify the change in duty hour assignment by PGY level while providing a sound educational rationale.

2. The GMEC must review and formally endorse the request for an exception as noted above.

3. The Designated Institutional Official (DIO) or the Chair of the GMEC must formally endorse via signature the request for exception prior to forwarding to the RRC for review and approval.

B. RRC REVIEW AND APPROVAL

The RRC Review will:

1. formally review such proposals at its regular meetings and will retain documentation of its actions in the program's history;
2. judge whether the request justifies granting approval of the extension of the maximum weekly number of duty hours from 80 up to 88 hours, averaged over four weeks;
3. specify the assignments and level(s) of training to which the proposal applies if the requested exemption is granted; and
4. will stipulate the duration of the exception, which will be no longer than the next review.
5. In the event that the RRC denies a request, the action is not appealable.

Approved by the GMEC on 5/13/03

SECTION FOUR

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IV.1
SECTION: TIME OFF
SUBJECT: MEDICAL LEAVE AND FAMILY LEAVE

I. PURPOSE

To provide guidelines for use of medical leave and family leave.

II. SCOPE

This policy is directed to all members of the housestaff.

III. DEFINITION

Housestaff – refers to all interns, residents, and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. The University policies regarding medical leave and family leave, as they apply to housestaff, shall be fairly and uniformly applied.

B. Housestaff must notify their Chief Resident or Program Director if they are unable to work. Housestaff are responsible for keeping their Department or Program Director aware of their status.

C. Each department is responsible for maintaining a record of house officers' usage of medical leave and family leave for each year.

D. Sick Leave Days

House officers will be credited with twelve (12) sick leave days at the beginning of each academic year. First year house officers or house officers in their initial year of appointment are not eligible to use sick time until six full months have been completed. House officers can accumulate up to forty-eight (48) sick leave days. Medical leave shall be used when a house officer is unable to work due to illness or personal injury. Approval for use of this time shall not be unreasonably denied by the Chief Resident or Program Director.

E. Medical Leave

Each house officer is eligible for up to twelve weeks of medical leave (they are eligible after six months of service). A house officer can use any remaining allotment of his/her sick leave prior to being in an unpaid status. Once sick leave days have expired and before the house officer chooses to be in "leave without pay" status and apply for disability, the house officer shall have the option to use any remaining portion of his/her vacation days. Once paid leave days have expired, the house officer would be in "leave without pay status" and eligible to apply for temporary disability.

The house officer must provide appropriate medical documentation to his/her Program Director. Upon submission of the appropriate medical documentation, such leave shall be approved.

F. Family leave.

1. For Birth or Adoption of a Child
   All house officers are eligible for unpaid family leave upon the birth or adoption of a child after one year of service. This leave, in accordance with the Family Medical Leave Act and New Jersey State Law, can be up to twelve (12) weeks. A house officer can use paid vacation leave to cover a portion of this twelve week period. Upon submission of appropriate documentation to the Program Director, such leave shall be approved.

2. For Serious Illness in the Family
   All house officers are eligible for unpaid family leave to take care of a seriously ill family member after one year of service in accordance with the Family Medical Leave Act and New Jersey State Law. This leave can be up to twelve (12) weeks. A house officer can use paid vacation leave to cover a portion of this twelve week period. Appropriate documentation must be provided to the Program Director. Upon submission of appropriate medical documentation, such leave shall be approved.

G. Impact of leave on completion of training program

If cumulative absences negatively impact the number of months of training of a house officer with respect to the number of months required to satisfy the criteria for completion of a residency or fellowship program, the Program Director shall assess the house officer's ability to fulfill his/her residency education obligations and may require additional training in lieu of termination. Individual RRC criteria for satisfactory completion of each residency program will determine the amount of additional training required because of leaves of absence. Housestaff should also refer to requirements for specialty board exams to insure eligibility. Effective July 1, 2003, such additional work time after the end of the academic year shall be paid up to four months if needed, as described by the contract between RUTGERS Robert Wood Johnson Medical School and the CIR.

Approved by the GMEC on 2/23/99. Revised 6/2/99 & 2/10/04 to reflect changes in the contract between RUTGERS Robert Wood Johnson Medical School and the CIR. Editorially changed 11/5/07.

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IV.2
SECTION: TIME OFF
SUBJECT: BEREAVEMENT

I. PURPOSE

To establish a policy and procedure for a house officer's absence in the event of a death of a member of his/her immediate family.

II. SCOPE

This policy is directed to all members of the housestaff.

III. DEFINITION

Housestaff refers to all interns, residents, and fellows enrolled in a RUTGERS Robert Wood Johnson Medical School - postgraduate training program. A member of the housestaff may be referred to as a house officer.

Immediate Family Member is defined as a spouse, child, parent, legal guardian, sibling or parent of a spouse, or unmarried domestic partner. For unmarried domestic partners to be included, prior notice of the relationship must have been provided to the University's Office of Labor Relations.

IV. RESPONSIBILITY/REQUIREMENTS

A. If there is a death in the immediate family, a house officer may utilize sick leave for up to three (3) consecutive days of bereavement leave. The University may require reasonable and appropriate documentation of the relationship or of cohabitation, such as leases or drivers license, etc. Additional leave may be granted as may be necessary without pay upon request to the Program Director.

B. The house officer will inform the Program Director or his/her designee of the need for his/her immediate absence.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IV. 3
SECTION: TIME OFF
SUBJECT: HOLIDAY TIME

I. PURPOSE

To establish a policy and procedure for the scheduling of holiday time-off for housestaff.

II. SCOPE

This policy is directed to all members of the housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents, and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. Housestaff are entitled to the following holidays: New Year's Day, Martin Luther King, Jr's Birthday, Good Friday, Memorial Day Observance, Independence Day Observance, Labor Day, Thanksgiving Day, Day After Thanksgiving, Christmas Day and three (3) float holidays, one of which shall be taken within (30) days of the house officer's birthday, except as mutually agreed upon between the Program and the house officer.

B. Housestaff who work (including beeper calls) on a scheduled holiday shall be granted an alternate day off during the rotation in which the holiday occurs or shall receive an additional day's pay in lieu of the holiday. (This provision does not apply to the float holidays.) Scheduling of an alternate day off shall be with the approval of the Program Director or designee as appropriate. In the event that an alternate day off cannot be granted within 2 months of the holiday, holiday pay shall be granted. Pay in lieu of a holiday shall be at the rate of one tenth (1/10) of a bi-weekly pay.

C. Holidays falling on Saturday shall be observed the preceding Friday. Holidays falling on Sunday shall be observed the following Monday.

D. The University shall inform all Program Directors and the CIR of the procedure to be followed to obtain an additional day's pay in cases where an alternate day off is not granted. Each Program Director must complete a request for Holiday pay form and submit to the Office of Graduate Medical Education for processing and payment.

Approved by the GMEC on 2/23/99

SECTION FIVE

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V. 1
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: GENERAL RESPONSIBILITIES OF HOUSESTAFF

I. PURPOSE

To provide guidelines to housestaff regarding their general responsibilities as a RUTGERS Robert Wood Johnson Medical School trainee. Specific responsibilities are contained in departmental job descriptions and manuals.

II. SCOPE

This guideline applies to all medical records and all housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Policy:

The RUTGERS Robert Wood Johnson Medical School housestaff are expected to take advantage of the educational opportunities offered within the institution and provide medical treatment to the hospital's patients in a competent and caring manner. Moral, ethical and professional behavior is expected at all times.

To meet these responsibilities, housestaff are expected to:

1. Attend and actively participate in all conferences and teaching rounds within the assigned department.

2. Render appropriate medical care to patients in a kind caring manner under the supervision of the attending/consulting physician.

3. Attend assigned clinics.

4. Participate in the evaluation of the program, peers and teaching faculty as requested by the Program Director.

5. Participate in research projects and quality improvement activities of the Program or Affiliated Hospitals.

6. Document care and sign patient charts/medical records in a timely manner.

7. Volunteer to serve as a member of various departmental and hospital committees.

8. Be on time for all assignments.

9. Respond to pages on a timely basis.

10. Conduct themselves in an ethical and moral manner.

11. Maintain a professional appearance, comportment and conduct.

12. Assume progressive responsibilities as he/she gains experience.

13. Contribute to the overall success of the operation within the Department and Hospitals.

14. Provide supervision and instruction to less senior house officers and students.

15. Document completion of procedures and submit information on a timely basis to the Program Director's office.

16. Cooperate with nursing and support staff.

17. Perform "other duties" as required by your Department/Program Director.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V. 2
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: HOUSESTAFF INVOLVEMENT IN MEDICAL SCHOOL & HOSPITAL AFFAIRS

I. PURPOSE

To provide guidelines that identifies opportunities for housestaff participation in hospital affairs.

II. SCOPE

This policy is directed to all members of the housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and fellows enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

The Medical School and it's affiliated hospitals encourage housestaff to participate on hospital and departmental committees in an effort to continually upgrade the educational process and to enhance patient care.

The housestaff representatives to the committees are appointed by the Program Directors (except for the GMEC) who may solicit volunteers. Housestaff representatives are expected to attend all activities associated with committee membership.

To further an understanding of the organization and to take advantage of the contributions which housestaff members can make, the University and Hospitals have provided for housestaff representation on these staff committees:

MEDICAL SCHOOL

*Graduate Medical Education Committee

DEPARTMENTAL

Case Based Learning Committee

Family Practice Committee
Journal Club Committee
Patient Satisfaction OSCE Committee
Performance Improvement Committee
Q/A Trauma Committee
Resident Educational Curriculum Committee
Resident Training Committee

HOSPITAL

Capital Health System

Critical Care Committee
Library Committee
Medical Records Committee
Pharmacy Committee
Transfusion Committee

Deborah Heart & Lung Center

Institutional GMEC
Medical Education Committee
Library Committee

Muhlenberg Regional Medical Center

Critical Care Committee
Medical Education Committee
Medical Records Committee
Performance Improvement Committee
Pharmacy & Therapeutic Committee
Transfusion Committee

University Medical Center at Princeton

Biomedical Ethics Committee
Blood Utilization Committee
Cancer Control/Tumor Board
Critical Care Committee
Infection Control Committee
Pharmacy & Therapeutics Committee
Ulticare Physician Advisory

Robert Wood Johnson University Hospital

Ambulatory/ER Committee
Cancer Committee
Cardiac Care Unit Committee
Critical Care Unit Committee
Infection Control Committee
Humanism & Professionalism Committee
Medical Records Committee
Medical Records Review Committee
Medical Intensive Care Unit
Nutrition Committee
Operating Room Committee
OPTI Medicine Task Force
Pediatric Critical Care Committee
Performance Improvement Committee
Pharmacy & Therapeutics Committee
Professional Advisory Committee
Q/A Trauma Committee
Radiation Safety Committee
Respiratory Care Committee
Rehabilitation Committee
Safety Committee
Surgical Intensive Care Unit Committee
Transfusion Committee
Utilization Management Committee

St. Peter's University Hospital

Cancer Committee
Critical Care Committee
CQI Committee

Ethics Committee
Infection Control Committee
Medical Records Committee
Performance Improvement Committee
Pharmacy Committee
Radiation Safety Committee
Safety Committee
Transfusion Committee
Utilization Management Committee

*Voting Membership on this committee must include residents **nominated by their peers**, appropriate program directors, other members of the faculty and the accountable institutional official or his or her designee.

Approved by the GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V. 3
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: MEDICAL RECORDS

I. PURPOSE

To establish guidelines for the prompt and accurate completion of medical records.

II. SCOPE

This guideline applies to all medical records and all housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. The Medical Record reflects the quality of patient care given in a hospital. The record is the basic tool for planning patient care and for communication between physicians and other persons contributing to patient care. The medical record must document the course of each patient's illness and care and must be available to the housestaff at all times. The medical records system must support the education of housestaff and quality assurance activities and provide a resource for scholarly activity.

B. Records for which the housestaff are responsible must be completed and discharge summaries dictated on the day of or immediately after discharge.

C. Notification by the Hospital's Medical Records Department is sent to each department indicating delinquent charts. These charts must be addressed immediately by housestaff. (Delinquencies in chart completion may result in disciplinary action.)

D. Housestaff should familiarize themselves with departmental and hospital-specific or site-specific procedures for prompt completion of medical records and the sanctions which result if they are not completed in a timely fashion.

E. The Medical Records Committee at each major affiliate institution must have a resident representative.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: V.4
SECTION: RESPONSIBILITIES AND SUPERVISION
SUBJECT: RESIDENT SUPERVISION

I. PURPOSE

To ensure that sponsored residency programs provide appropriate supervision for residents in accordance with the ACGME Institutional and Common Program Requirements.

II. SCOPE

This policy will apply to all sponsored residency and fellowship programs at RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL-RWJMS

III. RESPONSIBILITIES AND REQUIREMENTS

A. Each sponsored residency program will develop a policy and procedure on resident supervision which specifies that residents are provided with progressively increasing responsibility for patient care according to their level of education, ability, and experience. These policies must specify the extent to which residents may undertake patient care without direct supervision. The program must use the following classifications of supervision:

1) Direct Supervision – the supervising physician is physically present with the resident and patient.

2) Indirect Supervision:

a. With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide direct supervision.

b. With direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephone and/or electronic modalities, and is available to provide direct supervision.

3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

B. PGY-1 residents should be supervised either directly or indirectly with direct supervision immediately available. PGY-1 residents should be supervised directly until the resident has demonstrated sufficient competence to progress to being supervised indirectly with direct supervision available. Each program will define and list (with guidance from the applicable ACGME RRC's Specialty-Specific Program Requirements and RRC FAQ's) specific examples of procedures or other patient care activities for which a minimum number of directly supervised activities must be performed successfully as the basis for granting indirect supervision status to a PGY-1.

C. The program director and faculty members must evaluate and determine the level of responsibility for each resident in the provision of patient care with/without supervision, and in assuming a supervisory role, based on specific programmatic criteria.

D. Each sponsored program is to establish schedules which assign qualified faculty physicians, residents or fellows to supervise, at all times and in all settings, in which residents provide any type of patient care. The type of supervision to be provided is delineated in the residency program curriculum's rotation description.

E. The program must list guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members. Each program will reference the applicable ACGME Residency Review Committee's (RRC) Specialty-Specific Program Requirements and Frequently Asked Questions (FAQ) to identify, and incorporate as appropriate, specific circumstances in which the resident – regardless of level of training – should communicate with their supervising faculty attending physician, if such circumstances have been identified by the RRC. Programs are encouraged to add to the RRC's list of mandated communication events as appropriate.

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

G. Each sponsored program will provide the Graduate Medical Education (GME) Office with a copy of its policy on supervision. The DIO will report to the GMEC on these policies. Once the policies have been considered appropriate by the GMEC, the programs will be required to annually report to the GME office their ongoing implementation of their policy. The DIO will report annually to the GMEC on this issue, which will take any action necessary.

Approved by the GMEC on 2/23/1999; amended September 14, 2011

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V.5
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: RESEARCH MISCONDUCT

I. PURPOSE

To establish policy and procedures for the University's response to allegations, reports and apparent occurrences of research misconduct involving research for which the University is the applicant or grantee, or which is proposed or conducted by or under the direction of any employee or agent of the University in connection with his or her institutional responsibilities. The objective of this policy is to ensure the prompt and appropriate investigation of alleged or apparent misconduct while protecting the rights of individuals, both those who report misconduct and those about whom allegations are made.

This policy is intended to implement the Federal Law 42 U.S.C. Section 289b and the regulations promulgated pursuant thereto, 42 CFR Parts 50 and 93.

II. APPLICABILITY

This policy applies to faculty members, housestaff, trainees, students (including postdoctoral fellows), volunteers, attending physicians and staff members.

Time limitations: This policy applies only to research misconduct occurring within six (6) years of the date the University or the research sponsor receives an allegation of research misconduct, with the following exceptions:

A. **subsequent-use exception**: the respondent continues or renews any incident of alleged research misconduct that occurred before the six-year limitation through the citation, re-publication or other use of the research record that is alleged to have been fabricated, falsified or plagiarized for the potential benefit of the respondent;

B. **health or safety-of-the-public exception**: the alleged research misconduct, if it occurred, would possibly have a substantial adverse effect on the health or safety of the public in the opinion of the University or the sponsor.

III. ACCOUNTABILITY

Under the direction of the President, the Executive Vice President for Academic and Clinical Affairs shall ensure compliance with this policy. The Vice President for Academic Affairs shall implement this policy.

IV. DEFINITIONS

A. **Research misconduct** – fabrication, falsification or plagiarism, committed intentionally, knowingly or recklessly, in proposing, performing or reviewing research, or in reporting research results. Research misconduct does not include honest error, conflicting data, differences of opinion, or differences in interpretations or judgments about data or experimental design.

Fabrication is making up data or results and recording or reporting them.

Falsification is manipulating research materials, equipment or processes, or changing or omitting data or results such that the research is not accurately represented in the research record.

Plagiarism is the appropriation of another person's ideas, processes, results or words without giving appropriate credit. Authorship or credit disputes, and "self-plagiarism" of an author's work from one paper to another or from a paper to a grant application are not ordinarily considered plagiarism.

B. **EVPACA** – Executive Vice President for Academic and Clinical Affairs.

C. **VPAA** – Vice President for Academic Affairs.

D. **DHHS** – Department of Health and Human Services.

E. **PHS** – Public Health Service.

F. **ORI** – Office of Research Integrity.

G. **Complainant** – the individual who made an allegation of research misconduct.

H. **Respondent** – the individual against whom the allegation was made.

I. **Good faith** – as applied to a complainant or witness, shall mean having a belief in the truth of one's allegation or testimony, which a reasonable person in the complainant's or witness's position would have, based on the information known to the complainant or witness at the time. An **allegation is not in good faith or is made in bad faith** if the complainant knew or had reason to know it was false, or if the allegation was made with reckless disregard for or willful ignorance of information that would negate the allegation.

J. **Inquiry** – preliminary information gathering and preliminary fact finding.

K. **Preponderance of the evidence** – proof by information that, compared with that opposing it, leads to the conclusion that the fact at issue is more probably true than not.

L. **Investigation** – formal development of a factual record and examination of that record leading to a recommendation to make or not to make a finding of research misconduct, and which may include recommendations for other appropriate actions, including administrative actions.

V. POLICY

A. RUTGERS Robert Wood Johnson Medical School, administration, staff, students and volunteers have an important responsibility to maintain high ethical standards in scientific research, research training programs, and activities related to such research or training. These standards include validity, accuracy and honesty in proposing and performing research, in collecting, analyzing and reporting research results, and in reviewing the research of others. Failure to observe these principles that result in research misconduct damages the general public trust, the entire scientific community, and the University's image. In addition, University personnel who commit research misconduct breach their obligations to the University.

RUTGERS Robert Wood Johnson Medical School faculty, administration, staff, students and volunteers also have the responsibility to report known or suspected instances of research misconduct to the appropriate Campus Committee on Research Integrity (see Section V.F. below).

B. The evidentiary standards for a finding of research misconduct shall be as follows:

1. **standard of proof**: the University finding of research misconduct must be proved by a preponderance of the evidence.

2. **burden of proof**: the University has the burden of proof for making a finding of research misconduct. The destruction, absence of, or respondent's failure to provide research records adequately documenting the questioned research is evidence of research misconduct where the University establishes by a preponderance of the evidence that the respondent intentionally, knowingly, or recklessly had research records and destroyed them; had the opportunity to maintain the records but did not do so, or maintained the records and failed to produce them in a timely manner; and that the respondent's conduct constitutes a significant departure from accepted practices of the relevant research community.

C. The University shall make reasonable and practical efforts to assure that:

1. the positions and reputations of those reporting alleged misconduct in good faith, witnesses in misconduct proceedings, and members of the Campus Committees and Investigative Panels are protected or restored, and that these individuals are protected from retaliation;

2. appropriate action will be taken against individuals who attempt to retaliate against those reporting misconduct in good faith, witnesses in misconduct proceedings, and members of the Campus Committees and Investigative Panels;
3. appropriate action will be taken against individuals found to have made unsubstantiated allegations in bad faith;
4. the reputations of respondents against whom no finding of research misconduct is made are protected or are restored if requested and as appropriate.

D. Confidentiality

Disclosure of the identity of respondents and complainants in research misconduct proceedings is limited, to the extent possible, to those who need to know, consistent with a thorough, competent, objective and fair research misconduct proceeding, and as allowed by law. However, confidentiality may not be maintained if the allegation is determined to be false and is found to be made in bad faith. Protection of confidentiality does not preclude disclosures that are necessary in the process of handling allegations of misconduct; are in the public interest or in the University's interest; are required by federal or state statute or regulations, University policy or rules of the research sponsor; or are a component of sanctions and/or corrective actions in the resolution of allegations of misconduct.

Except as may otherwise be prescribed by applicable law, confidentiality shall be maintained for any records or evidence from which research subjects might be identified. Disclosure is limited to those who have a need to know to carry out a research misconduct proceeding.

E. Immediate Notification

At any time during the course of the preliminary assessment, inquiry, investigation or other research misconduct proceeding, the following notifications shall immediately be made:

1. If the Campus Committee or Investigative Panel becomes aware of a risk to human subjects or deviations in an Institutional Review Board (IRB)-approved protocol, or other breach of University policy regarding human subjects research, the chair of the Committee or Panel shall notify the Executive Director of Human Subjects Protection and the Campus IRB Chair.

2. If the Campus Committee or Investigative Panel becomes aware of the commission of a criminal act, the Chair shall notify Public Safety.

3. If the Campus Committee or Investigative Panel becomes aware of incidents or complaints of retaliation, harassment or discrimination

against a complainant, respondent, witness, Campus Committee or Investigative Panel member, the Chair shall notify the VPAA and the Office of Compliance Auditing. The Office of Compliance Auditing shall perform investigations as appropriate.

4. If the Campus Committee or Investigative Panel becomes aware of non-compliance with federal or state law or regulation or with University policy, the Chair shall notify the Office of Business Conduct and the Office of Legal Management.

5. If the Campus Committee or Investigative Panel becomes aware of any facts that may affect current or potential federal or other funding for the respondent, or facts that the funding agency or sponsor needs to know to ensure appropriate use of federal or other funds and otherwise protect the public interest, the Chair shall notify the VPAA who shall apprise ORI or the pertinent funding agency or sponsor.

6. At any time during a research misconduct proceeding, the VPAA shall be informed and shall notify immediately ORI (in the case of research conducted under a PHS grant or if the research results were used in a PHS grant, fellowship or contract application), or another funding agency or sponsor if there is reason to believe that any of the following conditions exist:

    a. Health or safety of the public is at risk, including an immediate need to protect human or animal subjects.

    b. DHHS resources or interests are threatened.

    c. Research activities should be suspended.

    d. There is reasonable indication of possible violations of civil or criminal law.

    e. Federal action is required to protect the interests of those involved in the research misconduct proceeding.

    f. The University believes the research misconduct proceeding may be made public prematurely so that DHHS may take appropriate steps to safeguard evidence and protect the rights of those involved.

    g. The research community or public should be informed.

F. Campus Committees on Research Integrity

Three Campus Committees on Research Integrity shall be established, one each for Newark, Piscataway/New Brunswick and Camden/Stratford. These Committees shall be called together by the Chairperson or his/her designee on an as-needed basis to review allegations and reports of research misconduct and apparent instances of misconduct.

1. Membership

   Membership of the Campus Committees shall consist of tenured faculty members representing the Schools on that campus. Members shall represent a mixture of the basic and clinical sciences, and shall have strong research experience and other appropriate qualifications to judge the issues raised by allegations of research misconduct.

   a. The Newark Committee shall have seven members, two faculty members from New Jersey Medical School (one of which shall be from the basic sciences and the other from the clinical sciences), and one faculty member each from the Graduate School of Biomedical Sciences-Newark Division, New Jersey Dental School, School of Health Related Professions, School of Nursing, and School of Public Health.

   b. The Piscataway/New Brunswick Committee shall have six members, three faculty members from RUTGERS Robert Wood Johnson Medical School(representing both the basic and clinical sciences) and one faculty member each from the Graduate School of Biomedical Sciences-Piscataway Division, School of Health Related Professions, and School of Public Health.

   c. The Camden/Stratford Committee shall have six members, one faculty member each from RUTGERS Robert Wood Johnson Medical School-Camden, School of Osteopathic Medicine, Graduate School of Biomedical Sciences-Stratford Division, School of Nursing, School of Health Related Professions and School of Public Health.

2. Appointment

   Members shall be appointed by the EVPACA upon the recommendations of the Deans.

3. Term of Appointment

   Members of the Campus Committees shall serve for terms of three years which may be renewed. In the event of an extended absence or resignation of a Campus Committee member, an alternate to serve out the term shall be appointed by the EVPACA in the same manner as original appointments.

4. Chair

Each Campus Committee shall elect a chairperson who should be at the rank of full professor, and who shall serve for a term of two years. The Chairperson or designee shall call all meetings in response to the receipt by any member of the Campus Committee of a report or allegation of research misconduct.

5. Functions

The functions of the Campus Committees shall be to:

a. receive reports or allegations of research misconduct, which can be written or oral statements or other communications, from any source within or external to the University about University individuals working and/or studying on that campus or whose primary academic appointment is at a School on that campus; however, when appropriate, any given allegation may be assigned by the Campus Committee for action to another Campus Committee;

b. conduct inquiries of allegations of research misconduct, and send resulting reports to the EVPACA; and

c. supply the VPAA with the information needed to make the University's annual submission to ORI pursuant to 42 CFR Parts 50 and 93.

6. Expenses of the Campus Committees

Expenses related to the general functioning and training of the Campus Committees shall be borne by the Schools on that campus.

G. Inquiry

The inquiry shall involve information gathering and preliminary fact finding to determine whether an allegation of research misconduct or apparent instance of misconduct has substance and warrants further investigation.

1. Preliminary Assessment

On behalf of the Campus Committee, the chairperson shall perform a preliminary assessment of an allegation or report to determine if an inquiry is warranted. Criteria warranting an inquiry are: whether the allegation falls within the definition of research misconduct as set forth in Section IV.A; and whether the allegation is sufficiently credible and specific so that potential evidence of research misconduct may be

identified. This determination shall take place within ten (10) working days of the Committee's receipt of the allegation or report, and shall be final. When an inquiry is not felt to be warranted, the Committee's reasons shall be documented and the complainant shall be informed. The identification of the respondent shall be kept confidential from everyone without a need to know.

In the case of research disputes when an inquiry is not felt to be warranted, the Committee may recommend other resources at the School or University, including the services of the School's research ombudsperson.

2. Initiation of Inquiry

The Campus Committee (hereinafter the Inquiry Committee) shall meet to begin the inquiry within ten (10) working days of the chair's determination that the allegation warrants an inquiry.

3. Notification of Inquiry

At the time of or before the initiation of the inquiry, the respondent, the complainant, the Dean of the appropriate School, the President/CEO of the pertinent patient care unit or the Vice President of the pertinent administrative unit (in the case of a non-faculty respondent who is an employee of such unit), and the VPAA shall be notified in writing of the inquiry by the Chairperson of the Inquiry Committee. If the Inquiry Committee subsequently identifies additional respondents, the Chairperson shall notify them in writing. Under certain circumstances set forth in Section V.E., ORI in the case of research conducted under a PHS grant, or another pertinent funding agency must be immediately notified.

4. Rights and Obligations of the Respondent

The respondent shall be informed of the charges, of the opportunity to be heard, as well as the obligation to cooperate fully, and that unreasonable refusal to supply relevant material or other uncooperative behavior shall constitute violation of this policy.

5. Sequestering of the Research Record and Evidence

No later than the time the respondent is notified of the allegation and/or the inquiry begins, whichever is earlier, the Inquiry Committee shall, with the assistance of the Dean's or Vice President's office and/or of campus security and/or Information Services & Technology personnel if necessary, take all reasonable and practical steps to obtain custody of any original data, research records and evidence, and other material and documents necessary to the conduct of the inquiry and potential future

investigation, and sequester them in a secure manner. Where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments. An inventory shall be made of each item removed. This inventory shall be signed by the Inquiry Committee Chairperson or designee, and a copy given to the respondent. Efforts should be made to permit the research to continue while the inquiry and other procedures go forward. Where appropriate, the Committee Chairperson or designee shall give the respondent copies of or reasonable supervised access to the sequestered research records and evidence during the proceedings. Materials sequestered shall be stored in a manner to ensure their preservation.

In the event, during the course of the inquiry, future investigation or other research misconduct proceeding, there is a need for additional research records or evidence necessary for the conduct of the proceedings, all reasonable and practical efforts will be made to take custody of, inventory and sequester such records or evidence, except that where the research records or evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.

6. Conflict of Interest/Bias

It is the responsibility of each member of the Inquiry Committee to divulge potential conflicts of interest. In the event that any member of the Inquiry Committee has any real or apparent, unresolved personal, professional or financial conflicts of interest or bias with respect to the respondent, complainant, witnesses or case, that member shall be recused. Such conflicts include, but are not limited to, involvement with the research in question, competition with the respondent, and a previous or ongoing close personal, professional or academic relationship with respondent, complainant or witnesses.

7. Staff to Inquiry Committee

The EVPACA and the Vice President for Legal Management shall assign non-voting staff to assist the Inquiry Committee. Staff shall consider themselves and their activities for the Inquiry Committee as strictly confidential.

8. Consultants and *Ad Hoc* Members for Inquiry Committee

For purposes of the inquiry, the Inquiry Committee in its discretion, may seek expert scientific advice and/or decide to add *ad hoc* members such as experts in a particular field.

9. Duration of Inquiry

The Inquiry Committee shall complete the inquiry and prepare a written report for the EVPACA summarizing the conduct of the inquiry and the reasons for its recommendations within sixty (60) calendar days from the date the inquiry began. If circumstances warrant a longer period, the record shall include documentation of the reasons for exceeding the 60-day period, and the respondent shall be so notified in writing.

10. Recommendations of Inquiry Committee

The Inquiry Committee shall decide by majority opinion whether to recommend that the allegation warrants an investigation to formally examine and evaluate all relevant facts to determine if misconduct has occurred. A recommendation for investigation is warranted if:

a. there is a reasonable basis for concluding that the allegation falls within the definition of research misconduct, and

b. the preliminary information gathering and preliminary fact finding from the inquiry indicate that the allegation has substance.

If the Inquiry Committee does not recommend an investigation, the reasons for this decision shall be documented in sufficient detail to permit future assessments of this decision by ORI or another sponsor or agency. The Inquiry Committee may make recommendations to the EVPACA regarding reasonable and practical actions to protect or restore the reputation of the respondent, and should consult with the respondent in this regard. The Inquiry Committee may also make recommendations to the EVPACA concerning actions against a complainant found to have made unsubstantiated allegations in bad faith. The Inquiry Committee may also make recommendations to the EVPACA about the conduct of the research in question or related matters in order to mitigate problems and/or ameliorate circumstances brought to the attention of the committee during the inquiry but which did not warrant an investigation.

If the Inquiry Committee recommends an investigation and finds there is a high probability that false or misleading information has been or may be disseminated to the scientific community and that such dissemination could cause significant harm, the Committee may recommend that the EVPACA, if he or she initiates an investigation, inform the following individuals of the existence and status of the investigation: (1) editors of scientific journals in which articles or other publications concerning the

research under investigation have been published or are pending publication; and (2) program directors of scientific meetings at which the research under investigation is scheduled to be presented.

11. Report of Inquiry Committee

A written report summarizing the conduct of the inquiry and the reasons for the Inquiry Committee's recommendation shall be prepared for the EVPACA. The respondent shall be given a copy of the report and the opportunity to provide written comments on the report. The respondent's comments, if any, shall be made part of the record. Comments of the respondent about the Committee's recommendation must be filed with the Committee within five (5) working days of receipt of the report. The complainant shall be notified in writing of the Committee's recommendation. Relevant portions of the report may be provided to the complainant for comment at the discretion of the Inquiry Committee.

12. Decision and Actions of the SVPAA

The EVPACA has the sole discretion to accept, reject, modify or seek additional information about the recommendation of the Inquiry Committee. The EVPACA shall make a final decision concerning the recommendation of the Inquiry Committee within ten (10) working days of receipt of the Committee's report.

a. If the EVPACA decides that further investigation is not warranted, the case shall be closed. The reasons for the EVPACA's decision shall be documented in sufficient detail to permit future assessments of this decision by ORI or another sponsor or agency.

The EVPACA shall notify in writing the respondent, the complainant, all individuals interviewed or otherwise informed of the allegation, and the appropriate Dean or Vice President of the disposition of the allegation. In the event that ORI or another pertinent funding agency or sponsor was notified during the inquiry, under the circumstances enumerated in Section V.E., the same shall be informed by the EVPACA of the finding of no cause following the inquiry, and that the University considers the case closed. If requested and appropriate, and in consultation with the respondent, all reasonable and practical efforts shall be undertaken to protect or restore the reputation of the respondent.

If the EVPACA finds that the allegation was made in bad faith, he/she shall determine whether and what administrative actions should be taken against the complainant pursuant to applicable University policies, procedures or contracts.

At the appropriate time following notifications of the EVPACA's decisions, all research records, original data and other evidence and materials sequestered by the Inquiry Committee from the respondent or complainant or furnished by others shall be returned, and the return documented by signed receipts.

The Chairperson of the Inquiry Committee shall gather the original records of the proceedings of the inquiry and copies of all pertinent documents and other materials furnished to the Committee. This file shall be sent to the EVPACA who shall seal it and retain it in a locked confidential cabinet for at least seven (7) years, and preferably indefinitely, after termination of the inquiry. The records shall, upon request, be provided to authorize personnel representing the funding agency or sponsor. Otherwise, access to materials in the file shall be available only upon authorization of the EVPACA for exceptional cause.

b. If the EVPACA decides that further investigation is warranted, the EVPACA shall initiate an investigation. All files accumulated by the Inquiry Committee in this matter shall be transferred to the Office of the EVPACA.

The EVPACA shall provide notice in writing to the respondent, the complainant, the appropriate Dean or Vice President, and the Vice President of Legal Management of the decision to perform an investigation before the investigation begins. If the research in question was funded by the PHS or if the research results were used in a PHS grant, fellowship or contract application, the EVPACA, on or before the date the investigation begins, will write to the Director of ORI reporting the decision to initiate an investigation and attaching a copy of the inquiry report, which shall include the following information:

1) the name and position of the respondent;

2) a description of the allegation of research misconduct;

3) the PHS support, including grant numbers, grant applications, contracts, and publications listing PHS support;

4) the basis for deciding that the alleged actions warrant an investigation; and

5) any comments on the report by the respondent or the complainant.

If the research in question was funded by an agency or sponsor other than the PHS which has similar reporting requirements, the EVPACA, within 30 days of deciding that an investigation is warranted, will communicate the same information as above to the director of that agency or sponsor. The EVPACA may also decide to notify certain editors of journals or program directors of scientific meetings.

13. Expenses of the Inquiry

Expenses of inquiries shall be borne by the Dean or Vice President in whose School or Unit the respondent's research in question has been or is being conducted.

H. Investigation

The investigation shall be a formal, thorough and documented examination and evaluation of all relevant facts, research records and other evidence to determine if a recommendation should be made that research misconduct has occurred. It shall include interviewing the complainant and the respondent as well as others who might have relevant information; reviewing original data, research records and other evidence and documents; talking with experts; considering materials and/or comments submitted by the respondent and complainant; reviewing relevant literature, publications, correspondence, memos, etc. An investigation shall begin within thirty (30) days after the EVPACA's decision that an investigation is warranted.

1. Notice to and Rights and Obligations of Respondent

Before the investigation begins, the respondent shall be notified in writing of the allegations to be considered in the investigation, the opportunity to be heard and to present witnesses, and the obligation to cooperate fully with the investigation. Such notice shall inform the respondent that the investigation may recommend: (a) whether or not research misconduct has occurred; and/or (b) if the actions or conduct investigated are/is otherwise unacceptable within the University for proposing, performing or reviewing research or reporting research results. The respondent shall also be informed that unreasonable refusal to supply relevant material or other uncooperative behavior constitutes violation of this policy.

The respondent shall be given written notice of all new or additional allegations to be considered in the investigation which were not stated in the original notice of the investigation.

2. Formation of Investigative Panel

An investigative panel shall be appointed by the EVPACA, consisting of three scientists with strong research experience and other appropriate qualifications to judge the issues raised in the investigation. These individuals may be internal to the University or external. University faculty serving on investigative panels must be tenured. Members of the Inquiry Committee shall not be appointed to the Investigative Panel.

3. Conflict of Interest/Bias

Individuals appointed to the Investigative Panel shall not have any real or apparent, unresolved personal, professional or financial conflicts of interest or bias with respect to the respondent, complainant, witnesses, or case. For example, Panel members should not be involved with the research in question, should not be professional competitors with the respondent, and should not have a previous or ongoing close professional or academic relationship with the respondent, complainant or witnesses.

4. Objections to Proposed Investigative Panel Members

The respondent and the complainant shall be informed of the proposed membership of the Investigative Panel. If the respondent or the complainant objects to the participation of any member of the Investigative Panel based upon personal, professional or financial conflict of interest or bias with respect to the respondent, complainant, witnesses, or case, this objection must be made in writing within five (5) working days to the EVPACA who shall decide whether to replace the challenged member. The decision of the EVPACA shall be final. Such challenges to the membership of the Investigative Panel must be resolved prior to the official appointment of the members by the EVPACA.

5. Charge to Investigative Panel

The EVPACA shall administer the charge to the Panel. The official date of the initiation of the investigation shall be the date of the first meeting of the Investigative Panel. This shall be within thirty (30) calendar days of the decision of the EVPACA that an investigation is warranted.

6. Chairperson of Investigative Panel

The Investigative Panel shall choose its chairperson at its first meeting.

7. Staff to Investigative Panel

The EVPACA and the Vice President for Legal Management shall assign non-voting staff to assist the Investigative Panel. Staff shall consider themselves and their activities for the Investigative Panel as strictly confidential.

8. Conduct of Investigation

a. Procedural Protections

Every effort shall be made to ensure a comprehensive, impartial, unbiased and expeditious investigation. The respondent shall have the opportunity to examine all evidence forwarded to the Panel, to present evidence to the Panel, including witnesses on the respondent's behalf, and to ask questions of the witnesses, including the complainant. Anonymous third-party statements will not be considered as evidence.

b. Security

Files shall be kept in a central location in a locked cabinet, accessible only to the appropriate individuals taking part in the investigation.

c. Testimony before the Investigative Panel

Tape recordings shall be made of all testimony given. Documentation (including original data) substantiating the Investigative Panel's findings will be carefully secured, prepared and maintained. Transcriptions of each taped interview shall be provided to the person interviewed for comment and correction, and included as part of the record of the investigation.

d. Sequestering of Additional Research Records and Evidence

To the extent not already carried out earlier, the University or the Investigative Panel shall secure, inventory and sequester in a secure manner additional pertinent original research data, research records and evidence, and other material and documents from the respondent or others, per the procedures in Section V.G.5 of this policy, before or at the time the respondent is notified of the investigation, and whenever additional items become known or relevant to the investigation.

e. Consultants for Investigative Panel

The Investigative Panel may seek additional expert scientific advice.

f. Broadening/Change in Subject Matter of Investigation

If, during the investigation, information becomes available which the Panel considers substantially related to the original charge from the EVPACA, the Panel may broaden the scope of its charge and must give written notice to the respondent of the new scope. If the Panel does not consider the new information substantially related to the original charge, the Panel may refer the new information to the Campus Committee as the basis of a new allegation.

9. Duration of Investigation

The investigation shall be completed within eighty (80) calendar days of its initiation date to allow sufficient time for review of the Investigative Panel's report by the respondent and the EVPACA, and submission of the University's report, including the decision of the EVPACA, to the funding agency, within a total of one hundred and twenty (120) calendar days of the initiation of the investigation. If the investigation cannot be completed within these time limits, the University may request an extension of time from ORI (in the case of research conducted under a PHS grant or if the research results were used in a PHS grant, fellowship or contract application) or from another pertinent funding agency or sponsor if required. If such an extension is granted, the respondent shall be so notified.

10. Recommendation of Investigative Panel

The requirements for reaching a recommendation of research misconduct are:

a. there was fabrication, falsification or plagiarism in proposing, performing or reviewing research, or in reporting research results;

b. the fabrication, falsification or plagiarism was committed intentionally, knowingly or recklessly; and

c. the allegation was proved by a preponderance of the evidence.

The Investigative Panel's recommendation shall be the majority opinion. There may be a minority report. The results of any vote taken shall be made known to the EVPACA in the written report of the Investigative Panel.

11. Report of the Investigative Panel

Upon conclusion of its investigation, the Investigative Panel shall prepare a draft written report. A copy of the draft report shall be given to the

respondent with the opportunity to provide written comments on the report, which must be considered and addressed by the Panel before issuing the final report. Concurrently, the respondent must be given a copy of or supervised access to the evidence on which the report was based. At the discretion of the Investigative Panel, the complainant may be provided with those portions of the draft report that address his/her role and opinions in the investigation. Comments, if any, from the respondent and complainant must be filed with the Panel within thirty (30) calendar days of receipt of the Panel's draft report. These comments shall be made part of the final report and considered by the EVPACA. A copy of the final report shall also be given to the appropriate Dean or Vice President.

The contents of the final investigation report must include:

a. Allegations – description of the nature of the allegations of research misconduct;

b. If applicable, the PHS support – description and documentation of the PHS support, including any grant numbers, grant applications, contracts, and publications listing PHS support;

c. Institutional charge – description of the specific allegations of research misconduct considered in the investigation;

d. Policies and procedures – inclusion of this policy (if not already provided to ORI or another sponsor with the inquiry report);

e. Research records and evidence – identification and summary of the research records and evidence reviewed, and identification of any evidence taken into custody but not reviewed;

f. Statement of recommendations – for each separate allegation of research misconduct identified during the investigation, the recommendation as to whether research misconduct did or did not occur; if the recommendation was that research misconduct did occur:

    1) Whether the research misconduct was falsification, fabrication or plagiarism committed intentionally, knowingly or recklessly;

    2) a summary of the facts and the analysis which support the conclusion and consideration of the merits of any reasonable explanation by the respondent;

    3) identification of the specific PHS support, if any;

4) whether any publications need correction or retraction;

5) the person(s) responsible for the misconduct; and

6) any current support or known applications or proposals for support that the respondent has pending with non-PHS federal or other agencies or sponsors.

g. Comments of respondent and complainant - inclusion and consideration of any comments made by the respondent and complainant on the draft investigation report.

The report may make recommendations about corrective measures, if any, to be taken.

The report may also include recommendations that a finding be made that the respondent has engaged in practices that are unacceptable within the University for proposing, performing or reviewing research, or reporting research results, whether or not research misconduct was found. The report may make recommendations about corrective actions, if any, to be taken under these circumstances.

The report may also include the Panel's concerns that violations of other University policies or of federal or state regulations may have occurred, with recommendations to refer these concerns for administrative action.

In addition, the Panel may make recommendations concerning notification of law enforcement agencies, professional societies, licensing boards, journal editors, collaborators of the respondent or other concerned parties of the outcome of the investigation.

In the event of a recommendation that there be no finding of misconduct, the Investigative Panel, after consultation with the respondent, may make recommendations to the EVPACA regarding actions to protect or restore the reputation of the respondent. The Investigative Panel may also make recommendations to the EVPACA concerning actions against a complainant found to have made unsubstantiated allegations in bad faith.

The Investigative Panel may also make recommendations to the EVPACA about the conduct of the research in question or related matters in order to mitigate problems and/or ameliorate circumstances brought to the attention of the Panel during the investigation but which did not warrant a finding of misconduct.

12. Expenses of the Investigation

The expenses of the investigation, including external consultants' fees if any, shall be borne by the pertinent Dean or Vice President.

13. Decision and Actions of the SVPAA

The EVPACA shall review the final report of the Investigative Panel and shall make a final decision in writing on behalf of the University.

The EVPACA may make one of the following decisions:

a. finding of no misconduct: If requested and appropriate, all reasonable and practical efforts shall be made, in consultation with the respondent, to protect or restore the reputation of the respondent, and appropriate action shall be taken against complainants found to have made unsubstantiated allegations in bad faith.

b. finding of misconduct: The decision shall include the EVPACA's determination about the appropriate corrective actions. The EVPACA shall either accept the Investigative Panel's recommendation about corrective actions or impose alternatives. Discipline imposed for research misconduct shall be exempt from grievance and arbitration proceedings. The EVPACA may direct the authors to withdraw from publication all pending abstracts and papers that are considered to be of questionable scientific validity as a result of the finding, and may notify the editors of journals, books and other publications in which the respondent's previous papers and abstracts have appeared during the preceding five years.

c. finding that actions or conduct investigated are/is unacceptable within the University for proposing, performing or reviewing research or for reporting research results, but do/does not constitute research misconduct. The decision shall include the EVPACA's determination about appropriate corrective actions.

14. Notification of Decision of SVPAA

The SVPAA shall provide a copy of his/her final decision to the respondent, the complainant, the Investigative Panel, the pertinent Dean or Vice President, and the Vice President for Legal Management.

The SVPAA shall forward to ORI (in the case of research conducted under a PHS grant or if the research results were used in a PHS grant, fellowship or contract application) or to another external funding agency or sponsor a copy of his/her final decision, together with the Investigative Panel's final report with all attachments, and any pending or completed institutional administrative actions against the respondent.

The SVPAA shall inform editors of scientific journals and program directors of scientific meetings who had been notified of the existence of an investigation, and all individuals interviewed or otherwise informed of the allegation of the outcome of the investigation.

I. Termination of the Case

1. Creation, Sealing, Storage of and Access to the File

The EVPACA shall ensure that the complete file, including the original records of all proceedings conducted by the Inquiry Committee and by the Investigative Panel, copies of all documents and other materials furnished to the Committee and the Panel, and transcripts of recordings of all interviews, is sealed and retained in a locked confidential cabinet for at least seven (7) years, and preferably indefinitely, after termination of the investigation. Access to materials in the file shall be available only to ORI in the case of research funded by PHS or if the research results were used in a PHS grant, fellowship or contract application, or to another sponsor with similar requirements, or upon authorization of the EVPACA for exceptional cause.

2. Return of Sequestered Data and Other Materials

The EVPACA shall decide on a case-by-case basis when the research records, original data, evidence and other original materials sequestered during the inquiry or investigation may be returned. Among the determining factors in this decision are the requirements of pertinent government agencies or other sponsor.

J. Investigation by Federal Agencies

Under 42 CFR Parts 50 and 93, federal agencies have reserved the right to perform their own investigation in cases involving federally funded research at any time prior to, during, or following the University's investigation, and to impose corrective actions of their own in addition to those imposed by the University.

K. Withdrawal of Allegation by Complainant

If the complainant withdraws his or her allegation prior to the completion of the inquiry or investigation, the proceedings shall continue if sufficient information is available to warrant such continuance.

L. If Respondent leaves the University

If the respondent leaves the University prior to the completion of the inquiry or investigation, the inquiry and investigation, if any, shall nevertheless continue

according to the procedures described above, and the respondent shall be afforded full opportunity to participate. The EVPACA may inform the respondent's new employer, if any and if known, of the existence and status of the investigation and of the final findings of the investigation.

M. Admission of Research Misconduct by Respondent

If the respondent admits to research misconduct prior to the completion of the inquiry or investigation, the admission must be in writing and must detail the full scope of the misconduct. An inquiry and investigation should ordinarily be conducted and continued to conclusion if doing so will uncover the scope of the misconduct or other problems and result in recommendations to the EVPACA. Under these circumstances, the inquiry and investigation shall be conducted according to the procedures described above. If the Inquiry Committee believes that no purpose will be served by an investigation, it may make that recommendation to the EVPACA, and the inquiry may serve as the investigation. In this event, the EVPACA shall notify in advance ORI (if the research in question was funded by PHS, or if the research results in question were used in a PHS grant, fellowship or contract application), or another sponsor with similar requirements if the University plans to close the case prior to conclusion of a full investigation based on the respondent's admission of guilt or for any other reason. By Direction of the President:

Vice President for Academic Affairs

University Policy Code: 00-01-20-60:00
Adopted: 07/15/89
Amended: 02/28/06 & 10/12/07

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V.6 MAGGIE'S LAW
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: COMPLIANCE WITH MAGGIE'S LAW

I. PURPOSE

To establish guidelines for housestaff adherence to "Maggie's Law", which refers to N.J.S.2C:11-5 2C:11-5. "Death by auto or vessel.

A. Criminal homicide constitutes vehicular homicide when it is caused by driving a vehicle or vessel recklessly. (For the purposes of this section, driving a vehicle or vessel while knowingly fatigued shall constitute recklessness. 'Fatigued' as used in this section means having been without sleep for a period in excess of 24 consecutive hours.) Proof that the defendant fell asleep while driving or was driving after having been without sleep for a period in excess of 24 consecutive hours (shall) may give rise to an inference that the defendant was driving recklessly."

B. "vehicular homicide is a crime of the second degree."

II. SCOPE

This applies to all postgraduate medical education programs and individual housestaff members.

III. DEFINITIONS

Housestaff - refers to all interns, residents and fellows enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Housestaff and residency program directors should be aware of the potential problems that may result from driving a vehicle after having been without sleep for a period in excess of 24 consecutive hours.

B. Housestaff who have been without sleep for a period in excess of 24 consecutive hours must, before driving, take one or more of the following actions.
1. sleep for a period of time sufficient to feel rested before driving

2. arrange to be driven to their home/ place of residence, alternative site
3. take public transportation to their home/ place of residence, alternative site.

C. The responsibility of the clinical site(s) is to ensure that a place conducive to sleep is available to residents at the end of any shift of 24 or more consecutive hours.

D. The program director shall inform all residents of the potential impact of sleep deprivation and fatigue on performance and the provisions of Maggie's Law. The program director must also ensure that any site at which residents work 24 hours has a space available that is conducive to sleep.

E. Oversight:
1. Each program must have written policies and procedures consistent with Maggie's Law. These policies must be distributed to the residents and the faculty and kept on file in the GME office. The program, the program director, and the faculty must monitor compliance with this policy
2. The GME office will oversee that programs comply with this policy.

Approved by GMEC on June 14, 2005

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: V.7
SECTION: RESPONSIBILITIES & SUPERVISION
SUBJECT: AUTHORSHIP OF COLLABORATIVE RESEACH

I. PURPOSE

To establish guidelines for authorship when publishing collaborative research projects.

II. SCOPE

This policy will apply to all housestaff in postgraduate training programs at the RUTGERS Robert Wood Johnson Medical School.

III. DEFINITIONS

Housestaff – refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

A. Housestaff are expected to conduct research and scholarly activity as part of their residency/fellowship training.

B. Housestaff are encouraged to collaborate, not only with faculty members, but also with housestaff and faculty of different departmental divisions, as well as other departments.

C. When such collaboration is anticipated, the housestaff should inquire about the interest of the relevant housestaff and faculty within their own departments and with other departments and the expectations of all parties should be agreed upon before the research begins. Authorship of abstracts, papers and presentations to local, national and international meetings should be discussed and agreed upon.

Each individual's contribution should adhere to the *RUTGERS* Robert Wood Johnson Medical School *Guidelines for Conduct of Research* http://www.rutgers.rwjms.edu/acadweb/Guidelines.pdf

“Clear policies on authorship should be established by each laboratory and research group. Authorship should be limited to those who have made a **substantial intellectual or technical contribution** to the conception, planning, design and/or performance of the research, and/or to the analysis and interpretation of the data. If possible, all such individuals should participate in drafting or revising the manuscript. In certain disciplines and in certain journals, the scope of the contribution of each author may be indicated in a statement or acknowledgment in the manuscript. Certain individuals who participate in or make specialized contributions to a study may more appropriately be acknowledged in the manuscript as having contributed materials, support, patients, advice, funds, etc., or as having collected the data, but should not be listed as authors. *General supervision of the research group is not sufficient for authorship. Purely "honorary" or mandatory authorships (as in the case of non-contributing department chairs, section heads or supervisors) violate these principles and are not acceptable.*

Ghost or guest authorship is also unacceptable, because authorship implies independent, substantial and fully disclosed participation in the research and in the preparation of the manuscript. However, a representative of a study sponsor may assist in drafting the manuscript if this activity is fully disclosed in the paper and to the journal.

The primary (submitting) author should have reviewed all primary data on which the manuscript is based, and be able to identify the specific contributions of each co-author. He/she has overall responsibility for determining co-authorship, for ensuring the review and approval of the final manuscript by each co- author, for defending the study if necessary, and for making responses to post-publication questions and challenges. Each author should review, approve, take responsibility for, and be prepared to defend his or her specific contributions to the research and those aspects of the publication in his or her area of expertise, even if no longer associated with the research group or laboratory. If possible, all authors should be able to agree with, take responsibility for, and defend the conclusions and interpretations of the entire manuscript. In collaborative work, scientists of each research group are expected to accept responsibility for the work done in their group; in such collaborations, authors should nevertheless review all aspects of the research.”

Approved by the GMEC 04/08/08

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY
GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: V.8
SECTION: RESPONSIBILITIES AND SUPERVISION
SUBJECT: TRANSITIONS OF CARE

I. PURPOSE

To ensure that sponsored residency and fellowship programs implement safe and accurate transitions of patient care procedures in accordance with the ACGME Institutional and Common Program Requirements.

II. SCOPE

This policy will apply to all sponsored residency and fellowship programs at RUTGERS Robert Wood Johnson Medical School.

III. POLICY

According to ACGME Guidelines, each program must:

1. Design clinical assignments to minimize the number of transitions in patient care.
2. Ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
3. Ensure that residents are competent in communicating with team members in the hand-off process.
4. Have schedules available that inform all members of the health care team of attending physicians and residents currently responsible for each patient's care.

IV. RESPONSIBILITIES/REQUIREMENTS

Each program must:

- Each sponsored program will provide the Graduate Medical Education (GME) Office with a copy of its policy on transitions of care. The DIO will report to the GMEC on these policies. Once the policies have been considered appropriate by the GMEC, the programs will be required to annually report to the GME office their ongoing implementation of their policy. The DIO will report annually to the GMEC on this issue, which will take any action deemed necessary
- Assure that scheduling of on-call shifts is optimized to ensure a minimum number of transitions, and there should be documentation of the process involved in arriving at the final schedule. The specifics of these schedules will depend upon various factors, including the size of the program, the acuity and quantity of the workload, and the level of resident education.
- Periodically monitor hand offs through attendance by program director, faculty, or chief resident.
- Implement an annual training program to ensure that residents and fellows understand the key components of each residency's transitions of care process.
- Institute a mechanism in which resident/fellow schedules are centrally available to the residency program, nursing staff, and consulting services.

APPROVED BY GMEC ON 11/13/12

SECTION SIX

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY
GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VI. 1
SECTION: GRIEVANCE PROCEDURE
SUBJECT: RESOLUTION OF PROBLEMS

I. PURPOSE

To identify/define the due process for housestaff seeking resolution to an individual problem.

II. SCOPE

This policy is applicable to all members of the housestaff.

III. DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

A. Policy:

Every house officer is a member of the bargaining unit of the Committee of Interns and Residents Union (CIR) and is required to follow the Grievance Procedure as outlined in the agreement between the University and the CIR. The purpose of this procedure is to assure prompt, fair and equitable resolution of disputes concerning terms and conditions of employment arising from the administration of this Agreement by providing the sole and exclusive vehicle set forth for adjusting and settling grievances related to non academic issues.

B. Definition:

A grievance is an allegation by a housestaff that there has been:

1. A breach, misinterpretation or improper application of the terms of the CIR agreement; or

2. An improper or discriminatory application of, or failure to act pursuant to, the written rules, policies or regulations of the University or statutes to the extent that any of the above established terms and conditions of employment which are matters which intimately and directly affect the work and welfare of housestaff and which do not significantly interfere with inherent management prerogatives pertaining to the determination of public policy.

C. Preliminary Informal Procedure

The parties agree that all problems should be resolved, whenever possible, before filing a grievance. Housestaff may orally present and discuss a grievance with his or her Chief Resident, or with the University's approval, an appropriate designee. The grievant may, at his or her option, request the presence of a CIR representative.

D. Formal Steps

1. Step One: A grievant shall initiate his or her grievance in writing and present it formally to his or her Program Director or designee and to the University's Office of Employee Relations no later than (30) calendar days after the date on which the act which is subject of the grievance occurred or thirty (30) calendar days from the date on which the individual housestaff should reasonably have known of its occurrence. The Program Director or designee shall meet with the grievant and a representative of the CIR for the purpose of discussing the grievance. The Program Director or designee shall issue a written decision, stating the reasons therefore, within fifteen (15) calendar days following the conclusion of the meeting.

2. Step Two: If the grievance is not satisfactorily resolved at Step One, the grievant may file a written request for review with the appropriate Dean or designee within (14) days following the decision of the Step One decision. The Dean or designee shall review the grievance and where he or she deems it appropriate, witnesses may be heard and pertinent records received. The hearing shall be held within (14) days, and a decision shall be rendered in writing within 14 days following the conclusion of the review.

3. Step Three: If the grievant is not satisfied with the disposition of the grievance at Step Two, he may appeal to the President.

4. Step Four: If the grievance involves a contractual violation of the Agreement, the CIR upon request of the grievant and as a representative of the grievant may, upon written notification of intent to arbitrate to the President or his designee, appeal the President's decision to arbitration.

E. Time Limits

A grievance must be filed at Step One within thirty (30) days from the date on which the act which is the subject of the grievance occurred or thirty (30) calendar days from the date on which the individual house officer should reasonably have known of its occurrence.

Approved by GMEC on 4/13/99

SECTION SEVEN

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VII. 1
SECTION: RESIDENCY CLOSURE/REDUCTION POLICY AND STATEMENT
SUBJECT: RESIDENCY CLOSURE/REDUCTION

I. PURPOSE

To provide institutional guidelines regarding residency closure and reductions.

II. SCOPE

This policy is applicable to all members of the housestaffs

III.

DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program.

IV. RESPONSIBILITY/REQUIREMENTS

The RUTGERS Robert Wood Johnson Medical School recognizes the need and benefits of graduate medical education. RUTGERS Robert Wood Johnson Medical School will provide programs in graduate medical education, which emphasize personal, clinical and professional development and encourage an awareness of, and responsiveness to, ethical and human aspects of health care among the health professionals. RUTGERS Robert Wood Johnson Medical School will ensure that all of its graduate medical education programs meet or exceed the Institutional and Special Requirements promulgated by the Accreditation Council for Graduate Medical Education (ACGME) and its individual Residency Review Committees.

A. Policy:

RUTGERS Robert Wood Johnson Medical School agrees to notify the Graduate Medical Education Committee, the Designated Institutional Official and all involved housestaff of any adverse actions by the ACGME affecting their graduate medical education programs. If the program cannot correct the citations and the ACGME withdraws accreditation or if the University decides to voluntarily withdraw accreditation and close the residency program, the University will attempt to phase out the program over a period of time to allow the housestaff currently in the program to finish training. If this is not possible, the University and the Program Director will assist the resident physician(s) in obtaining another accredited residency program position.

In the event that the University decides to reduce the number of housestaff positions in any graduate medical education program, the housestaff will be notified. The University will attempt to reduce the numbers over a period of time so that it will not affect the housestaff currently in the program. If this is not possible, the University and the involved Program Director(s) will assist the affected house officers in obtaining another residency program position.

Approved by GMEC on 2/23/99 Amended 11/13/07

SECTION EIGHT

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VIII. 1
SECTION: HUMAN RESOURCES- EMPLOYEE ASSISTANCE PROGRAM

I. PURPOSE

To offer professional counseling assistance to all RUTGERS Robert Wood Johnson Medical School staff members and their family members who may experience personal or emotional difficulties which may affect job performance. RUTGERS Robert Wood Johnson Medical School has contracted with University Behavioral Health Care to provide this free and confidential service.

II. ACCOUNTABILITY

Under the direction of the President, the Vice President and Chief Executive Officer for University Behavioral Health Care shall ensure compliance with this policy. The Deans, Vice Presidents and Associate Vice Presidents shall implement this policy.

III. APPLICABILITY

RUTGERS Robert Wood Johnson Medical School staff members and their family members.

IV. POLICY

Through this program, the RUTGERS Robert Wood Johnson Medical School expresses a social and caring attitude about its staff member and recognizes that most human problems such as marital or family distress, substance abuse, legal problems or other concerns can be treated successfully, particularly when identified early. Early identification, treatment and resolution serve to minimize human costs and the potential of difficulty with job performance. While RUTGERS Robert Wood Johnson Medical School has no intention of becoming involved in a staff member's private life, it is our policy to provide help when a staff member requests help for personal problems or offer help when deteriorating job performance and reduced productivity suggest problems outside of the work environment may be contributing to work problems.

A. Requirements:

1. RUTGERS Robert Wood Johnson Medical School encourages staff members and their family members to utilize the professional counseling services available through the Employee Assistance Program. In addition, supervisory staff members should utilize the resources of the

Employee Assistance Program as an integral part of an intervention program to deal with poor job performance.

2. The University acknowledges that use of the Employee Assistance Program does not in any way alter management's responsibility or authority as an employer.

3. Participation in the Employee Assistance Program will not in any way jeopardize future employment or career advancement; participation will not, however, protect the staff member from disciplinary action for continued substandard job performance or rule infractions.

B. Confidentiality:

1. All information shared with the Employee Assistance counselor is strictly confidential.

2. No records of staff member participation or the content of their discussion with the Employee Assistance Program and its staff member are kept in the medical or personnel records.

3. No release of information is made to anyone without specific written consent of the staff member concerned, except where required by law.

4. All information regarding a staff member or family member's participation in the Employee Assistance Program is part of the clinical record maintained by University Behavioral HealthCare-Managed Care Resources and is subject to state and federal confidentiality laws governing such medical records.

C. Sessions:

1. Appointments with the Employee Assistance Program should be scheduled during non work hours.

2. Each staff member and his/her family member is entitled up to three (3) free, confidential consultation sessions, per problem, with the Employee Assistance Program. The Employee Assistance Program is staffed by experienced professionals who are prepared to help with any type of behavioral health problem. If the concern is outside the Employee Assistance Program counselor's area of expertise, or if there is a need for longer term treatment, the Employee Assistance Program counselor will (with the Employee Assistance Program client's consent) make a referral for appropriate services.

D. Referral Procedures:

1. Self Referrals

a. The staff member or family member may request an assessment/evaluation by contacting University Behavioral HealthCare-Managed Care Resources (EXHIBIT I).

b. An appointment will be scheduled within three days, where mutual schedules permit. Emergencies will be seen immediately.

c. Following the initial assessment, referral for treatment or service will be made to appropriate providers in the community if this is deemed appropriate. Referrals will be based on clinical need, geographical convenience and health plan considerations.

d. At no time will the names of staff members or their family members be revealed or acknowledged to the University without written consent.

2. Supervisor Referrals

a. Supervisors and management personnel are responsible for observing job performance and, when appropriate, referring the staff member to the program based upon decline or difficulties in job performance. A referral form can be obtained from the Employee Assistance Program.

b. The decision to seek and/or accept help is entirely the responsibility of the staff member. No attempt will be made to force or require staff members to use the Employee Assistance Program. Whether help is sought or not, each staff member will continue to be judged on the basis of his/her job performance. No special advantages or disadvantages will accrue because a staff member participated in this program. This policy does not constitute a waiver of management responsibility to maintain appropriate performance standards or to take disciplinary action when necessary. Nor does this policy constitute a waiver of any staff member rights under law or the Collective Bargaining Agreements.

c. The supervisor will be requested to provide the Employee Assistance Program with written documentation specifying the staff member's job difficulties; action taken thus far; and consequences of failure to correct performance problems.

d. All information shared with the Employee Assistance counselor is strictly confidential.

e. The content of all sessions is confidential and will not be released to management or other individuals without the specific written consent of the staff member.

f. With the staff member's consent, the referring supervisor will receive feedback from the Employee Assistance Program reporting whether the staff member has followed through with the referral by attending an Employee Assistance Program consultation session. No other personal or diagnostic information will be supplied unless specifically authorized in writing by the staff member and a release of information has been signed listing the specific information to be released. This information will not be included in the staff member's Human Resources file nor any files maintained by the staff member's department.

V. EXHIBIT I

Contact Numbers for Employee Assistance Program

Campus	Phone Number	Hours
Newark	(973) 972-5459	8:30 a.m. - 5:00 p.m.
Piscataway/New Brunswick	(732) 235-5930	8:30 a.m. - 5:00 p.m.
Stratford/Camden	(609) 770-5750	9:00 a.m. - 5:00 p.m.

Approved by GMEC on 2/23/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VIII. 2
SECTION: HUMAN RESOURCES/ADMINISTRATION POLICIES
SUBJECT: PHYSICIAN IMPAIRMENT/SUBSTANCE ABUSE POLICY

I. PURPOSE

To establish an institutional policy regarding Counseling and Support Services to assist program directors and residents on finding resources for dealing with physician impairment and substance abuse.

II. SCOPE

This policy is directed to all housestaff.

III. DEFINITION

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled at RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

An impaired house officer is one who is unable to participate within the University community with requisite skill and safety. This impairment may be due to drug and/or alcohol dependency, mental disorder, or other medical disorders. The signs and symptoms of such impairment could include but are not limited to a persistent pattern of the following:

A. Patient injury and/or formal complaints
B. Unusual or inappropriate behavior
C. Negative changes in performance of assigned duties
D. Frequent or unexplained absences and/or tardiness from duties
E. Frequent or unexplained illnesses or accidents

F. Conduct which may constitute violations of law, including citations for driving while impaired
G. Significant inability to contend with routine difficulties and act to overcome them

IV. Responsibility/Requirements

A. Policy

Physical and mental disorders and alcohol and other drug abuse or dependencies are often treatable. It is the policy of the University to assist impaired housestaff (as defined above) in obtaining treatment, when such assistance does not adversely affect the University's ability to safeguard the public health and effectively discharge its missions.

This policy focuses on the behavior of the impaired house officer and its impact on the house officer and others, not on any underlying medical condition or disability. If impairment is caused by a disability, it shall be the house officer's obligation to comply with University policy, Individuals with Handicaps/Disabilities, 00-01-35040:00 with regard to requests for accommodation.

Impairment of housestaff due to substance abuse and other forms of mental and physical disorders adversely affects all aspects of the University's missions. These disorders may impair work performance and/or the provision of patient care. Conduct related to impairment may be sufficient grounds for disciplinary action, including dismissal, and may require immediate action to protect the health and safety of others.

The program director of the impaired house officer's training program shall be responsible for restricting and monitoring patient care privileges. In the event that the impairment poses a risk for patient care, clinical practice privileges and clinical duties shall be suspended immediately pursuant to existing University procedures.

Where an incident may involve a violation of Federal, state or local law, the Office of Legal Management may be consulted to determine whether there is an affirmative duty to report the violation or take other action.

Confidentiality of all referred and identified housestaff and of individuals making referrals shall be maintained to the extent possible and permitted by law.

B. Preliminary Report and Investigation

If any individual working in the hospital has a reasonable suspicion that a house officer is impaired, the following steps should be taken:

1. A written report shall be made to the Department Chair or Residency Program Director.

2. If, after discussing the incident(s) with the individual who filed the report, the Chair believes there is sufficient information to warrant an investigation:

   a. The Director/or Chair shall contact the Housestaff Assistance Committee which will have the basic functions:

   Assessment of reports of impairment;

   - presentation of concerns to identified housestaff;
   - referrals for diagnosis and treatment;
   - monitoring of impaired housestaff until final disposition;
   - referral of housestaff who are not cooperative or who are non-compliant in the evaluation, referral and/or treatment to the appropriate program director for possible disciplinary or other action.

   c. The composition of the Housestaff Assistance Committee shall consist of: The Dean(s) of the medical school shall appoint the members of the committee. The committee shall have representation by the School's administrator of graduate medical education, program directors, faculty/attendings and senior housestaff. One or more individuals with expertise in mental health and in addiction/substance abuse. Each committee shall name a chair and establish its own procedures and meeting schedule. Please refer to the University Policy on Impaired Housestaff, # 00-01-20-86:00 for detailed explanation on the "Functions of the Housestaff Assistance Committee"http://www.rutgers.rwjms.edu/oppmweb/Policies/HTML/AcademicAff/00-01-20-55_00.html)

   c. A list of the Housestaff Assistance Committee members shall be available at the education office of each patient-care facility participating in RUTGERS Robert Wood Johnson Medical School housestaff programs.

   d. Each health care facility participating in the graduate medical program shall identify a contact person to administer the policy at that institution, report to the committee and the program director as indicated, and assume other duties including assuring appropriate reporting to the Board of Medical Examiners.

   e. The committee shall prepare an annual report and submit to the Deans, school administrators responsible for Graduate Medical education.

C. Urine and/or blood testing for drugs

There shall be no mandatory, routine use of urine or blood testing for drugs. However, where there is a reason to believe that impairment is the result of substance abuse and the house officer refuses to submit to drug testing, the University reserves the right to take disciplinary action or other action as may be deemed appropriate to protect the health and safety of patients, students, other house officers and employees. Testing may be performed by the selected treatment program. The committees may also recommend drug testing to a house officer to help rule out the existence of a substance abuse problem. Drug testing may be required to verify a drug-free state during treatment and as a part of the follow-up and monitoring after the conclusion of formal therapy.

D. Confidentiality

The Housestaff Assistance Committees shall make every effort to maintain the confidentiality of referred individuals to the extent possible and permitted by law. Only case numbers rather than individuals' names shall be used during meetings and in records. Files involving impaired housestaff shall be stored under lock separately from personnel records. Inactive files and files of housestaff who have left the University shall be sealed and stored separately. If a house officer is referred to a state assistance program, the appropriate files shall be shared with that program, and a notation of the sharing kept at the University.

E. University Sanctions

Any house officer who violates the University's Drug-Free Workplace policy and the standard of conduct described within, will be subject to disciplinary action up to and including termination from the University and will be reported to the proper legal authorities for prosecution.

When a house officer is convicted under any criminal drug statute for any act occurring within the workplace, he/she must report this incident to the relevant department chair or immediate supervisor within five days whereupon the supervisor should apprise the appropriate Dean as well as Legal Management.

Approved by GMEC on 2/23/99 Amended 11/12/02

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VIII. 3
SECTION: HUMAN RESOURCES/ADMINISTRATION POLICIES
SUBJECT: POLICY PROHIBITING SEXUAL AND OTHER TYPES OF HARASSMENT

I. PURPOSE

This policy outlines the RUTGERS Robert Wood Johnson Medical School prohibition of any form of harassment and the procedures and mechanisms to resolve allegations of harassment including sexual harassment and sexual assault.

II. ACCOUNTABILITY

Under the direction of the President, the Associate Vice President for Affirmative Action and Equal Employment Opportunity (AA/EEO) through the Senior Vice Presidents shall ensure compliance with this policy. The Associate Vice President for Affirmative Action and Equal Employment Opportunity in conjunction with the Deans and Vice Presidents shall implement this policy.

III. APPLICABILITY

This policy applies to all full-time, part-time, permanent and temporary employees, faculty, staff and residents, applicants for employment, students, volunteers, patients, vendors, contractors, subcontractors and all parties engaged in business and educational relationships with the University.

IV. DEFINITIONS

See EXHIBIT C.

V. POLICY

The RUTGERS Robert Wood Johnson Medical School is committed to creating and maintaining a working and learning environment for all faculty, staff, and students that is free of objectionable, disrespectful, and harassing conduct or communication. The University prohibits sexual harassment and harassment on the basis of race, national origin, religion, disability, age, gender, sexual orientation and other impermissible factors in all educational, research, healthcare delivery and service components and has established procedures to address and resolve allegations of harassment.

The University views all forms of illegal harassment and all attempts to commit such acts as a serious offense and will impose disciplinary action up to and including but not limited to expulsion, required withdrawal, suspension or termination. Unlawful harassment will not be tolerated and allegations involving such behavior will be investigated in accordance with this policy.

The University regards sexual assault as a serious form of sexual harassment. Such conduct may result in civil or criminal prosecution by the State, as well as disciplinary action by the University. Allegations of sexual assault may be submitted pursuant to this policy for administrative resolution. The University is committed to maintaining an environment free from sexual assault and all other forms of violence. The University complies with and fully supports New Jersey's Campus Sexual Assault Victim's Bill of Rights, a copy of which is included as Exhibit D.

Information on rights and resources available to assist victims in coping with sexual assaults, whether at the time of an emergency or thereafter, is compiled and available in any office of Public Safety, Human Resources, AA/EEO, Ombudsperson, as well as from various offices of the Deans.

The Department of Public Safety is designated as the primary resource of protection and assistance for those who are sexually assaulted. Students are strongly encouraged, but not required, to report immediately any incident to the Department of Public Safety for assistance and investigation. In accordance with state statute RUTGERS Robert Wood Johnson Medical School police officers are authorized and prepared to enforce the criminal statutes of New Jersey, to make appropriate referrals for prosecution, and to assist victims in reaching appropriate sources of medical and personal help.

Any employee who has observed or is aware of an incident of sexual harassment or assault is required to immediately report the incident to the Office of AA/EEO or the Department of Public Safety for investigation.

A. Consensual Relationships:

1. Although the University acknowledges that consensual relationships are within the realm of individual privacy, it is necessary to advise that these relationships, particularly those occurring between supervisors and staff members, residents and students, or faculty members, especially where there is authority influence and responsibility for the staff member or student, can lead to circumstances which can be interpreted as sexual harassment.

2. Consensual relationships can also be viewed as causing a hostile or offensive work environment when other faculty, staff members, residents or students believe that the person(s) involved in the relationship(s) is/are receiving favorable treatment in employment or educational decisions and actions. Please refer to the Policy (00-01-25-50:00), Students Rights, Responsibilities and Disciplinary Procedures and Policy (00-01-10-05:00), Code of Ethics: General Conduct.

3. The University prohibits any consensual relationship among faculty members and students, supervisors, staff members, or residents, when one individual has authority, influence, or responsibility with regard to the other. Persons engaging in such conduct may be subject to disciplinary action, if the conduct results in an offensive or hostile environment or

interferes with the proper functioning of the University or any of its components or constituents.

4. An individual with supervisory or educational responsibility for an employee, resident, faculty member or student must inform his or her superior of the consensual relationship, so that the University can take action to change the reporting relationship between the two people. Failure to give proper notice to the supervisor's immediate superior may result in denial of legal representation and indemnification by the State in the event that a lawsuit is filed in connection with the relationship.

B. Harassment Hearing Committee:

A Harassment Hearing Committee shall be established to hear appeals of findings of the AA/EEO Office under Step 2 Section C. It shall consist of five (5) members. The composition of the committee shall include the Senior Vice President for Administration and Finance or designee, the Senior Vice President for Academic Affairs or designee, and a University attorney designated by the Vice President for Legal Management. The remaining committee members shall be selected by the Chair and shall include one representative from the constituency of the person(s) alleging harassment and one from the constituency of the person being accused, as may be required, but not from the same school or unit. The President shall designate the Chair. Committee members are responsible for notifying the Chair if there are any personal and/or professional conflicts of interest that make service on a particular committee inadvisable. Upon request by either party, the Chair of the Committee shall determine whether a particular Committee member should not serve because of an actual or perceived conflict of interest.

Any member of the Committee who is a witness or the subject of a complaint or in possession of evidence concerning any claim of harassment that is the subject of an investigation pursuant to this policy and procedure, shall be disqualified from participation as a member of the Committee for that complaint. The Chair will designate a replacement Committee member unless he or she is disqualified pursuant to this paragraph. In that case, the President or the Chair of the Board of Trustees shall designate the replacement.

C. Complaint Resolution Procedures:

Any University person covered by this policy who feels subjected to or has witnessed sexual harassment or other illegal harassment, as outlined in the policy should immediately, and no later than (30) days after the conduct, report to the University AA/EEO office (EXHIBIT A) as follows:

1. Any person covered by this policy shall report the conduct to the Office of AA/EEO, except that students may choose to report the conduct to the Office of the Dean or a designee of the School. Should the allegations involve personnel in either of said Offices or involve said personnel's supervisory chain of authority, the matter shall be referred directly to the University's President.

2. The Office of AA/EEO shall immediately commence investigation of the alleged conduct through Step 1 below. The AA/EEO Office may commence investigation at the Step 2 – Formal Investigation for more serious allegations or at the request of the accuser or accused.

   If the Office of the Dean of Student Affairs, the Dean or his/her designee*, receives the complaint, it may:

   a. discuss the allegations with all involved parties and attempt to reach resolution among the parties; or

   b. immediately refer the case to the Office of AA/EEO.

   If the first option (a) is chosen, the Office of the Dean of Student Affairs must notify the Office of AA/EEO of the outcome. If the Office of the Dean of Student Affairs is unable to reach resolution among the parties, it will then forward the matter to the Office of AA/EEO.

   *School Ombudspersons are a resource to help guide and assist students and housestaff in evaluating options for resolving problems. Because of their unique, informal problem-solving role, Ombudspersons shall not participate in the official complaint process.

Step 1: Informal Resolution

This process is designed to address harassment allegations being investigated by the Office of AA/EEO prior to a formal investigation and to seek resolution by agreement of all principal parties.

The informal resolution process includes the following:

1. interviews of the parties regarding the allegations, or

2. discussion with both parties of a resolution to which each agree, or

3. if both parties agree to resolution at this informal step, the Office of AA/EEO will conclude its review and close its file.

Informal resolution shall be completed within (30) calendar days from filing of the complaint. From receipt of accusation to informal resolution, a period of thirty (30) calendar days is the time limit for Step 1, applicable to all parties to the

allegation. The time limit may be extended by agreement of all parties. Absent resolution or mutual agreement to extend the time limit, the allegation will be forwarded to Step 2 of the procedure.

Step 2: Formal Investigation

1. Failing informal resolution at Step 1, within the time limits as set out above, or at the request of the either party, Step 2 shall proceed as follows:

2. The Office of AA/EEO shall review the record established at Step 1 and investigate the allegation(s) further as warranted. This investigation may include but it is not limited to:

    a. re-interview of the parties as warranted;

    b. discussion with witnesses; and

    c. gathering of any other information deemed relevant.

3. It is anticipated that Step 2 will be completed within (60) calendar days. Absent resolution within (60) calendar days, the matter will be forwarded to Step 3.

4. At the conclusion of Step 2, the Office of AA/EEO shall render its findings and forward any recommendations to the appropriate supervisor or Dean's office.

    The Office of AA/EEO may consult with the Office of Human Resources or the Office of Legal Management at any time. The parties shall be informed of the AA/EEO Office findings.

    If the allegation involves a student as a party, the Office of the Dean of Student Affairs or Dean as appropriate shall be informed, if inappropriate conduct has been found. If the allegation involves a faculty member, as a party, the Dean shall be informed, if inappropriate conduct has been found. The appropriate Senior Vice President shall direct the appropriate supervisor to implement the recommended discipline, if any.

Step 3: Appeal

Harassment Hearing Committee

If either party is dissatisfied with the resolution of a complaint at Step 2 Formal Investigation, he or she may appeal to the Harassment Hearing Committee by submitting a written appeal to the Office of AA/EEO within fourteen (14) days of that office's findings made in the previous step. The Committee shall be convened within fourteen (14) calendar days of the appeal to consider the matter. The Committee may conduct such interviews and inquiries as it deems

appropriate which may include consultation as to appropriate sanctions with the Office of Human Resources, the Office of Legal Management and the Office of AA/EEO. All Committee members, witnesses and other participants in the appeal hearing shall maintain confidentiality to the extent possible of the Committee's deliberations.

The Committee will render its determination including sanctions, if any, within fourteen (14) days of convening. The Committee's determination will be forwarded to the Office of AA/EEO who shall inform the parties, and the appropriate University Senior Vice President. The Senior Vice President shall ensure implementation of sanctions if any. If the allegation involves a student as a party, the Office of the Dean of Student Affairs shall be informed. If the allegation involves a faculty member as a party, the Dean shall be informed.

D. Sanctions:

Sanctions may include, by way of illustration but not limitation, directed counseling and/or mandatory education and training, warning, reprimand, probation, suspension, termination or expulsion. Sanctions shall be implemented fully and in a timely manner. An AA/EEO Officer will monitor that the sanctions have been implemented.

E. Withdrawal of Allegation(s):

If the party making the allegation decides to withdraw the allegation(s) of harassment at any time during any step in the procedure, the withdrawal must be in writing and specify voluntary retraction of the complaint. This action will not necessarily preclude further investigation, findings or sanctions.

F. Recordkeeping:

The Office of AA/EEO will maintain a record of all complaints, which have been processed by the Office of AA/EEO. This information will be used to monitor complaint activity and to document the incidents and corrective actions taken by the University. Records of informal complaints handled by the Office of the Dean of Student Affairs shall be maintained in that office and reported to the Office of AA/EEO.

G. False Complaints and Refusal to Cooperate:

The intentional filing of a false complaint is a violation of this policy and may subject such person to discipline. Refusal to cooperate with/or participate in an investigation is a violation of this policy and may subject such person to discipline, except for refusal to participate by victims of sexual assaults. Anyone who believes that he/she has been the subject of a false complaint of harassment may meet with the Office of AA/EEO to discuss the allegations. If evidence of an intentional false complaint has been found, the AA/EEO Office shall recommend appropriate sanctions.

This provision is not intended to discourage complaints where an individual believes in good faith that harassment has occurred.

H. Retaliation:

The University prohibits retaliation against staff, faculty, students, or residents who have filed complaints or cooperated in an investigation or proceeding designed to foster the implementation of this policy. No form of interference, coercion, reprisal or retaliation will be tolerated especially in the form of lower grades, evaluations, or recommendations. Retaliation is a separate and distinct offense under this policy. Any person found to have retaliated against anyone will be subject to disciplinary action, up to and including termination or expulsion.

I. Confidentiality:

All participants in the complaint, investigation and appeal proceedings are expected to maintain confidentiality, except if disclosure is required by law, or when lack of disclosure impedes a full and fair investigation of the complaint or pursuit of an appeal.

J. Education:

Education on the prevention and recognition of any type of unlawful harassment will be required for all employees, including supervisory and managerial personnel, residents and students. Materials compiled to inform the University community of victim's rights and resources in case of sexual assault shall be distributed by the Department of Human Resources to each new employee at the time of orientation and by special publication issued annually to each member of the University community.

K. Legal Representation:

No attorneys, representing either party will be permitted to participate in the above complaint procedures.

L. Exceptions:

The Office of AA/EEO may make any exceptions to this policy in individual cases.

VI. EXHIBITS

A. AA/EEO Campus Offices
B. Internal Complaint Form (form available at Campus AA/EEO office)
C. Definitions
D. New Jersey’s Campus Sexual Assault Victim’s Bill of Rights

President
EXHIBIT A

AA/EEO Campus Offices

Newark
65 Bergen Street, Suite 1214
Stanley S. Bergen Jr., Bldg.
University Heights
Newark, N.J. 07107-3001
(973) 972-4855

Piscataway/New Brunswick
Liberty Plaza
335 George Street, 3rd Floor, Room 3300
New Brunswick, N.J. 08903
(732) 235-9394

Camden/Stratford

Primary Care Center
40 East Laurel Road, Suite 241
Stratford, N.J. 08084
(609) 566-7119

EXHIBIT B

Complaint Form - (form available at Campus AA/EEO office)

EXHIBIT C

Definitions

A. **Harassment** is defined as any conduct directed toward an individual or group based upon one or more of the following categories or traits: race, religion, color, national origin, ancestry, age, sex, sexual orientation, disability, marital or veteran status that is sufficiently severe or pervasive to alter an individual's employment conditions, educational environment or participation in a University activity and that creates an intimidating, offensive or hostile environment for employment, education, or participation in a University activity.

B. **Sexual Harassment** - unwelcome or unwanted sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when it takes the form of:

1. Quid Pro Quo Sexual Harassment

   a. submission to or rejection of such sexual conduct is made implicitly or explicitly a term or condition of an individual's employment, study, or participation in University-sponsored activities; or

   b. submission to or rejection of such sexual conduct is used as the basis for decisions affecting individuals' study, employment, or participation in University-sponsored activities.

2. Hostile Environment Sexual Harassment

   Such verbal or physical conduct or images that have the purpose or effect of unreasonably interfering with an individual's academic or work performance or creating an intimidating, hostile, offensive academic or working environment.

3. Third Party Sexual Harassment

   Where employment opportunities or benefits are granted because of an individual's submission to the employer's sexual advances or requests for sexual favors, the employers may be liable for unlawful sex discrimination against other persons who were qualified for but denied that employment opportunity or benefit.

4. Examples of behavior which may be considered sexual harassment include, but are not limited to:

   a. direct or implied threats that submission to sexual advances will be a condition of employment, work status, promotion or grades;

   b. direct propositions of a sexual nature;

   c. sexually explicit and demeaning statements, questions, jokes or teasing;

d. unnecessary touching, patting, hugging or brushing against a person's body or invading a person's space;

e. remarks of a sexual nature regarding a person's clothing, body, sexual activity, previous sexual experience, or sexual orientation or speculation about sexual experiences;

f. repeated requests for dates or social interaction made through verbal requests, notes, telephone calls, facsimiles, e-mail, etc.;

g. visual displays of sexually explicit materials or inappropriate sexual images in the workplace or academic setting; and

h. attempted or actual incidents of sexual assault.

C. Consensual Relationships - shall include marriage, cohabitation, engagement, dating and other ongoing relationships of an intimate or close personal nature which passes beyond a platonic relationship.

D. Sexual Assault - refers to nonconsensual sexual contact. It may involve the threat or use of force, violence or intimidation. It may involve sexual contact with a person who is unable to consent due to incapacity or impairment. Any nonconsensual sexual touching may be considered sexual assault.

EXHIBIT D

New Jersey's Campus Sexual Assault Victim's Bill of Rights

The following Rights shall be accorded to victims of sexual assault that occur:

on the campus of any public or independent institution of higher education in the state of New Jersey, and where the victim or alleged perpetrator is a student at that institution, and/or when the victim is a student in an off-campus sexual assault.

Human Dignity Rights:

to be free from any suggestion that victims must report the crimes to be assured of any other right guaranteed under this policy to have any allegations of sexual assault treated seriously; the right to be treated with dignity; to be free from any suggestion that victims are responsible for the commission of crimes against them; to be free from any pressure from campus personnel to report crimes if the victim does not wish to do so; report crimes as lesser offenses than the victim perceives the crime to be; refrain from reporting crimes; and refrain from reporting crimes to avoid unwanted personal publicity.

Rights to Resources On and Off Campus:

to be notified of existing campus and community based medical, counseling, mental health and student services for victims of sexual assault whether or not the crime is formally reported to campus or civil authorities to have access to campus counseling under the same terms and conditions as apply to other students in their institution seeking such counseling to be informed of and assisted in exercising any rights to confidential or anonymous testing for sexually transmitted diseases, human immunodeficiency virus, and/or pregnancy; and any rights that may be provided by law to compel and disclose the results of testing of sexual assault suspects for communicable diseases.

Campus Judicial Rights:

to be afforded the same access to legal assistance as the accused;

to be afforded the same opportunity to have others present during any campus disciplinary proceeding that is allowed the accused; and

to be notified of the outcome of the sexual assault disciplinary proceeding against the accused.

Legal Rights:

to have any allegation of sexual assault investigated and adjudicated by the appropriate criminal and civil authorities of the jurisdiction in which the sexual assault is reported;

to receive full and prompt cooperation and assistance of campus personnel in notifying the proper authorities; and

to receive full, prompt and victim-sensitive cooperation of campus personnel with regard to obtaining, securing and maintaining evidence, including a medical examination when it is necessary to preserve evidence of the assault.

Campus Intervention Rights:

to require campus personnel to take reasonable and necessary actions to prevent further unwanted contact of victims by their alleged assailants to be notified of the options for and provided assistance in changing academic and living situations if such changes are reasonably available.

Statutory Mandates:

Each campus must guarantee that this Bill of Rights is implemented. It is the obligation of the individual campus governing board to examine resources dedicated to services required and to make appropriate requests to increase or reallocate resources where necessary to ensure implementation.

Each campus shall make every reasonable effort to ensure that every student at that institution receives a copy of this document.

Nothing in this act, or in any "Campus Assault Victim's Bill of Rights" developed in accordance with the provisions of this act, shall be construed to preclude or in any way restrict any public or independent institution of higher education in the State from reporting any suspected crime or offense to the appropriate law enforcement authorities.

University Policy Code: 00-01-35-25:00
Adopted: 2/24/81
Amended: 02/04/02

Approved by GMEC on 2/23/99, 09/14/10

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: VIII. 4
SECTION: HUMAN RESOURCES/ADMINISTRATION POLICIES
SUBJECT: HOUSESTAFF IMMUNIZATIONS & HEALTH REQUIREMENTS

I. PURPOSE

To prevent or reduce the risk of transmission of vaccine-preventable and other communicable diseases between RUTGERS Robert Wood Johnson Medical School medical, dental and podiatric interns and residents (housestaff) and their patients and other persons at RUTGERS Robert Wood Johnson Medical School and affiliated health care units.

II. ACCOUNTABILITY

Under the Executive Vice President for Academic Affairs and Clinical Affairs, the Deans shall ensure compliance with this policy. The Associate Deans or other administrators responsible for graduate medical, dental and podiatric education at each School, and the individual Program Directors shall implement this policy in conjunction with the campus Occupational Medicine Service.

III. APPLICABILITY

This policy shall apply to all interns and residents (including clinical fellows), hereinafter called “house officers” or "housestaff," enrolled in any RUTGERS Robert Wood Johnson Medical School sponsor graduate medical, dental or podiatric education program conducted in any health-care facility participating in the program, and all visiting, exchange or special-program housestaff from other institutions. New housestaff will preferably be in full compliance with this policy prior to beginning their programs, but must be in full compliance within six months of beginning their duties.

IV. DEFINITION

"RUTGERS Robert Wood Johnson Medical School sponsored graduate education program" is one for which RUTGERS Robert Wood Johnson Medical School maintains academic responsibility.

V. REFERENCES

A.	Tuberculosis Surveillance	00-01-40-42:00
B.	HIV, HBV and HCV	00-01-45-52:00

C. *Centers for Disease Control and Prevention,* Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-care Settings, 2005, *MMWR* 2005; 54 (RR-17), i-141.

D. *National Research Council,* Occupational Health and Safety in the Care and Use of Research Animals, National Academy Press, Washington, D.C., 1997.

E. Immunization of Health-Care Workers, *MMWR* 1997; 46 (No. RR-18).

F. *Centers for Disease Control and Prevention,* Guidelines for Infection Control in Dental Health-Care Settings – 2003. *MMWR* 2003; 52 (No. RR-17).

G. *Occupational Safety and Health Administration,* "Occupational Exposure to Bloodborne Pathogens," 29 CFR Part 1910.1030.

VI. POLICY

A. Immunization and Health Requirements

1. History and physical exam:

   Each house officer shall undergo a complete medical history review within thirty (30) days of beginning the program and, if needed, an appropriate physical examination based upon the history.

2. Hepatitis B:

   New housestaff shall undergo testing for HBV infection and immunity pre-placement (post-offer of employment), and prior to patient contact. These tests should ordinarily consist of hepatitis B surface antigen (HBsAg), antibody to HBsAg (HBsAb) and antibody to hepatitis B core antigen (HBcAb), followed by additional tests as deemed appropriate by the campus Occupational Medicine Service.

   a. If house officers *test negative for HBV* infection and immunity, and they have not been previously immunized, they shall begin immunization against HBV or sign a RUTGERS Robert Wood Johnson Medical School approved waiver declining immunization prior to patient contact or contact with blood or other potentially infectious body fluids or laboratory material. If house officers test negative for HBV infection and have been previously immunized but have inadequate levels of antibodies despite such previous immunization, they shall receive a booster dose of the vaccine or sign a RUTGERS Robert Wood Johnson Medical School - approved waiver declining immunization prior to patient contact or contact with other potentially infectious body fluids or laboratory material. Testing for antibody titers (HBsAb) 1-2 months post-immunization should be performed; non-responders to a primary

series of immunizations or booster dose should complete a second three-dose immunization series and be tested again for serologic response. Individuals who still do not respond with antibody production following a second series of immunizations are considered susceptible to HBV infection, and shall be counseled regarding precautions to prevent HBV infection and the need to obtain hepatitis B immune globulin (HBIG) prophylaxis for any known or probable significant exposure to HbsAg-positive blood.

In all instances, current CDC recommendations should be followed regarding initial HBV immunization, post-immunization antibody titers, re-immunization or booster doses for inadequate antibody titers, and post-exposure immunoglobulin prophylaxis for non-responders.

b. If the initial *HBV tests are positive* and indicate a significant potential for transmission of the virus, an evaluation shall be made prior to patient contact of the need for monitoring of clinical performance and/or of the scope of assigned or permitted clinical activities consistent with patient protection, especially the performance of exposure-prone procedures. This evaluation shall be made by a designated individual or individuals at each School or clinical unit who may consult with infectious disease experts knowledgeable about the most current information and recommendations of groups such as CDC, and national medical and dental professional and educational organizations. If hired under these circumstances, house officers may be restricted in their clinical activities.

c. Currently employed housestaff shall comply with all HBV requirements of the University policy on HIV, HBV and HCV, 00-01-45-52:00.

3. **Tuberculosis:**

All housestaff must meet the requirements of the University policy on Tuberculosis Surveillance, 00-01-40-42:00.

Each house officer shall undergo TB skin testing (TST) using the Mantoux method (5 tuberculin units of intradermal TST, or an FDA-approved blood assay for TB, prior to employment. All TST must be administered, read and interpreted in accordance with Centers for Disease Control and Prevention (CDC) guidelines (see Reference B). All FDA-approved blood assays for TB must be administered, read and interpreted according to guidelines issued by the CDC, FDA and the manufacturer. Positive reactions shall be appropriately followed up. The two-step method shall

be used if the pre-employment TST is negative and there is not another documented negative TST within the preceding 12 months.

Thereafter, annually or more frequently if indicated, house officers with negative reactions shall be re-tested. Housestaff with non-human primate contact shall receive periodic testing every six months in accordance with the *National Research Council*'s, Occupational Health and Safety in the Care and Use of Research Animals. Those with positive reactions shall be followed and treated as appropriate.

House officers with a history of BCG (bacille Calmette-Guerin) vaccination are not exempt from the TB testing requirement because there are no data to indicate that these individuals experience an excessively severe reaction to TST, and because anyone with a history of BCG with a positive TST test result is considered infected with TB and is treated accordingly.

House officers who have initial positive TB test results, subsequent TB test conversions, or symptoms suggestive of TB must be evaluated promptly for active TB. This evaluation should include a history, clinical examination and a chest X-ray. If the history, clinical examination or chest X-ray is compatible with active TB, additional tests, such as sputum microscopy and culture should be performed. If symptoms compatible with active TB are present, the house officer should be excluded from clinical activities until either (a) a diagnosis of active TB is ruled out or (b) a diagnosis of active TB is established, treatment is begun and a determination is made by the director of a RUTGERS Robert Wood Johnson Medical School Occupational Health Service that the house officer is noninfectious. House officers who do not have active TB should be evaluated for preventive therapy according to published CDC guidelines. However preventive therapy for latent infection in the absence of active disease cannot be required. If the evaluation for active TB, treatment for active TB and/or preventive therapy for latent infection is carried out at a facility other than a RUTGERS Robert Wood Johnson Medical School site or approved sites, all test results and documentation of care provided must be shared with the director of the appropriate RUTGERS Robert Wood Johnson Medical School Occupational Health Service. House officers receiving preventive treatment for latent TB infection need not be restricted from usual clinical activities.

4. **Measles-mumps-rubella:**

Each house officer must submit documented proof of immunity to measles, mumps and rubella prior to or within thirty (30) days of beginning the program. (People born before 1957 <u>may</u> be immune from childhood exposure to the naturally occurring diseases, but this evidence has proved unreliable.) Immunity can be proved by serologic (laboratory) evidence of immunity to each disease.

Housestaff lacking serologic immunity must receive at least one dose of MMR vaccination prior to or within thirty (30) days of beginning the program.

5. **Influenza:**

Housestaff should be immunized each year of their employment with RUTGERS Robert Wood Johnson Medical School during the fall season with seasonal and any other current influenza vaccines available.

6. **Varicella:**

Housestaff must receive two doses of varicella vaccine 4 to 8 weeks apart or prove immunity to varicella-zoster virus via serology prior to beginning the program or prior to patient contact. If the titer is negative, the Housestaff member will be offered varicella vaccine to complete a vaccination series. If the Housestaff member has a negative varicella titer and has not previously had varicella vaccine, the Housestaff member will be required to complete a series of varicella vaccination within the first three months of patient contact. Because of potential transmission of the vaccine virus to susceptible high-risk patients, such as immunocompromised patients, newborns and pregnant women, contact with high-risk susceptible patients should be avoided if a vaccine-related rash develops within three weeks of receipt of either the first or second dose of the vaccine.

7. **Tetanus-diphtheria-pertussis:**

Each house officer prior to beginning the program should have completed a primary series of tetanus, diphtheria and pertussis immunizations (DPT), and received a booster dose of Td (tetanus-diphtheria) every ten years since. Effective for house officers hired in 2007 or later, with the availability of Tdap (tetanus-diphtheria-acellular pertussis) immunization, house officers must, prior to employment, receive one dose of Tdap if two or more years have passed since the last Td booster dose or since the primary DPT series.

B. **Exemptions/Exceptions**

1. A house officer may be exempted from any required immunization if he/she has a medical contraindication for that immunization and if failure to receive this immunization does not prevent fulfillment of the requirements of the training program. Conditions comprising valid medical contraindications to vaccine administration are those set forth by the Centers for Disease Control and Prevention. Such housestaff must present a written statement from a physician licensed to practice medicine in the United States or a foreign country stating that a specific immunization is medically contraindicated, and giving the reasons for and

duration of this contraindication. These written physician's statements shall become part of the individual's immunization record and shall be reviewed annually by the Program Director in conjunction with the Director of Graduate Medical/Dental Education or infectious disease expert from the health-care unit where

the house officer works to determine whether this exemption shall remain in effect for the next year. When a medical contraindication no longer exists, the house officer must then comply with the immunization requirements. The University shall provide reasonable accommodations to those housestaff whose medical conditions contraindicate immunizations so long as the failure to be vaccinated will not prevent the individuals from fulfilling the requirements of the training program. Housestaff should be informed of the immunization and testing requirements prior to employment.

2. A house officer may be exempted from any required immunization if he/she submits a bona fide written signed statement explaining how immunization **c**onflicts with his or her religious beliefs and if failure to receive this immunization does not prevent fulfillment of the requirements of the training program. The individual may be required to acknowledge in writing that he or she was informed of the value of immunizations and has knowingly declined to have such immunizations for religious reasons. The University shall provide reasonable accommodations to those housestaff whose religious beliefs bar immunizations so long as the failure to be immunized will not prevent the individuals from fulfilling the requirements of the training program. Housestaff should be informed of the immunization and testing requirements prior to employment.

3. Housestaff who are not able to complete immunizations and tests by the start of the program may be employed on a provisional basis if temporary exemption is granted by the Program Director. However, depending upon which documentation, immunization or test is lacking, these housestaff may be excluded from certain activities such as patient contact or laboratory work. For example, housestaff may be restricted from contact with patients or with blood or other potentially infectious body or laboratory fluids if they have not received at least one dose of hepatitis B vaccine or cannot provide serologic evidence of current immunity to hepatitis B or have not signed a waiver. Housestaff shall not be permitted to have contact with patients unless they have received tuberculin testing and any required follow up. Provisional employment on this basis may be limited by the Program Director, at his or her discretion. If a house officer is restricted from patient contact or laboratory work and is unable to fulfill the academic requirements of the program, the house officer may be subject to dismissal.

C. Record-Keeping Requirements

1- There must be acceptable evidence of required immunizations, immune status or health status listed in Section VI.A for each house officer prior to beginning the training program.
2- Acceptable documents serving as evidence of previous immunization and/or immunity may include:
    a. an official school immunization record or copy thereof from any primary, secondary, undergraduate, graduate, health professions or other school;
    b. a record from any public health department;
    c. a medical record or form summarizing a medical record and prior immunizations signed by a physician licensed to practice medicine in any jurisdiction of the United States or foreign country or other licensed health professional approved by the New Jersey Department of Health and Senior Services;
    d. a report of serology from a licensed laboratory.

3- Records shall be maintained of the documented histories, physical exams, immunizations, immune status and any exemptions of all housestaff. These records shall be updated upon additional immunization, immunity testing or occurrence of a relevant infectious disease. Immunization records shall be kept for thirty (30) years following completion of the program, termination, transfer or other departure of a house officer from RUTGERS Robert Wood Johnson Medical School

4- Summaries of measles-mumps-rubella housestaff immunization/immune status shall be available for inspection by authorized representatives of the New Jersey Department of Health and Senior Services, and as part of the Annual Hospital Rubella and Measles Immunity Report required under hospital licensing standards.

By Direction of the President:

_____
Vice President for Academic Affairs

University Policy Code:	00-01-40-45:00
Adopted:	9/1/91
Amended:	07/24/01
Amended:	08/31/04
Amended:	05/02/07
Amended:	9/25/07
Amended	06/21/10

Approved by GMEC on 2/23/99, 8/10/10
Reviewed by the GMEC 10/9/07

SECTION NINE

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IX. 1
SEL**ECTION:** INSTITUTIONAL RESPONSIBILITIES
SUBJECT: MISSION AND ORGANIZATION STRUCTURE

I. PURPOSE

To outline the University's academic, healthcare and administrative management structure.

II. ACCOUNTABILITY

Under the direction of the President, the Senior Vice President for Administration shall ensure compliance with and shall implement this policy.

III. POLICY

A. The RUTGERS Robert Wood Johnson Medical School organizational chart identifies current hierarchical and lateral relationships within RUTGERS Robert Wood Johnson Medical School's academic, healthcare and administrative management structure. It serves as an overview of the major operating and functional areas of the University, which must collaborate to support the University's overall mission, objectives, strategies and priorities.

B. Information pertaining to the structural details for the individual academic, healthcare and administrative unit of the University will be maintained by the appropriate school, unit or department.

C. The appropriateness of the organizational structure will be regularly monitored by the University's management team to address changing needs of the University.

IV. EXHIBIT

RUTGERS Robert Wood Johnson Medical School Organizational Structure

By Direction of the President:

_____
Senior Vice President for Administration

University Policy code: 00-01-03-05:00
Adopted: 07/01/87 Approved by GMEC on 2/23/99

Amended: 02/25/02, 08/26/02, 03/30/05, 08/08/06 & 06/14/07

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IX. 2
SECTION: INSTITUTIONAL RESPONSIBILITIES
SUBJECT: INTER-INSTITUTIONAL AGREEMENTS

I. PURPOSE

To establish guidelines for letters of agreement between RUTGERS Robert Wood Johnson Medical School and affiliated institutions for graduate medical education.

II. SCOPE

For all programs participating in housestaff training accredited by the ACGME, sponsored by RUTGERS Robert Wood Johnson Medical School.

III. RESPONSIBILITY/REQUIREMENTS

The RUTGERS Robert Wood Johnson Medical School requires that programs have Letters of Agreement with all sites and that they be reviewed annually and updated if necessary. The letters should follow the format of the attached agreement. The purpose of the letter should be clearly stated, followed by a description of the functional rotations at that training site. It should be stated that RUTGERS Robert Wood Johnson Medical School retains overall authority over residents' activities. The letter must address the essentials as required by the ACGME, including:

A. identify the faculty who will assume both educational and supervisory responsibility for the residents
B. the educational goals and objectives for residents
C. the period(s) of assignment, financial arrangements, and details for their insurance and benefits
D. specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified by this document
E. policies and procedures that govern the residents' education while on rotation at the affiliate.

Once the agreement is completed, a draft should be forwarded to the GME Office for review. After the document is approved, it should be signed by the Program Director of the Training Program, Department Chair, Associate Dean for Graduate Medical Education of the Medical School and the appropriate officials of the affiliate institution. This agreement must be signed by all parties before the start of the academic year in which housestaff will rotate at that affiliate.

Approved by GMEC on 5/11/99 Amended by GMEC on 4/10/01, 6/13/00 & 9/13/05, 3/28/12

ATTACHMENT 1

(Hospital/Institutional Representative) Date
(Site name)
(Address)

Re: Description of Rotation for _____ residents at _____ (site)

Dear Dr. (Institutional Representative)

The purpose of this letter of agreement is to continue to formally document the conditions of our long-standing affiliation, as it affects the assignment of residents from our residency program in (description of Program) at RUTGERS Robert Wood Johnson Medical School to the (name of Hospital/Institution). The term of this Agreement shall be for a period of one (1) year from the Effective Date. Renewal thereafter shall be automatic for successive periods of one (1) year, unless either party notifies the other party, in writing, that they wish not to renew the Agreement. The following description outlines the functioning rotations of (type of Program) residents while at your institution essentially as they have been in place since (date).

Consistent with ACGME requirements for inter-institutional agreements, RUTGERS Robert Wood Johnson Medical School as the sponsoring institution continues to be responsible for the quality of our residents' educational experiences and retains overall authority over our residents' activities while they are at (Hospital/Institution's Name). As required by the ACGME, this letter covers: 1) the officials of (Hospital/Institution's Name) who will assume administrative, educational and supervisory responsibility for our residents while on rotation; 2) the educational goals and objectives to be attained by our residents while at (Hospital/Institution's Name); 3) the period of assignment of our residents to the (Hospital/Institution's Name) rotation, the financial arrangements, and the details for their malpractice insurance and benefits; 4) (Hospital/Institution's Name) responsibilities for teaching, supervising and formally evaluating our residents' performances while on rotation; 5) the policies and procedures that govern our residents' education while they are rotating to (Hospital/Institution's name)

Item 1: _____, MD and the teaching faculty at (Hospital/Institution's name) will assume administrative, educational, and supervisory responsibilities for the residents, subject to the overall control and direction of the RUTGERS Robert Wood Johnson Medical School Program Director.

Item 2: The educational goals and objectives of the rotations at (Hospital/Institution's name) include the following:

Item 3. _____ (number of residents at each PG level on site) will rotate to (hospital/institution's name) for _____weeks/months each year. ([Hospital/Institution name, and/or RUTGERS Robert Wood Johnson Medical School will continue to pay our residents' salaries, malpractice insurance and benefits while they are at [Hospital/Institution's Name]-Please be specific about the FTE's to be paid by other hospital/institution). RUTGERS Robert Wood Johnson Medical School residents at (hospital/institution name) will not be reassigned to other sites or assigned to additional types of duties without the express approval of the RUTGERS Robert Wood Johnson Medical School Program Director.

Item 4. (Hospital/Institution name) is responsible for providing sufficient resources and assuring supervision for the proper conduct of the resident during the period of the residents' rotation at (Hospital/Institution name) During these rotations, there is ongoing communication between the faculty at both institutions in connection with the residents' activities and progress. At the completion of each rotation, the supervising (Hospital/Institutions' Name) faculty complete written resident evaluations, and provide the residents with an opportunity to meet to discuss their evaluations. The residents will evaluate their rotations at (Hospital/Institution's Name), in writing, and the results of those evaluations will be shared with you.

Item 5. In each of the _____ residents' _____ rotations at (Hospital/Institution's Name), the residents' education is governed by the policies and procedures of (institution name), which may set standards and establish reasonable rules and regulations which may govern the conduct of residents. (Hospital/Institution name) shall orient and adequately inform residents regarding any rules, policies, procedures or customs.

Please be aware of your need to comply with the new HIPAA regulations.

Your signature below indicates that I have accurately described the experiences obtained by _____ residents during their rotations at (institution name). Please sign where indicated below and return this letter to _____ by _____(date).

Sincerely,

_____
(RWJMS Program Director)

_____
(Chair of the Department)

_____
Michael Kelly, MD
Associate Dean for Graduate Medical Education
.....

_____
(Person in charge of residents at [name of institution])

_____
(CEO of other institution)

copy: Office of Graduate Medical Education RUTGERS Robert Wood Johnson Medical School
One RWJ Place, MEB 587, New Brunswick, NJ 08901

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IX. 3
SECTION: INSTITUTIONAL RESPONSIBILITIES
SUBJECT: GRADUATE MEDICAL EDUCATION COMMITTEE RESPONSIBILITIES

I. PURPOSE

The Graduate Medical Education Committee (GMEC) functions as an important mechanism through which the program directors of the training programs, residents, administrators and other interested parties, in concert with the Associate Dean for Graduate Medical Education, meet to advise the Dean on and monitor all aspects of the RUTGERS Robert Wood Johnson Medical School's residency/fellowship educational programs.

The Associate Dean for Graduate Medical Education, the directors of all residency and fellowship programs, representatives of the administration of each hospital participating in programs sponsored by RUTGERS Robert Wood Johnson Medical School and appointed and peer elected residents serve on the Graduate Medical Education Committee. Housestaff members are elected and appointed. The committee meets at least eight times per academic year or at the call of the Chair. Any Faculty member of the committee (including the Associate Dean for Graduate Medical Education) may be elected Chair by vote of the committee. The term shall be for three years. There shall be no limit on the number of successive terms a person may serve. Minutes are kept, distributed as specified by the Chair and available for review in the Office of Graduate Medical Education.

II. POLICY/SCOPE

Establish and implement policies that affect all residency programs regarding the quality of education and the work environment for the residents in each program. These policies and procedures must include:

A. Stipends and position allocation: Annual review and recommendations to the Sponsoring Institution regarding resident stipends, benefits, and funding for resident positions.

B. Communication with program directors:
   1. Ensure that communication mechanisms exist between the GMEC and all program directors within the institution.
   2. Ensure that program directors maintain effective communication mechanisms with the site directors at each participating institution for their respective programs to maintain proper oversight at all clinical sites.

C. Resident duty hours: The GMEC must:

1. Develop and implement written policies and procedure regarding resident duty hours to ensure compliance with the Institutional, Common, and specialty/subspecialty-specific Program Requirements.
2. Consider for approval requests from program directors prior to submission to an RRC for exceptions in the weekly limit on duty hours up to 10 percent or up to a maximum of 88 hours in compliance with ACGME Policies and procedures for duty hour exceptions.

D. Resident Supervision: Monitor programs' supervision of residents and ensure that supervision is consistent with:
1. provision of safe and effective patient care;
2. educational needs of residents;
3. progressive responsibility appropriate to residents' level of education, competence and experience; and
4. other applicable Common and specialty/subspecialty-specific program requirements.

E. Communication with Medical Staff: Communication between leadership of the medical staff regarding the safety and quality of patient care that includes:
1. the annual report to the OMS;
2. description of resident participation in patient safety and quality of care education; and,
3. the accreditation status of programs and any citations regarding patient care issues.

F. Curriculum and evaluation: Assurance that each program provides a curriculum and an evaluation system that enables residents to demonstrate achievement of the ACGME general competencies as defined in the Common and specialty/subspecialty-specific Program Requirements.

G. Resident Status: Selection, evaluation, promotion, transfer, discipline and/or dismissal of residents in compliance with the Institutional and Common Program Requirements.

H. Oversight of program accreditation: Review of all ACGME program accreditation letters of notification and monitoring of action plans for correction of citations and areas of noncompliance.

I. Management of institutional accreditation: Review of the Sponsoring Institution's ACGME letter of notification from the IRC and monitoring of action plans for correction of citations and areas of noncompliance.

J. Oversight of program changes: Review of the following for approval, prior to submission to the ACGME by program directors:

1. all applications for ACGME accreditation of new programs;
2. changes in resident complement;
3. major changes in program structure or length of training;

4. additions and deletions of participating institutions;
5. appointments of new program directors;
6. progress reports requested by any review committee;
7. responses to all proposed adverse actions;
8. requests for exceptions of resident duty hours;
9. voluntary withdrawal of program accreditation;
10. requests for an appeal of an adverse action; and,
11. appeal presentations to a Board of Appeal or the ACGME.

K. Experimentation and innovation: Oversight of all phases of educational experiments and innovations that may deviate from Institutional, Common, and specialty/subspecialty-specific Program requirements, including:

1. approval prior to submission to the ACGME and/or respective Review Committee
2. adherence to Procedures for "Approving Proposals for Experimentation or Innovative Projects" in *ACGME Policies and Procedures*; and,
3. monitoring quality of education provided to residents for the duration of such a project.

L. Oversight of reductions and closures: Oversight of all processes related to reductions and/or closures of:

1. individual programs;
2. major participating institutions, and,
3. the Sponsoring Institution

M. Vendor Interactions: Provision of a statement or institutional policy (not necessarily GME-specific) that addresses interactions between vendor representatives/corporations and residents/GME programs.

Approved by GMEC on 2/23/99
Amended by GMEC on 4/10/01, 5/13/03 & 6/12/07

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY
GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: IX. 4
SECTION: INSTITUTIONAL RESPONSIBILITIES
SUBJECT: REQUIREMENTS FOR RESIDENTS ROTATING FROM EXTERNAL GRADUATE MEDICAL EDUCATION PROGRAMS

I. PURPOSE

To provide a policy concerning rotations by residents from external graduate medical education programs.

II. SCOPE

This policy applies to all Programs / Departments whereby housestaff will be rotating into RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL from external GME programs.

III. DEFINITION

External housestaff refers to all interns, residents and sub-specialty residents (fellows) enrolled in A.C.G.M.E. or A.O.A. approved GME programs outside of RUTGERS Robert Wood Johnson Medical School.

IV. RESPONSIBILITY/REQUIREMENTS

All rotations by external housestaff must be approved by the RWJMS Program Director and the RWJMS Associate Dean for GME. Residents from external programs must be at a PGY 2 level or above in order to qualify as a rotating resident at RUTGERS Robert Wood Johnson Medical School.

Housestaff from other training programs interested in a clinical rotation in one of the RUTGERS Robert Wood Johnson Medical School Graduate Medical Education programs are welcome to apply. Completed applications are reviewed and approval is granted on a case-by-case basis provided trainees meet specific qualifications and entry requirements. Generally, trainees will be considered if they:

1) are in good standing in an accredited training program
2) obtain approval and support to rotate from a RUTGERS Robert Wood Johnson Medical School Program Director
3) complete and submit all rotator documentation and properly enroll prior to start date
4) Applicants wishing to apply for a rotation in a RUTGERS Robert Wood Johnson Medical School program should:

    1) Contact the program coordinator of the desired RUTGERS Robert Wood Johnson Medical School program to determine if the program is currently accepting rotators. The recommended time to contact a program is at least three months prior to the start of the rotation.

    2) Complete and submit the following documents to the respective

RUTGERS Robert Wood Johnson Medical School program **at least two (2) months** prior to the expected rotation start date: *:*

A) Letter of support indicating housestaff in good standing from home institution (indicating rotation dates)

B) Letter of approval from RUTGERS Robert Wood Johnson Medical School *Program Director (indicating rotation dates)*

C) Current Curriculum Vitae (CV)

D) Copy of valid/unexpired picture identification (driver's license, passport, etc.)

E) Attestation that the following documentation for the individual are on file with their institution:

1.An annual or the initial Health Assessment within the past twelve (12) months certifying fitness for duty for the rotator's work functions in a health care facility.

2.Record of Immunity by laboratory titers to rubella, rubeola, mumps and varicella. If laboratory titers are nonimmune, then record of full vaccination is required (at least 2 MMRs, Varivax series) unless there is a documented medical contraindication to vaccination.

3.Documentation of laboratory testing for Hepatitis B (HB) Surface Antigen, HB Surface Antibody and HB Core Antibody. Evidence of immunity by positive antibody titers to Hepatitis B or documentation that full Hepatitis B vaccination has been received or proof of declination of Hepatitis B vaccine. If Rotator is Hepatitis B Surface Antigen positive, the New Jersey Medical School Occupational Medicine Service (973-972-2900) must be contacted regarding further evaluation prior to rotation at RUTGERS Robert Wood Johnson Medical School

4.Record of Tdap in adulthood or record of medical contraindication to Tdap vaccination.

5.Record of seasonal influenza vaccination or documentation of medical contraindication to influenza vaccination.

6.Record of annual TB skin test (or blood assay for TB) if negative. If positive, documentation of negative chest xray at initial evaluation and annual symptom survey. If chest x-ray revealed evidence of active TB, documentation of appropriate medical treatment and annual symptom survey.

7.Medical clearance for respirator fit testing for N95 respirator or PAPR if needed .

8.Orientation training including preventing harassment and discrimination, radiation safety, patient safety, infection control/influenza and environment of care.

9. Cleared a criminal background check.

F) Copies of BLS, ACLS, or PALS valid certification through the rotation timeframe, if required by RWJMS program.

G) Malpractice insurance coverage verification from home institution (must indicate coverage through rotation timeframe). Coverage must be acceptable to RUTGERS Robert Wood Johnson Medical School *Risk and Claims*

H) Copy of medical license, DEA, or training permit from trainees Board of Medical Examiner's Office

I) US Medical Graduates-Copy of Medical School Diploma or Foreign Medical Graduates- Copy of ECFMG certificate/Fifth Pathway Certificate

J) RUTGERS Robert Wood Johnson Medical School *Confidentiality Statement*

K) RUTGERS Robert Wood Johnson Medical School *EMR Confidentiality Statement (if applicable)*

Approximately one month prior to the requested rotation, the resident will

receive notification from the RWJMS Program Director, with copy to the RWJMS GME Office, indicating if the application was approved. The resident will be provided with instructions for completing the mandatory online training as well as instructions to obtain an identification card/parking. **FAILURE TO COMPLETE ONLINE TRAINING BEFORE START DATE WILL FORFEIT ROTATION APPROVAL. The resident must** provide all online training certificates to RWJMS program director no less than ONE WEEK prior to start date. It is the rotator's responsibility to make arrangements for housing and transportation as necessary.

V. SALARY SUPPORT AND MALPRACTICE INSURANCE

Salary support, all fringe benefits and malpractice insurance coverage must be provided by the originating program unless explicitly stated otherwise in an Affiliation Agreement. Verification of malpractice insurance coverage is required prior to the initiation of the rotation at RUTGERS Robert Wood Johnson Medical School and must include the following:

A certificate of insurance naming RUTGERS Robert Wood Johnson Medical School as a certificate holder or, if the external program is a self-insured program, actuarial certification of self-insurance funding mechanism issued through the external program's risk management office; coverage limits of $1,000,000 / $3,000,000; coverage dates that include the time the resident will be at RUTGERS Robert Wood Johnson Medical School and a statement that the coverage includes the resident's activities at RUTGERS Robert Wood Johnson Medical School.

VI. HOUSING, MEALS, AND PARKING:

There will not be any subsidization for housing, meals, or parking by RUTGERS Robert Wood Johnson Medical School for rotating residents. This must be communicated to the rotating resident by the Division or Department prior to the initiation of the rotation. (Individual Divisions or Departments may provide subsidization for housing, meals or parking).

VII. ORIENTATION:

Rotating residents should be oriented by a member of the Department or Division in which they will be rotating. Individual residents should receive instructions as to the policies and procedures of both the University and Department or Division pertaining to: safety, parking, library availability, cafeteria hours, laundry facilities, on-call rooms and security issues.

Approved by GMEC on 11/9/99, 1/11/11
Amended 11/12/02, 01/10/11

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION

POLICY#: IX. 5

S**ECTION:** INSTITUTIONAL RESPONSIBILITIES
SUBJECT: REQUIREMENTS FOR RESIDENTS ROTATING TO EXTERNAL GRADUATE MEDICAL EDUCATION PROGRAMS

I. PURPOSE

To provide a policy concerning rotations by housestaff to external graduate medical education programs.

II. SCOPE

This policy applies to all Programs / Departments whereby housestaff will be rotating away from RUTGERS Robert Wood Johnson Medical School to external GME programs.

III. DEFINITION

Housestaff refers to all interns, residents and sub-specialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITY/REQUIREMENTS

The trainee must make a formal request in writing to the Program Director to obtain permission to perform an away rotation. This request must be made at least 90 days prior to the beginning of the away rotation. Residents seeking rotations away from RUTGERS Robert Wood Johnson Medical School programs must be at a PGY 2 level or above in order to qualify. Each housestaff must possess either a NJ permit or license. Appropriate qualifications must be verified by the respective Program Director or Chair.

B. Approval by Program Director or Chair

The Program Director will consider whether a comparable elective rotation is available at RUTGERS Robert Wood Johnson Medical School, or if the proposed away elective provides a unique educational opportunity that is specific to the individual's career goals, is valuable to RUTGERS Robert Wood Johnson Medical School or is humanitarian. The Program Director will then approve or disapprove the request.

Away rotations must be approved in writing by the Program Director or Chairman and a copy of that approval must be kept in the trainee's academic file.

C. Approval by Risk & Claims Management for Malpractice Coverage

The Program Director must provide the Graduate Medical Education Office with the following information, so that written documentation of malpractice insurance coverage can be requested from the Office of Risk & Claims Management prior to the initiation of any rotation away from RUTGERS Robert Wood Johnson Medical School:

- the reasons for which the educational experience requires an out of school rotation
- if the rotation is out of state, reason an out of state, rather than in-state rotation is necessary
- name of Program Director at away training site
- objectives of the rotation
- location of away Program training site
- copy of an approval letter from the program director indicating type of rotation, specifying the dates and duration of away rotation.

Approval letters from Risk Management will specify both the limits of liability at the stated amounts of $1,000,000/$3,000,000, as well as the duration of coverage for the houseofficer while at the specified away training site/program.

Risk Management must obtain commercial coverage for certain high risk locales (Philadelphia, New York City, Chicago, Florida and California) and requires at least 60 days notice for processing. All housestaff must obtain an approval letter prior to beginning any away rotations.

D. Letter of Understanding/Program Specific Letter of Agreement

Once approved by Risk & Claims Management, the Program Director must obtain a letter of understanding from the away Program Director specifying the goals and objectives and who will be responsible for supervision and evaluation. For elective rotations one month or longer in duration, Program Directors must check with their respective RRC's in determining if a program specific letter of agreement is required as outlined in Policy IX.2 of this manual. Some RRC's require a letter for each rotation, regardless of duration.

E. Documentation for the Graduate Medical Education Office

Copies of the approval letter and letter of understanding, along with proof of malpractice coverage must be submitted to the Office of Graduate Medical Education at least 30 days prior to the start of the away rotation.

V. SALARY SUPPORT

Funding of Salary support, all fringe benefits and malpractice coverage will remain as fiscally approved by RUTGERS Robert Wood Johnson Medical School unless explicitly stated otherwise in an Affiliation Agreement.

VI. HOUSING, MEALS, AND PARKING

RUTGERS Robert Wood Johnson Medical School will not be responsible for any subsidization for housing, meals, or parking for housestaff while on away rotations. This must be communicated to the rotating houseofficer by the Division or Department prior to the initiation of the away rotation. (Individual Divisions or Departments may provide subsidization for housing, meals or parking).

VII. ORIENTATION

RUTGERS Robert Wood Johnson Medical School rotating housestaff should receive instructions as to the policies and procedures of away training Program/Institution. These may pertain to areas of: safety, parking, library availability, cafeteria hours, laundry facilities, on-call rooms and security issues.

Approved by GMEC on 11/9/99 Amended 11/12/02, 5/13/03 & 11/13/07

Letter of Understanding

DATE

(addressee)
Dear Dr. ( ):

I am writing to confirm the following arrangements for Dr. (resident), one of our (program) residents, who will be rotating to your site from (date) to (date).

Academic standing: Dr. (resident) is currently in good academic standing in (his/her) residency program.

Stipend/Benefits and Malpractice insurance will be provided by RUTGERS Robert Wood Johnson Medical School during this rotation.

Supervision/Teaching/Evaluation: All patient care services provided by Dr.(resident) shall be under the direct and exclusive supervision and control of the physician staff having practice privileges at (rotation site). The physician staff of the (rotation department) will be responsible for the teaching, supervision and written evaluation of Dr. (resident) assigned to (rotation site) under this agreement.

The (title of appropriate person) at (rotation site) will assume administrative responsibility for Dr. (name of resident) while on rotation.

Goals and Objectives: The “teaching curriculum” attached has been submitted to and approved by the resident’s RUTGERS Robert Wood Johnson Medical School program director.

Policies and Procedures Governing Residents: Residents enrolled in the program rotation covered by this letter of agreement will be governed in accordance with the policies and procedures established through RUTGERS Robert Wood Johnson Medical School’s residency programs. Residents shall also follow applicable (name of host institution) policies and procedures while completing their rotation.

Please sign and return this letter in the envelope provided. By signing this letter, you are agreeing to the conditions listed above for the resident on rotation at your site. We appreciate your participation in our resident’s training program. Should you have any questions, please feel free to call me at ( ).

Sincerely,

_____
Name printed

_____
Title (Program Director)

_____
(Title) Signature

_____
Date

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: IX.6
SECTION: INSTITUTIONAL RESPONSIBILITIES
SUBJECT: REQUIREMENTS FOR RESIDENTS WISHING TO DO INTERNATIONAL ELECTIVES

I. PURPOSE

To provide a policy concerning housestaff requests to do an international elective rotation.

II. SCOPE

This policy applies to all Programs / Departments whereby housestaff wish to do an international elective away from RUTGERS Robert Wood Johnson Medical School

III. DEFINITION

Housestaff refers to all interns, residents and sub-specialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. A member of the housestaff may be referred to as a house officer.

International elective refers to any elective rotation outside of the 50 states in the United States of America.

IV. RESPONSIBILITY/REQUIREMENTS

A. Request from Housestaff

1. The house officer must first review travel restrictions, requirements of US citizens, insurance information, etc., provided by the US Department of State (http://travel.state.gov/travel/cis_pa_tw/cis_pa_tw_1168.html). The international elective site cannot be on the US warning list for travel.

2. RUTGERS Robert Wood Johnson Medical School contracts with International SOS (ISOS) to provide travel assistance services for the University community while traveling abroad on university approved activities. ISOS provides security and medical evacuation services, and a variety of online health, safety, and security resources. Enrollment is required. Information is available at www.internationalsos.com. The trainee should plan to obtain any required/recommended immunizations, pending approval of the international elective.

3. The trainee must make a formal request in writing to the Program Director to obtain permission to perform an away rotation. This request must be made at least 90 days prior to the beginning of the away rotation. Residents seeking rotations away from RUTGERS Robert Wood Johnson Medical School programs must be at a PGY 2 level or above in order to qualify. Each housestaff must possess either a NJ permit or license. Appropriate qualifications must be verified by the respective Program Director or Chair.

B. Approval by Program Director or Chair

The Program Director will consider whether a comparable elective rotation is available at RUTGERS Robert Wood Johnson Medical School or if the proposed away elective provides a unique educational opportunity that is specific to the individual's career goals, is valuable to RUTGERS Robert Wood Johnson Medical School or is humanitarian. The Program Director will then approve or disapprove the request.

Away rotations must be approved in writing by the Program Director or Chairman and a copy of that approval must be kept in the trainee's academic file.

C. Approval by Risk & Claims Management for Malpractice Coverage

The Program Director must provide the Graduate Medical Education Office with the following information, so that written documentation of malpractice insurance coverage can be requested from the Office of Risk & Claims Management prior to the initiation of any rotation away from RUTGERS Robert Wood Johnson Medical School.

- the reasons for which the educational experience requires an out of school rotation
- if the rotation is international, reason an international rotation is necessary
- name of Program Director or Medical School Faculty member at away training site
- objectives of the rotation
- location of away Program training site
- copy of an approval letter from the program director.faculty indicating type of rotation, specifying the dates and duration of away rotation.

Approval letters from Risk Management will specify both the limits of liability at the stated amounts of $1,000,000/$3,000,000, as well as the duration of coverage for the houseofficer while at the specified away training site/program. Risk Management requires at least 60 days notice for processing. All housestaff must obtain an approval letter prior to beginning any away rotations.

D. Letter of Understanding/Program Specific Letter of Agreement

Once approved by Risk & Claims Management, the Program Director must obtain a letter of understanding from the away Program Director/ Faculty specifying the goals and objectives and who will be responsible for supervision

and evaluation. For elective rotations one month or longer in duration, Program Directors must check with their respective RRC's in determining if a program specific letter of agreement is required as outlined in Policy IX.2 of this manual. Some RRC's require a letter for each rotation, regardless of duration.

E. Documentation for the Graduate Medical Education Office

Copies of the approval letter and letter of understanding, along with proof of malpractice coverage must be submitted to the Office of Graduate Medical Education at least 30 days prior to the start of the away rotation.

V. SALARY SUPPORT

Funding of Salary support, all fringe benefits and malpractice coverage will remain as fiscally approved by RUTGERS Robert Wood Johnson Medical School unless explicitly stated otherwise in an Affiliation Agreement.

VI. HOUSING, MEALS, AND PARKING

RUTGERS Robert Wood Johnson Medical School will not be responsible for any subsidization for housing, meals, or parking for housestaff while on away rotations. This must be communicated to the rotating house-officer by the Division or Department prior to the initiation of the away rotation. (Individual Divisions or Departments may provide subsidization for housing, meals or parking).

VII. ORIENTATION

RUTGERS Robert Wood Johnson Medical School rotating housestaff should receive instructions as to the policies and procedures of away training Program/Institution. These may pertain to areas of: safety, parking, library availability, cafeteria hours, laundry facilities, on-call rooms and security issues.

Approved by GMEC on 2/14/12

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: IX.7
SECTION: INSTITUTIONAL RESPONSIBILITIES
SUBJECT: GME ANNUAL PROGRAM EVALUATION

I. Purpose

To provide a guideline for how the annual program evaluation (APE) is to be completed, reviewed and presented to the GMEC.

II. Scope

Covers all graduate medical education programs and associated programs at Rutgers Robert Wood Johnson Medical School

III. Definitions

Program Evaluation Committee: a committee formed by the program director that is charged with reviewing the associated training program on no less than an annual basis.

Annual Program Evaluation Sub-Committees: three sub-committees that are responsible for reviewing submitted APEs and reporting the results of this review to GMEC

Resident: for purposes of this policy, resident refers to a trainee in a graduate medical education program

IV. Responsibilities/Requirements:

A. The program director is responsible for an APE to be completed and submitted in a timely manner to the appropriate sub-committee
B. The APE must be presented at a faculty meeting and/or available for review by all faculty members.
C. The chair of the department is required to sign the APE
D. The chairs of the APE sub-committees (see below) are responsible for presenting the review of the APE to the GMEC
E. The GMEC is responsible for reviewing the reports as submitted by the APE sub-committees.
F. Policy/Procedure for APE
    i. The APE is to be completed by the program evaluation committee, functioning in accordance with ACGME requirements.
        1. an APE must be completed even if there are no residents currently enrolled in the program
    ii. The following items are to be reviewed as part of the APE:
        1. Action items from previous APE, including the status of the item (closed, ongoing)
        2. Board Passage Rate for previous 5 years
            a. Include first time passage rate
            b. Overall passage rate (as available)
            c. Compare to required board pass rate (e.g., ACGME)
        3. Duty Hours- review compliance, note rate of violations
        4. Resident & Faculty Surveys- following evaluations should be reviewed with trend analysis
            a. ACGME surveys
            b. GME surveys
            c. Internal (program) surveys
        5. Scholarly Activity for core faculty and residents- table from webADS (as applicable) should be included with report. Any other scholarly activity that PEC feels is appropriate should be included

6. Quality/Performance Improvement- list resident, PI project/committee, note whether planned, ongoing or completed and mentor
7. Curriculum Analysis
    a. Verify that curriculum has goals and objectives specified by level of training
    b. Summary of resident and faculty evaluation of the curriculum
    c. Recommended changes to the curriculum
    d. Recommended educational activities for the upcoming year
8. Faculty Development Activities
    a. Indicate if activity was developed by department/division
9. Attrition in residency program or core faculty, including analysis of impact, if any
10. Resident Milestone Data- review resident performance in comparison to national data if available
11. Program Letters of Agreement- reviewed and current
12. Policies- reviewed and current
13. Case Logs- review case logs of most recent graduating class to ensure meeting ACGME requirements
14. Participating Sites- program director has met with site director within past year; note any comments
15. Identified Areas of non compliance with ACGME standards- corrective plan should be listed as part of action plan
16. Residency Size- list educational rationale (including workforce analysis), educational and financial resources (in place, planned, needed) and timeline
17. Program Director Concerns

iii. The report is to conclude with an action plan which includes the item, proposed action, leader and target date

iv. The report is to list the members of the PEC that participated in the review, the date of the review and the date it was presented to the faculty

G. Policy/Procedure for review of APE

i. Three sub-committees are charged with reviewing the APEs. These committees are:
    1. Medical based specialties
    2. Surgical based specialties
    3. Hospital based specialties

ii. Programs will be assigned to the committees based on the ACGME descriptions

iii. Each committee will have a chair and a number of members (including at least one resident) that is equivalent to one third of the total programs in that particular group
    1. Program directors, assistant/associate program directors, program coordinators and residents are eligible to serve on the sub-committees
    2. The chair of the sub-committee must be a program director or an assistant/associate program director

iv. The committee will be responsible for reviewing the APEs from their assigned programs. This review is to note:
    1. that the review is complete and meets all requirements
        a. the sub-committee can determine that programs may be exempt from completing certain items, based on specific factors (for example, is a non-ACGME accredited program)
    2. commendable items
    3. concerning items
    4. If the program is requesting a change in size, the committee must give their opinion of this
    5. overall recommendation for the program
        a. continue
        b. action needed

i. items and needed resources must be identified

c. closure

i. if closure is recommended, this is to be presented to the appropriate departmental chair and the DIO prior to submission to GMEC

v. The review is documented on the evaluation of the APE form and presented to the GMEC by the chair of the sub-committee

vi. Each committee is responsible for ensuring that all programs under that committee complete the APE on an annual basis and that the evaluation of the APE and presentation to GMEC is completed in a timely manner

APPROVED BY GMEC on September 10, 2013

SECTION TEN

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: X.1
SECTION: PATIENT CARE SERVICES
SUBJECT: AUTOPSY RESPONSIBILITIES

I. PURPOSE

To provide institutional guidelines regarding residency autopsy responsibilities.

II. SCOPE

This policy is applicable to all members of the housestaff.

III. DEFINITIONS

Housestaff - refers to interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program.

IV. RESPONSIBILITY/REQUIREMENTS

To establish an institutional policy regarding the utilization of autopsies as a medical education training tool.

Policy:

All deaths must be reviewed and autopsies performed whenever possible. Autopsies are an essential part of a house officer's education. He/she must make an effort to secure permission for an autopsy on all patients who expire on the teaching service. Housestaff should be present at autopsies or should review the gross pathological specimens of the autopsies performed on their patients and should review the autopsy reports. Formal teaching sessions with reviews of autopsy, biopsy, and surgical pathology cases must be regularly scheduled.

Protocol for Autopsy Request

In all cases, it is the responsibility of the attending physician to obtain consent for autopsy. The request for consent must be documented in the medical record. A note must be entered in the medical record if circumstances exist which, in the judgment of the attending physician, prohibit requesting a consent for autopsy.
When a patient dies, a house officer should determine if the Medical Examiner's Office must be notified. If the medical examiner declines the case, housestaff are obligated to offer the family an autopsy. When a patient is pronounced dead, it is the responsibility of the house officer to inform the patient's family about the autopsy examination. This should not be perceived as an emotionally charged issue.

The following points of information should/must be communicated to the family:

A. The person taking responsibility for the body, usually the next of kin, may give permission for the autopsy.

B. There is no charge to the family for the autopsy service.

C. The autopsy may confirm the clinical diagnosis or uncover additional contributory causes for the patient's death.

D. The autopsy contributes toward improved patient care, research and physician education.

A packet of forms is available in the units. Assistance with previous or pending autopsies. eg., facilitating the process or arranging a gross review, can be directed to the Autopsy Service Director.

For further information and reports:

RWJUH Admitting Office # (732) 937-8602
Autopsy Pathology Directors Office # (732) 937-8651
RWJUH Autopsy Room # (732) 828-3000; ext. 5802
RWJUH Pathologist-on-call # (732) 828-3000; Pager (732) 880-6256
Pathology Residents' Room #(732) 828-3000, ext. 2087
Medical Examiner of Middlesex County # (732) 826-0331
SPUH- Nursing Unit Manager, day shift, # (732) 745-8600
SPUH- Chief of Autopsy Service/Autopsy Room: # (732) 745-8600, ext. 8234
SPUH- Autopsy Room: # (732) 745-8600, ext. 8239
SPUH- Pathologist on-call: # (732) 390-2583
The Medical Center at Princeton: # (609) 497-4351
Muhlenberg Regional Medical Center: # (908) 668-2270
Deborah Heart and Lung Center: # (609) 893-6611, ext. 4269
Jersey Shore Medical Center # (732) 776-4148
VA New Jersey Health Care System: (973) 676-1000, ext.

Approved by GMEC 2/23/99
Revised 5/3/99

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: X. 2 `
SECTION: PATIENT CARE SERVICES
SUBJECT: PRESCRIPTIONS AND HOUSESTAFF

I. PURPOSE

To provide a policy concerning circumstances under which residents may or may not complete written prescriptions for a patient to fill at a site outside the hospital.

II. SCOPE

This policy applies to all Programs / Departments. It incorporates the "Prescription Blank Security Procedure, adopted April 14, 2011, and found in the Robert Wood Johnson Medical Group Clinical Care and Operations Policy and Procedure (appended).

III. DEFINITION

Housestaff refers to all interns, residents and sub-specialty residents (fellows) enrolled in A.C.G.M.E. or A.O.A. approved GME programs outside of RUTGERS Robert Wood Johnson Medical School .

"Registered resident" refers to a participant in a graduate medical education program in New Jersey who has been granted authorization to engage in the practice of medicine in New Jersey in the first year of a graduate medical education program, subject to limitations.

"Permit holder" refers to a resident authorized to engage in the practice of medicine, as appropriate, while in the second year, or beyond, of a graduate medical education program in NJ, subject to limitations.

"Licensed physician" refers to a physician who has a current license to practice medicine in New Jersey, granted by the New Jersey Board of Medical Examiners.

IV. RESPONSIBILITY/REQUIREMENTS

A. A registered resident may engage in the practice of medicine provided that such practice shall be confined to a hospital affiliated with the graduate medical education program and outpatient facilities integrated into the curriculum of the program, under the supervision of licensed physicians. All prescriptions and orders issued by registered residents in the inpatient setting shall be countersigned by either a licensed physician or a permit holder at the minimum upon the patient's discharge. All prescriptions issued by registered residents in the outpatient setting which are to be filled in a pharmacy outside a licensed health care facility shall be signed by a licensed physician.

B. Prescriptions and orders may be issued by permit holders in the inpatient setting without countersignature. All prescriptions issued by permit holders in the outpatient setting, which are to be filled in a pharmacy outside a licensed health care facility, shall be signed by a licensed physician.

C. Residents may not use signature stamps of licensed physicians to sign prescriptions without the express, formal authorization of the licensed physician.

D. Residents may not make use of blank prescriptions or incomplete prescriptions pre-signed by a licensed physician.

E. A resident who does not comply with the above policy will be subject to disciplinary action by the residency program, the department, the school, or the State of New Jersey, as appropriate to the circumstances of the event.

Refer also to: RUTGERS Robert Wood Johnson Medical School Group Policy “Prescription Blank Security Procedure”

Approved by RUTGERS Robert Wood Johnson Medical School - Graduate Medical Education Committee at its meeting on

May 11, 2011.

SECTION ELEVEN

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.1
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: INTELLECTUAL PROPERTY COPYRIGHTS & ROYALTIES

I. PURPOSE

To set policy regarding copyrights and royalties for all copyrightable material created by University personnel related to or within the scope of their employment at the University.

II. STATEMENT OF PRINCIPLES

The University encourages the dissemination of knowledge and development of creative work that fulfills its educational, research and service missions and benefits the public it serves. The University supports the preparation and publication of copyrightable works resulting from the teaching, research, scholarly and artistic endeavors of faculty, staff and students as part of their roles at the University. The University seeks to foster an intellectually stimulating environment in which creative efforts and innovations are encouraged and rewarded, the careers of its members are enhanced, and the University's reputation and prestige are furthered. The University respects, acknowledges and promotes the intellectual property rights in works created by its members. The University strives to maintain a balance among the interests of Creators, sponsoring bodies and the University in copyrightable material and income resulting from such works.

All University personnel are encouraged to retain ownership of the copyright to Traditional Works of Scholarship (as defined herein) or to obtain a perpetual license from the copyright owner to reproduce, distribute, perform, and/or display the work and to make Derivative Works therefrom.

III. ACCOUNTABILITY

Under the direction of the President, the Vice President for Academic Affairs and the Vice President for Legal Management shall ensure compliance with this policy. The Director, Office of Patents and Licensing shall implement this policy. The Deans shall ensure that each new faculty member receives a copy of this policy or is directed to it on the University's web site.

IV. APPLICABILITY

This policy shall apply to the following persons: full-time and part-time faculty, postdoctoral appointees, housestaff, non-faculty employees and student employees.

V. DEFINITIONS

A. "Creator": Person who transforms ideas into a tangible form of expression thereby creating Copyrightable Material.

B. "Copyrightable Material": Material that is subject to U.S. copyright laws, including, but not limited to, literary works, musical works, dramatic works, choreographic works, graphic works, photographic works, cardiographic, radiographic and pictorial works (e.g., x-rays, images), sculptural works, audiovisual and videotaped works, sound recordings, films, theses, and works in electronic media (e.g., digitized works and network transmission of digitized works, multimedia broadcast, web-based products, recorded materials, remote transmission of information, instructional software, CD-ROMs).

C. "Derivative Works": Copyrightable Material based on or derived from one or more already existing copyrighted works. Derivative works include, but are not limited to, new versions, translations, dramatizations, fictionalizations, reproductions, compilations, revisions and condensations.

D. "Traditional Works of Scholarship": Copyrightable Material reflecting research and/or creativity which is considered evidence of accomplishment in the Creator's academic discipline or professional field, and is specifically created for predominant use by persons or entities other than the University and/or its students. Such works include, but are not limited to, books, book chapters, journal articles, abstracts, student theses, plays, poems, pictorial and sculptural works, films, cassettes, musical compositions and other literary works.

E. "Institutional Works": Copyrightable Material created (1) specifically or predominantly for use by or at the University, or (2) at the request or behest of the University, or (3) under the specific direction of the University, or (4) by a person acting within the scope of his or her employment at the University, or (5) under a written contract between the Creator and the University, or (6) under a contract between the University and an external agency. "Traditional Works of Scholarship" will not be considered "Institutional Works" for the purposes of this policy.

F. "Instructional Materials": A type of "Institutional Work," including textbooks and study guides, used for the instruction of RUTGERS Robert Wood Johnson Medical School students, housestaff and/or postdoctoral fellows.

G. "Other Intellectual Property": Any Copyrightable Material other than Traditional Works of Scholarship, Institutional Works and Instructional Materials.

H. "University Resources": Tangible resources provided by the University to a Creator, including funds, office space, lab space, equipment, electronic network resources (hardware and software), support personnel, secretarial support, research, teaching and lab assistants, assistance from medical students or residents, media specialists or illustrators, supplies, utilities. Funds include grants and contracts or awards made to the University by an extramural sponsor.

VI. REFERENCES

A. Patents 00-01-90-45:00

B. Educational Use of Copyrighted Works 00-01-90-50:05

VII. POLICY

A. Copyright Ownership

1. Institutional Works and Instructional Materials as defined herein shall be deemed as having been created within the scope of employment of the Creator. Copyright ownership of such works shall vest with the University unless otherwise agreed in writing. Rights associated with copyright ownership become enforceable where the University has sought and obtained a copyright, which shall be done where the University determines that the material is commercially viable.

2. Traditional Works of Scholarship as defined herein shall be deemed as having been created outside the scope of employment of the Creator. Copyright ownership of such works shall vest with the Creator.

3. Ownership of the copyright in Other Intellectual Property will be determined by the University on a case-by-case basis, based upon the level of use of University Resources in its creation.

4. Absent the establishment of such by law or contract, the University shall assert no ownership rights to any Copyrightable Material developed by a Creator before joining the University.

B. Marking and Disclosure

1. Copyrightable Material shall be marked at the earliest possible opportunity with the copyright symbol "©" or the word "copyright" or the abbreviation "Copr.", the year of first production or publication, and the name of the owner of the copyright in the work.

2. The Creator shall promptly file a copyright disclosure form with the Director, Office of Patents and Licensing for any (a) Institutional Works, (b) Instructional Materials and (c) Other Intellectual Property created with the use of University Resources.

   a. The disclosure form shall be filed when the material is in final form or when it is close to completion. Should the Creator desire that the University release its ownership rights in the copyright in the disclosed work, the disclosure form should contain such a request.

   b. The University may release its ownership rights to the Creator when, as determined by the Director, Office of Patents and Licensing (1) there are no overriding special obligations to a sponsor or other third party, and/or (2) the best interests of the University would be so served. The University shall make this decision within 90 days of receipt of the disclosure form.

   c. If the Director denies the Creator's request that the University's ownership rights in the copyright be released to the Creator, the Creator may appeal this decision to the University Intellectual Property Faculty Committee for final decision. The University will endeavor to seek qualified faculty representation from all RUTGERS Robert Wood Johnson Medical School on this committee.

   d. The Director, Office of Patents and Licensing shall file an application to register the University's copyright interest in the disclosed work when copyright ownership remains with the University.

C. Rights to License, Market and Use Copyrightable Material

1. Traditional Works of Scholarship and Other Intellectual Property created without the use of University Resources:

   a. The Creator has the right to determine his/her own licensing, marketing and use of these materials.

   b. When a Creator departs from the University, she/he shall grant the University a license to distribute, display and reproduce this Copyrightable Material and to produce Derivative Works there from

for educational and research purposes within RUTGERS Robert Wood Johnson Medical School except if copyright ownership of Traditional Works of Scholarship has been transferred to a publisher as a requirement of publication.

2. Institutional Works, Instructional Materials and Other Intellectual Property created with the use of University Resources:

   a. The University, through the Office of Patents and Licensing, shall have the right to determine the licensing, marketing and use of material for which the University has sought and obtained copyright ownership. This determination shall take into account the interests of the University, the public and the Creator, including the Creator's preferences.

   b. The Creator shall have the right to be identified or to refuse to be identified as the Creator by the University and by subsequent licensees and assignees, except as required by law.

D. Royalties and Revenue Distribution

1. Traditional Works of Scholarship, and Other Intellectual Property that is created without the use of University Resources: All revenue from material within these categories belongs exclusively to the Creator.

2. Institutional Works, Instructional Materials and Other Intellectual Property that is created with the Use of University Resources: A fee of 10% shall be paid to the Office of Patents and Licensing. This fee as well as other expenses (e.g., legal fees, registration fees, other licensing fees) shall be subtracted before revenue is distributed. The remaining revenue from material within these categories shall be divided as follows:

   a. The Creator shall receive 40%.

   b. The department/program/unit/center employing or contracting with the Creator shall receive 25%; primary consideration in the use of this portion of the revenues shall be given to support the Creator’s further research or his/her other creative efforts at the University.

   c. The School in which the Creator has an academic appointment or the administrative or patient care unit in which the Creator is employed shall receive 25%; this portion of the revenues shall be utilized at the discretion of the pertinent Dean, Vice President or President/CEO of the Healthcare Unit.

3. In the event of the Creator's death, any compensation payable under this policy shall be paid to his/her estate or assigns.

E. Traditional Works of Scholarship that are created as, or are transformed into, electronic media by faculty will be treated in a similar manner as other Traditional Works of Scholarship.

F. Except where otherwise provided, resolution of disputes concerning the application of this policy or the ownership of copyrights shall be brought directly to the Vice President for Academic Affairs, who shall, in consultation with the Vice President

for Legal Management and appropriate Dean or other Vice President, render a final decision within 30 calendar days.

By Direction of the President:

_____	_____
Vice President for Academic Affairs	Vice President for Legal Management

University Policy Code: 00-01-20-21:00
Adopted: 7/01/87
Amended: 8/19/99 & 12/3/02 & 8/31/04

Approved by GMEC on January 11, 2000

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.2
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: PATIENT CONFIDENTIALITY AND HEALTH INFORMATION

I. PURPOSE

To protect patient privacy as electronic health-care records and networked information systems are introduced into the University by ensuring the highest level of confidentiality of individually identifiable patient health-care information, whether paper or electronic, that is compatible with current technology and with legitimate needs for accessibility of the information.

II. APPLICABILITY

This policy shall apply to health information that is generated during provision of health care to patients in any of the University's patient-care units, patient-care centers or faculty practices, as well as to clinical information generated from human subject's research under the auspices of the University or by any of its agents.

III. ACCOUNTABILITY

Under the President, the Vice President/CEO of University Hospital (UH), the Vice President/CEO of University Behavioral HealthCare (UBHC) and the deans shall ensure compliance with this policy. Appropriate individuals at University Hospital, University Behavioral HealthCare, the schools and faculty practices, in conjunction with the Vice President for Information Systems & Technology (IST), shall implement the policy by means of unit-specific procedures and standards.

IV. IMPLEMENTATION

This policy shall be fully implemented by January 1, 2001. A committee composed of representatives of the University's patient-care units, patient-care centers, faculty practices and IST shall oversee the implementation. This committee shall also be responsible for reviewing and recommending revisions to the policy at least annually.

V. DEFINITIONS

A. Privacy is an individual's desire to limit the disclosure of personal information.

B. Confidentiality is a condition in which information is shared or released in a controlled manner.

C. Security consists of measures to protect the confidentiality, integrity and availability of information and the information systems used to access it.

D. Electronic health information (such as electronic medical records) is a computerized format of the health-care information in paper records that is used for the same range of purposes as paper records, namely to familiarize readers with the patient's status, to document care, to plan for discharge, to document the need for care, to assess the quality of care, to determine reimbursement rates, to justify reimbursement claims, to pursue clinical or epidemiological research, and to measure outcomes of the care process.

E. A firewall is a computer positioned at a single focused point of entry for external users over unsecured public networks, such as the Internet, into an internal trusted network; firewalls can be configured to monitor and regulate messages passing into and out of the private network, or prevent particular programs from passing through.

VI. REFERENCES

Information Management 00-01-10-30:00

For the Record: Protecting Electronic Health Information, National Research Council, 1997 (from which sections of this policy have been taken verbatim).

VII. POLICY

A. General Principles:

1. Electronic health-care information has many advantages over paper records, including immediate availability to authorized individuals; clear organization; ready adaptability for analyses and research; legibility; and ability to provide alerts, suggestions, warnings, reminders, critical pathways and links to relevant literature. It will be the predominant form of health-care information at the University in the future. Properly implemented and managed, electronic health records have the potential to increase the security of health information and the privacy of patients over that in a paper-records environment.

2. Individuals have a fundamental right to control the dissemination and use of information about themselves, including health-care information. Individuals have the right to expect that their identifiable health information will not be disclosed without their express informed consent. Respect for patients' privacy is part of the ethical practice of the health-care professions.

3. The University is committed to providing appropriate safeguards for patient privacy and for confidential health-care information, consistent with available technology and with legitimate needs for accessibility of the information to authorized individuals for effective delivery of health care, for efficient functioning of the health-care delivery system (including audit and accreditation functions), for biomedical, behavioral, epidemiological and health services research, and for education.

4. Protection of health-care information depends on both technology and organizational measures to minimize potential abuse by authorized users, whether intentional or unintentional, and from outside attacks.

5. The technical and organizational security measures required to safeguard patient privacy and the confidentiality of health-care information must be balanced against: (a) costs (impediments to clinicians' access to information relevant to their decision-making; expense of purchase and of integration into the current system; costs of ongoing management, operations and maintenance; user frustrations with suboptimal interfaces and procedures; user time lost in satisfying security protections); (b) the need of authorized users to access critical information in a timely manner so that provision of health care is not compromised; (c) the need of researchers and educators for information that will further knowledge; (d) and the desire of payers not to be defrauded.

6. The University requires compliance with all state and federal laws, rules and regulations governing the confidentiality of patient medical records in any medium, as well as with the guidelines established by organizations such as the JCAHO.

7. Any individual who violates this policy or is responsible for unauthorized breaches of patient confidentiality shall be subject to discipline up to and including dismissal from the University as well as civil and criminal penalties. Sanctions shall be applied consistently to all violators regardless of job title or level in the organization.

B. Security breaches, violations of policy, unauthorized access, audit-trail data or other system warnings about unusual or inappropriate activity, and identified weaknesses in security measures shall promptly be reported by the assigned data steward or confidentiality officer to the pertinent dean or vice president and to the Vice President for IST.

C. Mechanisms for protecting health information include technical measures for improving computer and network security, and organizational measures for ensuring that health-care workers understand their responsibility to protect information and that processes are in place for detecting and reporting violations:

1. Technical Practices and Procedures: The University and its patient-care units shall adopt the following technical security practices:

a. Individual authentication of users. In order to establish individual Accountability for actions on-line and to implement access controls based on individual needs, every individual shall have a unique identifier or log-on ID for use in logging into patient- care information systems. Individuals shall be informed that it is a violation of this policy to share identifiers with others. Passwords shall be changed no less frequently than every six (6) months. Names, English-language words and common

acronyms shall not be used as passwords. Passwords should include letters, numbers and other characters. There shall be strict procedures set up at each patient-care unit for issuing and revoking identifiers.

b. Access controls. As soon as current technology at the University permits, each patient-care unit, patient-care center and faculty practice shall develop procedures to ensure that users can access and retrieve only that information for which they have a legitimate need to know.

c. Audit trails. Each patient-care unit shall maintain in retrievable and usable form audit trails that log accesses to patient information. The logs may include information such as the date and time of access, the information or record accessed, the user ID under which access occurred, and if possible the reason for the access. Audit-trail information shall be kept in a safe place to prevent erasure or modification. Procedures shall be established for regularly reviewing and analyzing audit logs or a random sample thereof to detect inappropriate accesses. Audit trails should be used together with system-generated prompts or warning screens informing users of the sensitive content of patient records and reminding them about audit logs and sanctions for unauthorized access.

d. Physical security and disaster recovery. IST and each patient-care unit shall:

(1.) limit unauthorized physical access to computer systems, displays, networks and health-care records;

(2.) position monitors and keyboards so they are not easily seen by anyone other than the user;

(3.) where appropriate, program workstations to display passworded screen savers if left idle for a specified period of time;

(4.) properly dispose of outdated equipment, tapes, disks, paper printouts and other media that contain confidential information;

(5.) establish plans for providing basic system functions and ensuring access to health-care records in the event of a natural emergency or mechanical or software failure by means such as redundant processing facilities, regular full-system back-ups and annual practice drills;

(6.) store backup data in safe places or in encrypted form; and

(7.) ensure that contractors used to transport and store back-up tapes have adequate policies and procedures to protect the integrity and confidentiality of the information.

e. Protection of remote access points. IST shall install and monitor a firewall and/or other forms of protection that provide strong centralized security to host machines that allow external public or insecure connections such as the Internet or dial-in telephone lines. Outside access shall be allowed only to those systems critical to outside users or for the conduct of University business. There shall be an additional secure authentication process (either encrypted or single-session passwords) for remote and mobile users, such as those using home or portable computers, or remote access shall be allowed only over dedicated lines.

f. Protection of external electronic communications. In order to prevent interception by unauthorized individuals, all patient-identifiable information should be encrypted before transmission over open public networks such as the Internet, or such transmission should be only over secure dedicated lines. The inclusion of patient-identifiable information in unencrypted E-mail is forbidden.

g. Software discipline. IST shall ensure the installation of virus-checking programs on all servers University-wide. The University shall maintain an inventory of all software on all workstations and servers. Vendor licensing agreements must be adhered to.

h. System assessment and technological awareness. IST shall formally assess the security and vulnerabilities of the University's information systems on an ongoing basis, e.g., running “hacker scripts” and password “crackers” against the systems, and routinely using software protection tools such as virus-detection software and software checksum protection. IST shall also continuously appraise the University's system architecture, hardware and software technologies, and procedures to eliminate outdated components and practices. IST shall aggressively stay current with standards and technologies for security management, and make recommendations to the University's patient-care units concerning the future implementation of new security practices that become state of the art, such as strong authentication practices, University-wide authentication systems, access validation, expanded audit trails, electronic authentication of records via electronic signatures, cryptographic technologies.

2. Organizational Practices: The University and its patient-care units shall adopt the following organizational security practices:

a. Unit-specific security and confidentiality procedures. Each patient-care unit, patient-care center and faculty practice shall develop explicit and clear confidentiality procedures governing both paper and electronic media that:

(1.) state the types of information considered confidential;

(2.) stipulate who may have access to which elements of patient information for what purposes;

(3.) identify the people authorized to release the information and the procedures that must be followed to make a release;

(4.) identify the types of people authorized to receive information, under which circumstances, and when additional patient consent is required;

(5.) specify a method of disposal of paper records containing patient identifiers that ensures their complete destruction (i.e., shredding or bonded disposal);

(6.) enforce sanctions that will be applied for breaches of confidentiality and unauthorized access; and

(7.) set up training programs for staff, faculty and students in privacy, confidentiality and security. These policies and associated procedures should be reviewed annually and publicized regularly, preferably by senior management.

b. Unit security and confidentiality committees. Each patient-care unit, center and faculty practice shall establish a broadly based committee or assign a person or office to develop, implement, monitor and maintain the unit-specific procedures for protecting patient privacy and ensuring the security of information systems. Similarly, responsibility shall be assigned for granting and removing access privileges to/from users of the unit's information system.

c. Education and training programs. Each patient-care unit, patient-care center and faculty practice, in conjunction with IST, shall establish formal educational programs to ensure that all users of information systems receive the required training in professional responsibilities and personal accountability for security and confidentiality, in relevant security practices, and in existing confidentiality policies and proper procedures before being granted access to any health-information systems. Annual refresher courses should also be conducted with the participation of the medical staff leadership. Other educational tools, such as in-service sessions, grand rounds, continuing medical education, selective use of one-on-one or small- group training for physicians, videos, pamphlets, posted reminders, on-line screens, memos and newsletters should be considered. System users requiring training include full-time, part-time, temporary and newly transferred employees, admitting and referring physicians, contractors, vendors, housestaff, students, volunteers, and outcomes or epidemiological researchers.

Log-in screens should be developed that remind users that health-care information is limited to legitimate health-care or research purposes, that

misuse of health-care information is a violation of University policy and can lead to sanctions, and that audit logs record all user activities.

d. User confidentiality agreements. Any individual (employee, student, volunteer, contract worker, vendor or other non-employee) accessing patient-information systems must sign a form stating that she or he has read, received a copy of, understood and will comply with this University policy and the patient-care unit's procedures. This form should be signed prior to access being given and retained in the pertinent department. The unit's data steward or confidentiality officer shall ensure the signing of these agreements and keep the forms on file.

e. Informing patients. Each patient-care unit, patient-care center and faculty practice shall develop means to inform patients of the existence of electronic health records, to describe health-data flows within the unit and with external organizations, to describe the policies and procedures in place to protect patient privacy, to request additional patient authorizations for other proposed uses of their health information, and to inform patients of their rights of access to their health records. This information should list the types of organizations and individuals to whom identifiable and unidentifiable information is commonly released (such as insurers, managed care companies, responsible researchers with appropriate IRB approval and patient consent, certain government agencies, courts, accreditation and oversight bodies, authorized social-welfare agencies, etc.). Methods to accomplish this include disclosure authorization forms separate from other consent forms such as those for medical care or research. The time period for which authorizations are valid should be indicated.

f. Patient access to audit logs. The University's health-care units, centers and faculty practices should give patients the right to request and review audits of all accesses to their health records, as well as the right to review the contents of their health records and annotate or supplement information they believe to be inaccurate, incorrect or incomplete (without removing any information). Patients' primary care physicians also have the right to review audit logs of their patients' health records.

By Direction of the President:

_____
Vice President for Information Services & Technology

_____
Vice President for Academic Affairs

University Policy Code: 00-01-40–60:00
Adopted & Amended: 8/16/99
Approved by GMEC on 1/11/00

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.3
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: RIGHTS & RESPONSIBILITIES FOR THE USE OF THE UNIVERSITY ACCESSED ELECTRONIC INFORMATION SYSTEM

I. PURPOSE

To set policy for the use of the University's electronic information systems, broadly defined, including users' rights and responsibilities.

II. APPLICABILITY

A. This policy applies to all individuals accessing and using computing, networking, telephony and information resources through any facility of the University. These individuals include students, faculty, visiting faculty, staff, volunteers, alumni, persons hired or retained to perform University work, external individuals and organizations, and any other person extended access and use privileges by the University under contractual agreements and obligations or otherwise.

B. This policy covers all computing, networking, telephony and information resources owned by, procured through, operated or contracted by the University. Such resources include computing and networking systems (especially those connected to the University's telecommunications infrastructure---the University-wide and campus-wide backbones---as well as local area networks), public-access sites, shared computer systems, personal desktop computers, other computer hardware, software, databases stored on or accessible through the network, IST support personnel and services, physical facilities, and communications systems and services.

III. ACCOUNTABILITY

Under the President, the Senior Vice President for Academic Affairs and the Vice President for Information Services & Technology (IST) shall ensure compliance with this policy. The Deans, Vice Presidents, IST Directors, associate deans for student affairs, and individual managers shall implement the policy.

IV. DEFINITIONS

A. The Internet is a combination of international, national, state and local electronic networks employing a common set of protocols that enables people around the world rapidly and easily to access and exchange information, regardless of origin or location, and provide and receive services.

B. The World Wide Web is a client/server environment on the Internet that provides multimedia information and services with hypertext navigation.

V. REFERENCES

A.	Information Management	00-01-10-30:00
B.	Patient Confidentiality & Health Information	00-01-40-60:00
C.	Intellectual Property: Copyrights & Royalties	00-01-20-21:00
D.	Sexual Harassment	00-01-35-25:00

VI. EXHIBITS

A. UMDnet Account Holder Use Agreement

B. Academic Computing Services Accounts Policy

C. Academic Computing Services E-mail Policy

VII. POLICY

A. General Principles:

1. The University owns its computing, networking, telephony and other communications systems and its information resources, and has the right to monitor them. The University also has various rights to the software and information residing on, developed on, or licensed for these computers and networks. The University has the responsibility for the security, integrity, maintenance and confidentiality of the electronic systems.

2. Computing, networking, telephony and information resources of the University, including access to local, national and international networks, exist to support students, faculty and staff as they carry out the education, research, health-care and public-service missions of the University, and its administration and management. Toward these ends, the University encourages and promotes the use of these resources by the University community. Access to and use of these resources for purposes or activities which do not support the University's missions are subject to regulation and restriction to ensure that they do not interfere with legitimate work; and any access to or use of these resources and services that interferes with the University's missions and goals is prohibited.

3. When demand for computing, networking, telephony and information resources exceeds available capacity or resources, priorities shall be established for allocating the resources, with a higher priority to activities essential to the missions of the University. The Deans and Vice

Presidents, in conjunction with the Vice President for IST, shall set these priorities.

4. Data stewards and system administrators shall develop and publicize specific written procedures to protect the rights of legitimate authorized users, to protect the integrity of the information and systems under their management, and to delineate the responsibilities of users. The University has the authority to control or refuse access to anyone who violates these procedures or threatens the rights of other users or the availability and integrity of the systems and the information. Actions that may be taken under this authority include deactivating accounts, access codes or security clearances; stopping processes; deleting affected files; and disabling access to computing, networking, telephony and information resources.

5. Users' expectation of electronic privacy must be balanced against the University's reasonable need to supervise, control and operate the University's information systems.

6. The University does not archive E-mail that has been sent or received by its systems. The user is responsible for archiving E-mail messages that the user wishes to retain.

B. Rights of Users:

1. Privacy and confidentiality: Because the primary use of the University's communications systems is to further the University's missions, members of the University community should not have the expectation of privacy in their communications, whether work-related or personal. By their nature, electronic communications, especially E-mail connected to the Internet, may not be secure from unauthorized access, viewing or infringement. Although the University employs technologies to secure certain categories of electronic messages, as a rule confidentiality of E-mail and other electronic documents cannot be assumed. The University cannot and does not make any guarantee, explicit or implied, regarding the confidentiality of E-mail and other documents and messages stored in electronic media unless provisions, approved and maintained by the University, are specifically implemented to this purpose. Users should not expect total privacy when using E-mail.

   Although the University will not monitor the content of electronic documents or messages as a routine matter, it reserves the right to examine all computer files in order to protect individuals and the University. In addition, during the course of routine conduct of University business, routine management of the University's computing and networking systems, as well as during emergencies, the University has the right to view or monitor users' files, data, messages or other activity for legitimate business purposes, with or without notice to users. Information seen in such a manner will ordinarily be kept confidential, but

may under certain circumstances be used in disciplinary proceedings if appropriate. If an individual is suspected of violations of his/her responsibilities as described in this policy or of other misconduct, the University reserves the right to take any and all actions to abide by the law and maintain network integrity and the rights of access of others authorized to use the system. The University also reserves the right to access and disclose messages, data, files, and E-mail back-up or archives, if such exist, to law enforcement authorities and others as required by law, to respond to legal processes, and to fulfill its obligations to third parties. E-mail is subject to legal discovery during the course of litigation, even if deleted, by means of message archives, back-up tapes and undeleting the messages.

Therefore, good judgment dictates the creation only of electronic documents that may become public without embarrassment or harm.

2. Safety: Unwanted communications and offensive or objectionable materials are available through the Internet and may be blocked or regulated by the University. The University accepts no responsibility for the content of electronic mail received. However threatening, harassing or offensive communications received by University personnel over the network should be reported to IST, Public Safety and, if appropriate, to the Office of Affirmative Action/Equal Employment Opportunity.

3. Intellectual freedom: The network is a free and open forum for the expression of ideas. The University will not prevent expressions of academic opinions on the network as long as these opinions are not represented as the views of the University and are not in conflict with University policies or state and federal laws. Even with disclaimers about not representing the views of the University, appropriate language, behavior and style should still be used in communications distributed on the University's computing and networking facilities. It should be remembered that certain categories of speech---defamation, obscenity and incitement to lawlessness---are not protected by the Constitution. The University reserves the right, at its sole discretion, to decline to post, to remove posted pages or to restrict University Web sites or computer accounts which contain or are used for personal expressions of a non-academic nature.

C. Responsibilities of Users:

1. Individuals with access to the University's computing, networking, telephony and information resources have the responsibility to use them in a professional, ethical and legal manner. Users are required to take reasonable and necessary measures to safeguard the operating integrity of the systems and their accessibility by others, while acting in a manner to maintain an academic and work environment conducive to carrying out the University's missions efficiently and productively. Specifically, responsibilities of users include:

a. Respecting the rights of others, including intellectual property, privacy, freedom from harassment, and academic freedom;

b. Safeguarding the confidentiality of certain information and the privacy of patients;

c. Using systems and resources so as not to interfere with or disrupt their normal operations or their access use and use by others so authorized;

d. Protecting the security of University electronic systems and the integrity of information stored there;

e. knowing and obeying University and unit-specific policies and procedures governing access and use of electronic systems information.

2. Individuals are prohibited from sharing passwords or log-in IDs or otherwise giving others access to any system for which they are not the data stewards or system administrators with appropriate authority. Users are responsible for any activity conducted with their computer accounts and are responsible for the security of their passwords.

3. Individuals may not use another person's network account or try to obtain password or access code to another's network account to send or receive messages.

4. Individuals must identify themselves and their affiliation accurately and appropriately in electronic communications and may not disguise the identity of the network account assigned to them or represent themselves as someone else.

5. The University's communications systems may not be used to harass, intimidate, threaten or insult others; to interfere with another's work or education; to create an intimidating, hostile or offensive working or learning environment; or to conduct illegal or unethical activities.

6. The University's networks may not be used to gain or attempt to gain unauthorized access to remote networks or computer systems.

7. Individuals are prohibited from deliberately disrupting the normal operations of the University's computers, workstations, terminals, peripherals or networks.

8. Individuals may not run or install on any University computer system a program that may result in intentional damage to a file, or that may intentionally compromise the integrity of the University's systems or the

integrity of other computing environments via the University's network (e.g., computer viruses, Trojan horses, worms or other rogue programs).

9. Individuals are prohibited from circumventing access and use Authentication systems, data-protection mechanisms, or other security safeguards.

10. Individuals must abide by all applicable copyright laws and licenses, and respect other intellectual-property rights. Information and software accessible on the Internet is subject to copyright or other intellectual-property-right protection. University policy and the law forbid the unauthorized copying of software that has not been placed in the public domain and distributed as "freeware." Therefore nothing should be downloaded or copied from the Internet for use within the University unless express permission to do so is stated by or received from the owner of the material, and the owner's requirements or limitations on use of the material are observed. The use of software on more than the licensed number of computers, unauthorized installation of unlicensed software on University computers, plagiarism and invasion of privacy are also prohibited. "Shareware" users must abide by the requirements of the shareware agreement.

11. Activities that waste or unfairly monopolize computing resources (such as unauthorized mass mailings; electronic chain letters, junk mail and other types of broadcast messages; unnecessary multiple processes, output or traffic; exceeding network directory space limitations; excessive game-playing or other trivia applications; and excessive printing) are prohibited.

12. Reading, copying, changing or deleting programs or files that belong to another person or to the University without permission is prohibited.

13. The University's computing resources may not be used for commercial purposes or personal financial gain.

14. All network communications exiting the University are subject to the acceptable-use policies of the network through which they flow.

15. Use of the University's systems that violates local, state or national laws or regulations or University policies, standards of conduct, or guidelines is prohibited.

16. Confidential information should be encrypted before transmission over open public networks such as the Internet, or such transmission should only be over secure dedicated lines. Including confidential University information in unencrypted E-mail is forbidden.

D. E-mail and other electronic communications (Internet services, voice mail, audio- and video-conferencing, and facsimile messages):

1. The use of University resources for electronic communications must be related to University business, including academic pursuits, and not for personal or commercial purposes, except for incidental and occasional personal non-commercial use when such use is clearly insignificant, does not generate a direct cost for the University, and does not interfere with or compete with legitimate University business.

2. Only authorized persons may use the University's electronic communications systems.

3. Electronic communications whose meaning, transmission or distribution is illegal, unethical, fraudulent, defamatory, harassing or irresponsible are prohibited. Electronic communications should not contain anything that could not be posted on a bulletin board, seen by unintended viewers, or appear in a University publication. Material that may be considered inappropriate, offensive or disrespectful to others should not be sent or received as electronic communications using University facilities.

4. Appropriate standards of civility and decency should be observed in electronic (as well as all other forms of) communication.

E. World Wide Web:

1. "Official" University Web pages are those that provide information about established, University-recognized entities, such as its Schools; patient-care units; administrative offices; research institutes, centers and programs; educational programs; clinical centers, institutes and programs. Information on official University Web pages represents the institution and therefore must be accurate, timely and useful and must conform to this and all other University policies, standards and requirements. Official Web pages shall be held to the same standards as any University, school or unit printed publication.

    a. The pertinent Dean, Vice President or Department Chair has the ultimate responsibility for official Web pages. These individuals or their designees must authorize the establishment of any official Web page under their purview.

    b. The University logo must appear on all official Web pages, or their equivalent.

    c. Official RUTGERS Robert Wood Johnson Medical School Web pages shall be reviewed by the responsible party every six to twelve months and these reviews documented by changing the revision date at the bottom of the page.

    d. Official RUTGERS Robert Wood Johnson Medical School pages may be copyrighted. Official RUTGERS Robert Wood Johnson

Medical School Web pages should not contain copyrighted materials without appropriate copyright permission.

2. Faculty professional Web pages and personal Web pages of a faculty member, student or staff member may not: promote illegal activities; harass anyone inside or outside the University; include offensive or objectionable material or language or link to other sites that do; distribute copyrighted materials; be used for commercial purposes or personal gain unrelated to the University's missions; contain the University logo; represent the contents as being the official policy or positions of the University. Personal pages from individuals or groups must include the identity of the author, and should contain the following statement: "The views and opinions expressed in this page are strictly those of the author. The contents have not been reviewed or approved by the RUTGERS Robert Wood Johnson Medical School." The University reserves the right to not post or remove posted pages for any reason.

F. Non-compliance and Sanctions:

Non-compliance with this policy may result in denial or removal of access privileges to the University's electronic systems; disciplinary action under applicable University policies and procedures; civil litigation; and/or criminal prosecution under applicable state and federal statutes.

By Direction of the President:

_____

Vice President for Information Services and Technology

EXHIBIT A

UMDnet Account Holder Use Agreement
http://www.RUTGERS Robert Wood Johnson Medical School.edu/istweb/prodserv/acs_use.htm
August, 1999

As a UMDnet account holder of the RUTGERS Robert Wood Johnson Medical School, ("University"), and as a user of the computing and communications facilities of the University, I agree to observe the University Policy on Rights & Responsibilities for the Use of University-accessed Electronic Information Systems, the Academic Computing Services Email Policy and the following rules and regulations governing the use of same:

1. Only I will use the computer User Account(s) provided to me and I will take the responsibility to protect my account(s) from unauthorized access. I will not allow anyone else to use my User Account. I understand that I will be requested to change my password at thirteen week intervals, although I may elect to do so at more frequent intervals if I believe that the privacy of my password has been compromised. This rule is primarily intended for the protection of my User Account(s) and its data.

2. If I have information regarding attempts to breach the security of the University's computer facilities, I agree to promptly report such information to the Department of Information Services and Technology.

3. I shall respect the privacy of information on the University's computing facilities. I shall not attempt to access any data or programs that I do not own unless they have been made publicly available or I have the express permission of their owner. I shall make no attempt to modify data or program material available for general (public) use without the permission of the owner.

4. I agree to abide by any patent or copyright restrictions which may relate to the use of computing facilities, products, programs or documentation. I agree not to copy, disclose, modify or transfer any such materials that I did not create, without the expressed consent of the original owner or copyright holder. I agree not to use the University's computing facilities in any way which violates the terms of any software license agreement; applicable local, state or federal laws or University policy.

5. Facilities are available for the conduct of University business, i.e., research, instruction, health care and administration. No other uses are permitted.

6. I shall not use the University's computing facilities for any form of private financial gain. Business pursuits other than those outlined in 5. above will require special approval from IST along with approval of the requester's department. A separate, billable account may be established depending on the nature of the proposed use.

7. I understand that access to the University's computing facilities by unauthorized persons or for unauthorized purposes is forbidden. I shall not use University computing facilities in any way that intentionally compromises their availability or effectiveness to other individuals. Some examples are presented for clarification:

Attempts to access restricted portions of an operating system, accounting software or the private file space of other users;

Use of information systems in such a way as to disrupt the operation of computer or communication systems within or outside of the University;

Attempts to breach security mechanisms or exploit or publicize problems that might exist in them;

Failure to abide by policy posted at public computer centers.

8. I shall not use my computer account privileges to attempt access to computing facilities within or external to the University to which I have not received prior authorization.

9. I agree to abide by any and all other rules and regulations of the University regarding the use of its computer facilities, now in effect or hereinafter enacted by the University.

10. I understand that non-compliance with this Agreement may result in denial or removal of access privileges to the University's electronic systems; disciplinary action as set forth by other University policies and guidelines, civil litigation; and/or criminal prosecution under applicable state and federal statutes. I agree to be personally liable for all claims, lawsuits and damages to the University which result from my breach of this Agreement. The terms of this section 10 will survive the termination of this Agreement.

11. I agree to immediately notify the RUTGERS Robert Wood Johnson Medical School Information Services & Technology Department to terminate my account in the event that I am no longer employed by, a student at or affiliated with the University.

This agreement will remain in force as long as I have a UMDnet Account.

_____ _____ _____

Print Name Signature Today's Date

_____ _____

Employee: Unit/School and Department Student: School and Graduation Year

EXHIBIT B

Academic Computing Services Accounts Policy
http://www.RUTGERS Robert Wood Johnson Medical School/edu/istweb/prodserv/acs_acpl.htm
August, 1999

Eligibility

1. All salaried RUTGERS Robert Wood Johnson Medical School full-time faculty or staff.

2. All students enrolled or matriculated in a RUTGERS Robert Wood Johnson Medical School or program.

3. Other students enrolled in a single RUTGERS Robert Wood Johnson Medical School course - eligible for temporary accounts.

4. RUTGERS Robert Wood Johnson Medical School part-time or voluntary faculty or other volunteers who have a demonstrated need for computer resources available from ACS (other than general Internet access) in connection with their work at the University - eligible for temporary accounts.

5. Employees or students of affiliated hospitals or educational institutions that have relationships with RUTGERS Robert Wood Johnson Medical School departments and have a demonstrated need for computer resources available from ACS (other than general Internet access) in connection with their responsibility at the University - eligible for temporary accounts.

6. Affiliated organizations with an academic or health care mission whose activities in connection with the University require computing resources the affiliate cannot reasonably supply on its own - eligible for temporary accounts.

Applying for an ACS Computer Account on a RUTGERS Robert Wood Johnson Medical School Campus Host

1. In person at one of the following campus Academic Computing Labs:

   a) Newark: MSB Room C632
   b) Piscataway: RWJMS Room N217
   c) New Brunswick: MEB RWJ Library of the Health Sciences
   d) Camden: E&R Bldg Room 140A in the RUTGERS Robert Wood Johnson Medical School and Coriell Research Library
   e) Stratford: Academic Center Room 247
   f) Scotch Plains: Room 319

2. By phone, call your campus Academic Computing Lab Support Desk:
   a) Newark: 2-6789 (973-972-6789)
   b) Piscataway: 5-4436 (732-235-4436)

c) New Brunswick: 5-7773 (732-235-7773)
d) Camden: 7-7875 (856-757-7875)
e) Stratford: 6-3200 (856-566-6437)
f) Scotch Plains: (908-889-2447)

Obtaining Account Name and Password

1. In person at one of the following campus Academic Computing Labs:
   a) Newark: MSB Room C632
   b) Piscataway: RWJMS Room N217
   c) New Brunswick: MEB RWJ Library of the Health Sciences
   d) Camden: E&R Bldg Room 140A in the RUTGERS Robert Wood Johnson Medical School and Coriell Research Library
   e) Stratford: Academic Center Room 247
   f) Scotch Plains: Room 319

2. Present one of the following:

   a) RUTGERS Robert Wood Johnson Medical School ID - for individuals satisfying items 1 or 2 of the eligibility requirements.

   b) For individuals satisfying items 3, 4, or 5 of the eligibility requirements, a letter signed by your RUTGERS Robert Wood Johnson Medical School department chair, faculty sponsor, or course director stating:

      1) You are working for/affiliated with a RUTGERS Robert Wood Johnson Medical School department or enrolled in a RUTGERS Robert Wood Johnson Medical School course.
      2) The intended uses for the account and the IST/ACS resources required for your work/class.
      3) The period for which the account will be necessary (cannot exceed one year).

   c) For individuals satisfying item 6 of the eligibility requirements, a letter signed by a senior official of the affiliated organization stating the resources needed not available through the affiliated organization.

3. Read and sign the UMDnet Account Holder Use Agreement form (http://www.RUTGERS Robert Wood Johnson Medical School.edu/istweb/prodserv/acs_use.htm). This details the acceptable uses of the IST/ACS' computational and information services and must be strictly adhered to.

Temporary Accounts

Temporary accounts are given to individuals satisfying items 3, 4, 5, or 6 of the eligibility requirements. The account will be opened for the specified time period determined by the individual's needs and will not exceed one year. Temporary accounts will expire automatically. In order to renew the account the individual must re-apply in person.

Alumni Accounts

Alumni accounts are given to all RUTGERS Robert Wood Johnson Medical School graduates. These are non-interactive email accounts with Internet access and only are accessible through a SLIP/PPP connection using client software (ex. web browsers, email clients). You cannot connect to these accounts by telnet or other "terminal" protocols. If the account shows no activity for twelve months it will be deleted permanently. If you forget your password the account will eventually age out after twelve months. Passwords cannot be reset for these alumni accounts.

Deactivating and Removing Accounts

1. An account will remain active providing that the account holder continues to meet the eligibility requirements, the account is accessed directly through a campus host login (ex. telnet) at least once in a 6 month period and the account is renewed prior to its expiration (temporary accounts). To reactivate the account, you must go in person with your RUTGE Robert Wood Johnson Medical School ID to your campus Academic Computing Lab.

2. An account will become non-interactive if, within a 6 month period, the only method of access is through client software (ex. web browser, email client). Once an account becomes non-interactive, you cannot run terminal sessions; however, you can continue to use your client software. To reinstate direct access to your account, you must go in person with your RUTGERS Robert Wood Johnson Medical School ID to your campus Academic Computing Lab.

3. An account will be deactivated if it is not accessed at least once in a 6 month period through a resource that requires authentication (ex. telnet, remote access via SLIP/PPP). Note: LAN logins in an Academic Computing Center do not prevent the account from being deactivated. To reactivate an account, you must go in person with your RUTGERS Robert Wood Johnson Medical School ID to your campus Academic Computing Lab.

4. An account will be removed for any of the following reasons:

   a) The account holder no longer meets the eligibility requirements.
   b) The account is established as temporary and the expiration date has been reached without renewal.
   c) The account has not been accessed in 13 consecutive months.
   d) The account holder is in violation of the UMDnet Account Holder Use Agreement (http://www.RUTGERS Robert Wood Johnson Medical School.edu/istweb/prodserv/acs_use.htm), the Academic Computing Services Email Policy (http://www.rutgers.rwjms.edu/istweb/prodserv/acs_empl.htm) and/or the University Policy on Rights & Responsibilities for the Use of University-accessed Electronic Information Systems.

Passwords

1. Accounts will be opened with a pre-assigned password that must be changed upon logging in for the first time.

2. Passwords must conform to the following rules:

   a) Passwords must be 6, 7 or 8 characters in length and contain at least one non-alphabetic character. It is suggested that passwords be a combination of lowercase alpha characters and numbers.

   b) Avoid the use of names such as hostname, account name, real name or any other information associated with your account. Avoid words that can be found in a dictionary.

   c) Passwords with an embedded word of a length greater than 3 or with 3 or more repeated characters will be rejected.

   d) A new password must differ from the old password by at least three characters.

   e) Passwords must be changed every 13 weeks. To make a password eligible for re-use, the password must have been followed by a succession of at least 3 password changes and at least 1 year must have elapsed since it was last used.

3. Passwords cannot be retrieved from the system. If a password is forgotten the account holder must visit in person one of the listed Academic Computing Labs where a valid RUTGERS Robert Wood Johnson Medical School ID or proper identification must be presented. A new password will be issued. Call your campus Academic Computing Lab for the appropriate procedure on your campus.

4. Passwords automatically expire every 13 weeks. You will be prompted to change your password after logging in. You may elect to change your password at more frequent intervals and should do so if you believe that the privacy of your password has been compromised.

5. It is strictly forbidden to share or divulge passwords.

EXHIBIT C

Academic Computing Services Email Policy
http://www.rutgers.rwjms.edu/istweb/prodserv/acs_empl.htm
August, 1999

In accordance with the University Policy on Rights & Responsibilities for the Use of University-accessed Electronic Information Systems:

"Individuals with access to the University's computing, networking, telephony information resources have the responsibility to use them in a professional, ethical and legal manner. Users are required to take reasonable and necessary measures to safeguard the operating integrity of the systems and their accessibility by others, while acting in a manner to maintain an academic and work environment conducive to carrying out the University's missions efficiently and productively."

"Electronic communications whose meaning, transmission or distribution is illegal, unethical, fraudulent, defamatory, harassing or irresponsible are prohibited. Electronic communications should not contain anything that could not be posted on a bulletin board, seen by unintended viewers or appear in a University publication. Material that may be considered inappropriate, offensive or disrespectful to others should not be sent or received as electronic communications using University facilities."

I. Actions Considered Violations of the UMDnet Account Holder Use Agreement (http://www.rutgers.rwjms.edu/istweb/prodserv/acs_empl.htm):

Sending unsolicited bulk email messages ("junk mail" or "spam") which is disruptive or generates a significant number of user complaints.

Sending email to any person whom does not wish to receive it.

Harassment, whether through language, frequency, content or size of messages.

Forwarding or otherwise propagating chain letters and pyramid schemes, whether or not the recipient wishes to receive such mailings.

Malicious email, such as "mailbombing" or flooding a user site with very large or numerous pieces of email.

Forging of sender information other than accountname@rutgers.rwjms.edu or other pre-approved header address.

Sending email for commercial gain.

IST has the right to remove access to accounts found in violation of this policy.

II. Email Rules & Controls:

A size limitation of 4MB for ALL email messages addressed to accountname@RUTGERS Robert Wood Johnson Medical School.edu whether they originate from within or outside of the University.

Email messages through the ACS campus hosts will be blocked where neither the sender nor the recipient's address belongs to RUTGERS Robert Wood Johnson Medical School

The inclusion of patient-identifiable information in unencrypted email is forbidden.

The University does not archive email.

For ACS campus host accounts only:

A size limitation of 4MB for outgoing (sent) messages.

Received messages may not exceed 4 MB.

Messages will be removed from INBOX when they are older than 45 days.

When an account becomes deactivated all incoming mail will be returned to sender as "undeliverable".

User accounts have a quota of 4MB of space and 200 files. Users are requested to clean up the folders where they store copies of outgoing and incoming email periodically.

Note: Junk mail sent directly to a RUTGERS Robert Wood Johnson Medical School.edu address from the outside is not preventable. It should be treated like junk US postal mail. Filters are available and may be used on an individual basis with the understanding that side effects such as filtering out "good" mail might occur. ACS provides boilerplate filters and instructions in the use of filtering programs. Some mail programs that run on your own computers also offer filtering capabilities.

University Policy Code: 00-01-10-40:00

Adopted: 8/31/99

Amended: 2/08/00

Approved by GMEC on 1/11/00

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.4
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: EDUCATIONAL USE OF COPYRIGHTED WORKS

I. PURPOSE

To establish policy for the use of copyrighted works of others by University faculty, staff and students for educational and other academic purposes.

II. ACCOUNTABILITY

Under the direction of the President, the Deans and Vice Presidents shall ensure compliance with this policy. The Vice President for Legal Management shall implement this policy.

III. APPLICABILITY

A. This policy applies to all University faculty, staff and students.

B. This policy covers all copyrighted works of others that are incorporated in University documents, publications, courses and computer files.

C. Use of copyrighted works under this policy include, but are not limited to: (1) reproduction of the work; (2) distribution of the work to others by sale, rental, lease or broadcasting; (3) performance of the work in the case of performing arts, audio and audiovisual work; and (4) displaying the copyrighted work, including audiovisual works by broadcasting and on Web sites. Written permission from the owner of the copyright is required in all these instances.

IV. GENERAL PRINCIPLES

A. The University respects the legal rights of the owners of copyrights. Copyright works may be incorporated in University documents, publications and courses only if in compliance with copyright laws.

B. University faculty, staff and students shall respect the legal rights of owners of copyrights. This includes the use of the materials of others in courses, publications, journals, research projects, videos, computer software, video tapes, conference presentations, etc.

C. It is the policy of the RUTGERS Robert Wood Johnson Medical School to adhere to the requirements of the United States Copyright Law of 1976, as amended (Title 17, United States Code, hereafter referred to as the “Copyright Act”). This policy applies only to copyrighted materials. Uncopyrighted materials may

therefore be copied without restriction. Works authored by the United States Government or by some states are not copyrighted. Works published after March 1, 1989 do not require a copyright notice and should therefore be presumed to be under copyright protection. States and their instrumentalities are liable for violations of the Copyright Act and all remedies for copyright infringement apply to states as well as to private individuals (PL 101-553). The University does not condone copyright infringement by any RUTGERS Robert Wood Johnson Medical School faculty, staff or student; individuals who violate copyright are not protected by the University and may be subject to University disciplinary actions, civil litigation and/or criminal prosecution. Files belonging to the University or any University employee and containing copyrighted material may be subject to subpoena.

D. It is the policy of RUTGERS Robert Wood Johnson Medical School to invoke the doctrine of "Fair Use," as defined by Section 107 of the Copyright Act, in order to enable legal copying of copyrighted materials by faculty, staff and students without seeking the permission of a copyright holder and without the payment of royalty fees to the copyright holder. "Fair Use" for educational purposes may not be automatically invoked simply on the basis of copying copyrighted material for educational purposes nor on the basis of such copying being made by a non-profit organization. Each claim of "Fair Use" must instead be evaluated against four criteria:

1. the purpose and character of the use;

2. the nature of the copyrighted work;

3. the amount and substantiality of the portion used in relation to the copyrighted work as a whole; and

4. the effect of the use upon the potential market for or value of the copyrighted work.

Guidelines for "Fair Use" are discussed in Section V below.

V. GUIDELINES

The following guidelines reflecting copyright laws have been adopted by RUTGERS Robert Wood Johnson Medical School to provide faculty, staff and students with general guidance on the use of copyrighted works and to reduce the risk of copyright infringement. Copyright infringement is a criminal act as well as a civil violation and may result in grave consequences to the University and to the individual.

A. Faculty and Classroom Copying of Copyrighted Material

1. Single copying

A single copy may be made by a faculty member or staff member (or for a faculty or staff member at his/her individual request) of any of the following:

a. a chapter from a book;

b. an article from a periodical or newspaper;

c. a short story, short essay or short poem, whether or not from a collective work;

d. a chart, graph, diagram, drawing, cartoon or picture from a book, periodical or newspaper.

"Systematic" copying of single articles that has the cumulative effect of copying an entire journal issue or volume without permission from the copyright holder or without payment of royalty fees is a violation of the Copyright Act and constitutes a criminal act.

2. Multiple copying for classroom use Multiple copies (no more than one copy per student in a course) for classroom use or discussion may be made by or for a faculty member giving the course, provided that:

a. the test for brevity and spontaneity as provided in the examples below is met;

b. the cumulative-effect test as defined below is met; and

c. each copy includes a notice of copyright.

Any copying of copyrighted material which exceeds these limits must have the written permission of the copyright holder or royalty fees must be paid.

3. Examples of "brevity" are:

a. Prose: either a complete article, story or essay of less than 2,500 words or an excerpt from any prose work of not more than 1,000 words or 10 percent of the work, whichever is less, but, in any event, a minimum of 500 words. Each of these numerical limits may be expanded to permit the completion of an unfinished line of an unfinished prose paragraph.

b. Illustration: one chart, graph, diagram, drawing, cartoon or picture per book or periodical issue.

c. Special works: Certain works in prose often combine language and illustration and fall short of 2,500 words in their entirety. Such

special works may not be copied in their entirety, but an excerpt comprising not more than two pages and containing not more than 10 percent of the words found in the text may be copied.

4. Examples of “spontaneity” are:

   a. The copying is an immediate need as a result of the inspiration of the individual faculty member.

   b. The inspiration and decision to use the work and the moment of its use for maximum teaching effectiveness are so close in time that it would be unreasonable to expect a timely reply to a request for permission to copy from the copyright holder.

5. Examples of “cumulative effect” are:

   a. The copying is for only one course in the school.

   b. Not more than one short article, story or essay or two excerpts is copied from the same author, nor more than three from the same collective work or periodical volume during one class semester.

      The limitations in a and b above shall not apply to current news periodicals, newspapers and current news sections of other periodicals.

   c. There are not more than nine instances of such multiple copying for one course during one class semester.

6. Examples of prohibitions based on brevity and spontaneity are:

   a. copying used to create, replace or substitute for anthologies, compilations or collective works, regardless of whether copies of various works or reproduced and used separately;

   b. copying of or from works intended to be “consumable” in the course of study or of teaching. These include workbooks, exercises, standardized tests, test booklets, answer sheets and similar consumable materials.

   c. Copying:

      (1) to substitute for the purchase of books, publishers’ reprints or periodicals;

      (2) that is directed by higher authority (e.g., a faculty member directing his/her students to copy an article);

(3) which is repeated with respect to the same item by the same faculty member from semester to semester.

(4) where costs and charges for copying are charged to the student beyond the actual cost of the photocopying.

B. Music and Audiovisual Use in the Face-to-Face Classroom

If copyrighted music or audiovisuals are used in a face-to-face conventional class, some utilizations may be made under "Fair Use." No more than ten percent of a copyrighted work of music may be used, but not repeated for the course in the next semester, unless permissions have been obtained from the copyright holder. Under provisions of Section 110 of the Copyright Act, a lawfully obtained copyrighted film or videocassette not labeled “Home Use Only” may be aired in a face-to-face class, provided that such airing is within the scope of the educational intent of the course. No copy of such a film or videocassette may be made without first securing the permission of the copyright holder.

C. Individual (and Student) Copying of Copyrighted Material

RUTGERS Robert Wood Johnson Medical School has no mechanisms to monitor photocopying. For this reason, RUTGERS Robert Wood Johnson Medical School photocopy machines (including self-services machines) have posted warnings that the copying of copyrighted materials is subject to the Copyright Act.

D. Copy-Center Copying of Copyrighted Material

The RUTGERS Robert Wood Johnson Medical School Department of Supply, Process and Distribution may legally provide faculty and staff with single or multiple copies of copyrighted materials that meet the guidelines outlined in Section V.A above. The Department of Supply, Process and Distribution reserves the right to refuse to make copies of materials when such copying, in its judgment, is not in compliance with the Copyright Act. RUTGERS Robert Wood Johnson Medical School faculty, staff and students are also advised that they, as individuals, remain responsible for compliance with the Copyright Act when they make use of off-campus copy vendors.

E. Library Copying of Copyrighted Material

1. Internal library copying

The RUTGERS Robert Wood Johnson Medical School libraries may legally provide faculty, staff, students and the general public with single copies of copyrighted materials that meet the guidelines outlined in Section V.A above. Each copy thus made must include either the copyright notice from the material provided or shall be stamped with the following notice:

"This material may be protected by copyright law (Title 17, U.S. Code)." The RUTGERS Libraries will not make multiple copies under any circumstances. The Libraries may make one copy of a copyrighted journal article for placement on reserve for class use upon receipt of a written request of the course teacher. Each copy thus made shall bear the following notice:

"This material may be protected by copyright law (Title 17, U.S. Code)." The RUTGERS Robert Wood Johnson Medical School Libraries will not make multiple copies of articles for placement in the Reserve Collection. The Libraries reserve the right to refuse to make copies of copyrighted materials which are not in compliance with the Copyright Act.

2. Inter-library loan

Libraries may also be liable under the law for acquisition of copyrighted materials obtained via inter- library loan from other libraries. The inter-library loan convention permits the securing of, for example, photocopied journal articles from other libraries. This convention, set forth by the Commission on New Technological Uses of Copyrighted Works (CONTU), permits as "Fair Use" the annual request of a maximum of five journal articles per journal title for the then-current five-year period. Paper records and computerized records of inter-library loan requests shall be retained by the RUTGERS Robert Wood Johnson Medical School Libraries for a period of three years.

F. Copying for Broadcast

Copying of copyrighted materials for broadcast purposes, including broadcasts utilizing copyrighted printed works, video, music or other recordings, whether for "live" video broadcasts or pre-recorded video programs, presents a special set of problems with regard to copyright compliance. The RUTGERS Robert Wood Johnson Medical School environment has at least four specific areas of broadcast activity which must be considered: closed-circuit, interactive, distance-learning classes; closed-circuit medical consultations and peer conferences; educational offerings or conferences which are broadcast to the external environment by satellite or other broadcast means; and Web-based, distance-learning courses. In the case of closed-circuit broadcasts, it is assumed that such broadcasts are not-for-profit and are aired from a specific classroom, conference room or consultation room at a specific site (e.g., RUTGERS Robert Wood Johnson Medical School Campus). If programs containing copyrighted materials are aired for commercial gain by RUTGERS Robert Wood Johnson Medical School, "Fair Use" may not be invoked and permissions from all copyright holders must be obtained. The guidelines below refer to only those airings which incorporate copyrighted material.

1. Closed-circuit, live, interactive, distance- learning classes

a. Display or copying of copyrighted materials for closed-circuit, live, interactive, distance-learning classes shall closely follow "Fair Use" guidelines for print materials as described in Sections V.A.1 and 2 above. Each such class shall begin with a text screen that states:

"This class session may contain copyrighted material legally available to this class session as set forth in Title 17 of the United States Code." Copies of such a broadcast may not be made by the host nor by the receiving site unless permission to do so has been granted by the copyright holder.

b. A teacher having used a specific copyrighted item under terms of "Fair Use" in a closed-circuit, live, interactive, distance-learning class session may not use that item in a following class session, nor from semester to semester, unless specific permission to do so has been granted by the copyright holder.

c. As in the case with face-to-face conventional classroom use of Copyrighted material, students at both the host classroom and the receiving classroom in a closed-circuit, interactive, distance-learning class may be provided with copies of printed or graphic (but not music nor audiovisual) copyrighted material (one copy per student). Each copy provided must bear the following copyright statement: This material may be protected by copyright law (Title 17, U.S. Code)."

d. If copyrighted music or audiovisuals are used in a closed-circuit, interactive, distance-learning class, some utilization may be made under "Fair Use." No more than 10 percent of a copyrighted work of music may be used, but may not be repeated for the course in the next semester unless permission has been obtained from the copyright holder (see Section V.B above). Under provisions of Section 110 of the Copyright Act, a lawfully obtained copyrighted film or videocassette not labeled "Home Use Only" may be aired to a closed-circuit, interactive, distance-learning class, provided that such airing is within the scope of the educational intent of the course. No copy of a closed-circuit, live, interactive, distance-learning class containing such a film or videocassette may be made without first securing permission of the copyright holder.

e. In any closed-circuit, live, interactive, distance-learning class session which utilizes copyrighted material; it is the responsibility of the faculty member to assure that such utilization is lawful.

2. Closed-circuit, live, medical consultations and peer conferences

a. Closed-circuit, live, peer conferences or medical consultations may make use of print or graphic (but not music or audiovisual) copies (one copy per

conference attendee) of copyrighted material. Each copy provided must bear the following copyright statement:

"This material may be protected by copyright law (Title 17, U.S. Code)."

b. Assurance of copyright compliance is the responsibility of the moderator of such closed circuit, live consultations or conferences.

c. If copies are to be made of such live consultations and peer conferences which include copyrighted material, permission must be obtained from the copyright holder.

3. Broadcasts to the external environment

Broadcasts to the external environment (non-RUTGERS Robert Wood Johnson Medical School or non-RUTGERS -related) which make use of satellite or other broadcasting technology may fall into two general categories: not-for-profit educational and for-profit commercial (which might be educational).

a. In the case of all external-environment, for-profit, live or for-profit, pre-recorded broadcasts, regardless of educational intent, all uses of copyrighted material must be accompanied by permission from the copyright holder or his/her/its royalty-and-permissions agent. Additionally, if copies are to be made of such broadcasts, permission to copy must be obtained. Non- authorized copying of such broadcasts is illegal.

b. In the case of external-environment, not-for-profit, educational, live broadcasts which make use of copyrighted material, the same rights and prohibitions as outline in Section V.F.1 above may apply. If subscription and/or licensing fees are assessed to the recipient of such broadcasts, the broadcasts are for-profit and thus subject to permission and the payment of royalties. In any event, copies may not be made of such broadcasts without the permission of the copyright holder or his/her/its royalty-and-permissions agent.

c. In the case of all external-environment, pre-recorded broadcasts, permission must be obtained for use of all copyrighted material. A pre-recorded broadcast must include a list of all copyrighted material and the statement of permission for that material. Additionally, copies may not be made of such broadcasts without the permission of the copyright holder or the royalty- and-permissions agent.

4. Web-based, distance-learning courses

a. All uses of copyrighted material must be accompanied by permission from the copyright holder or the appropriate royalty-and-permissions agent. Copyright material may include printed works, videos, music or graphics.

The document should include a list of all copyrighted material and the statement of permissions for that material.

b. If the students involved in the Web-based, distance-learning courses are provided with copies of printed or graphic material, permission to copy must be obtained.

c. Permission must be obtained for copying of the digitalized material and any distribution to others.

d. Links may be made to other Web sites. However the material on other Web sites may not be copied without permission.

e. If the course is given only once, if the copy meets the tests for brevity and cumulative effect, and if each copy has a notice of copyright, then the material may be used without obtaining permission.

G. Computer-Related Copying

Computer-related copying may take many forms, such as copying of software, printing of items from computerized files, and downloading of computerized files or items from computerized files to hard disk or to diskette. Many items within computerized files are copyrighted or are subject to licensed control. Users of computers must exercise care in the use of such materials. The following guidelines relate only to the copying of copyrighted or licensed materials.

1. Copying of software

Software operating systems and application programs should be considered copyrighted material unless they are termed “free-ware” or “public domain” by their producers and manufacturers. In most cases, a software program carries a license to which the purchaser agrees upon purchase or at the time of the software's installation. It is customary for software producers to permit the creation of one archival or “back-up” copy for each installation permitted by the license. A license may be for one installation or for multiple installations of a specific software program. Copies of licenses for software programs which are purchased by RUTGERS Robert Wood Johnson Medical School departments or individuals shall be kept on file within the department or by the individual as long as the software is in use. Certain basic utility and applications programs are made available to RUTGERS Robert Wood Johnson Medical School individuals and departments as “site license” programs. Such site- licensed programs will generally have only one license for the campus or for the institution as a whole. Licenses for such programs are kept on file centrally at the Campus or University.

a. Copying, adapting and electronic transmission of computer software is strictly forbidden by RUTGERS Robert Wood Johnson Medical School personnel and students, except:

(1) in strict compliance with Public Law 96-517, Section 10(b) which, in amending Section 117 of Title 17 (U.S. Code) to allow for the making of computer software back-up copies, states (in part) "...it is not an infringement of the owner (purchaser) of a copy of a computer program to make or authorize the making of another copy or adaptation of a computer program provided:

(a) "that such a new copy or adaptation is created as an essential step in the utilization of the computer program in conjunction with a machine and that it is used in no other manner, or

(b) "that such a new copy and adaptation is for archival purposes only and that all archival copies are destroyed in the event that continued possession of the computer program should cease to be rightful."

(2) where appropriate, written consent from the copyright holder is obtained;

(3) where the software is in the public domain or is "free-ware," and that fact can be verified.

(a) Illegal copies of software may not be used on RUTGERS Robert Wood Johnson Medical School computers.

(b) Software (whether on tape or CD-ROM) may not be installed so as to permit multiple use or multiple-site use unless such permission is granted by the software license itself, or granted by the copyright holder or royalty-and-permissions agent.

2. Copying of computerized files and their contents

a. Copies (to paper or downloaded to disk) may legally be made of computerized files and their contents, provided that the program license does not forbid such copying. Generally, a computerized file will carry an on-screen warning if copying is not permitted.

b. Care must be exercised in the copying of material found in other home pages on the Internet. Some home pages may contain copyrighted materials but may neglect to inform visitors to their Web sites or home pages of the presence of such copyright protection material. It is the position of RUTGERS Robert Wood Johnson Medical School that the presence of such copyrighted material is the responsibility of the owner of the Web site or home

page, and liabilities for copyright non-compliance must rest with that owner. RUTGERS Robert Wood Johnson Medical School home pages and Web sites may not include copyrighted material unless permission has been granted by the copyright holder or the royalty-and-permissions agent.

c. Legally obtained copies of copyrighted materials may legally be scanned by use of telefacsimile equipment or by use of scanners attached to computers for purposes of transmission. Materials thus copied must bear the following statement:

"This material may be protected by copyright law (Title 17, U.S. Code)."

Such materials may not be scanned for storage in digital form unless permission to do so has been granted by the copyright holder. If such permission has been granted, the scanned and stored material must bear the following statement:

"This material may be protected by copyright law (Title 17, U.S. Code)."

d. RUTGERS Robert Wood Johnson Medical Schoolfaculty, staff and students may not incorporate copyrighted material into locally-created databases which are installed on RUTGERS Robert Wood Johnson Medical School machines which are housed on RUTGERS Robert Wood Johnson Medical School property unless specific written authorization and permission has been granted to do so by the copyright holder or the royalty-and-permissions agent. Any permitted copyrighted material shall be identified as such on a screen within a body of the program or as a footnote where such display of copyrighted material normally occurs.

H. Copyrighted Material Incorporated into Articles, Books, Courseware, Videos

Faculty, staff and students shall carefully consider the use of copyrighted material in all works prepared by them. This includes any copyrighted work of others incorporated in journal articles, books, courseware, software, video and conference material created for academic research as well as educational purposes. Faculty and staff are required to obtain permission and/or licenses from the copyright owner in order to reproduce, publish, distribute or display the copyrighted work.

I. Legal Advice Regarding Copyright

Before any RUTGERS Robert Wood Johnson Medical School faculty, staff or student takes action or causes action to be taken that could possibly infringe any "exclusive right in copyrighted works" that are not exempted under the law or are not clearly "Fair Use" under the guidelines delineated above, the matter must be

submitted in writing to the RUTGERS Robert Wood Johnson Medical School Office of Legal Management for legal advice. Submissions in writing must include:

1. the work (original, reasonable facsimile or reproduction) which could possibly be infringed;

2. a description of the use/action contemplated or anticipated that could possibly cause the infringement;

3. an explanation as to why the use/action is necessary and how it is of benefit to RUTGERS Robert Wood Johnson Medical School; and

4. all related pertinent materials, including timelines and deadlines that have a bearing on the amount of time available for rendering the legal advice.

J. Seeking Permissions

Permissions for copyrighted materials may be obtained through a variety of mechanisms. For most of the journal literature, permissions information is available at the Copyright Clearance Center, Inc. (CCC), 222 Rosewood Drive, Danvers, MA 01923, telephone (508)750-8400, fax (508) 750-4744. Many book publication permissions may be obtained at CCC as well. Music permissions information may generally be obtained from ASCAP, One Lincoln Plaza, New York, NY 10023, telephone (212) 621-6000, or BMI, 320 W. 57th Street, New York, NY 10019, telephone (212) 586-2000. Information on intellectual property and related matters may be obtained from the International Confederation of Societies of Authors and Composers (CISAC) (home page http://cisac.org). Many book and software permissions may be obtained by writing directly to the author. Publishers of books frequently provide addresses for their authors.

VI. SANCTIONS

Non-compliance with this policy may result in disciplinary actions under University employee and student policies and procedures, civil litigation, and/or criminal prosecution.

* Sections of this policy are excerpted from the policies of the Texas Tech University Health Sciences Center, with permission.

By Direction of the President:

_____
Vice President for Legal Management

_____
Vice President for Academic Affairs

University Policy Code: 00-01-90-50:05

Adopted: 8/31/99

Amended: 8/31/99

Approved by GMEC on 1/11/00

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY
GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.5
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: PHARMACEUTICAL & DEVISE MANUFACTURERS REPRESENTATIVE'S POLICY

I. Pharmaceutical and Devise Manufacturers Representatives (PDMR's), who wish to contact employees of the RUTGERS Robert Wood Johnson Medical School must sign a statement that they have read this policy and agree to comply with these policies.

II. All PDMR's must have approval from the employee(s) with whom they are scheduled to meet, prior to all appointments. Once approval is granted, all PDMR's must sign in with the Department of Public Safety in the ground floor of the Medical Education Building, or the equivalent entity in other venues, immediately upon entrance to the facility.

III. While on site and during appointments, all conversations and interactions must take place in a private setting (and not in the hallways, etc.).

IV. PDMR's are proscribed from using the paging systems to contact either faculty physicians or housestaff.

V. Housestaff are not permitted to interact with PDMR's in facilities associated with RWJMS, except for approved educational activities.

VI. Educational activities by PDMR's for housestaff are permitted, but only after approval by a faculty member of RWJMSs. A faculty member must be present during the educational activity.

VII. Pharmaceutical and devise manufacturer's promotional materials, without substantial education content, are barred from RWJMS facilities. Exhibits and discussion of pharmaceutical and devises as part of medical education programs are permitted in appropriate educational locations.

VIII. **Please refer to University Policy #00-01-10-05:00 Code of Ethics: General Conduct** for the receipt of gifts and favors, other than educational materials and grants, from PDMR's by RWJMS employees.

IX. Drug and devise samples may NOT distributed to patient care areas.

Approved by RUTGERS Robert Wood Johnson Medical School Executive Council August 18, 1998
Amended by GMEC 9/11/07, 10/09/07, 04/13/10

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.6
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: BLOODBORNE PATHOGENS

I. PURPOSE

The purpose of this policy is to establish procedures that will ensure compliance with the Occupational Safety and Health Administration's (OSHA) "Bloodborne Pathogens Standard" (29 CFR 1910.1030) as promulgated by the New Jersey Public Employees Occupational Safety and Health Act (PEOSHA).

II. ACCOUNTABILITY

Under the direction of the President, the Senior Vice President for Academic Affairs, the Deans, Vice Presidents and Associate Vice Presidents shall ensure compliance and implement this policy. The Director of Environmental and Occupational Health and Safety Services (EOHSS) shall assist with implementation of this policy by providing guidance and technical assistance to all RUTGERS Robert Wood Johnson Medical School and patient care facilities.

III. APPLICABILITY

A. This Bloodborne Pathogens policy applies to the following Potentially Infectious Materials:

1. Human body fluids: blood, semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pericardial fluid, pleural fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

2. Any unfixed tissue or organ (other than intact skin) from a human (living or dead).

3. HIV or HBV-containing cell or tissue cultures, organ cultures, and HIV or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV. (Bloodborne pathogens as they relate to the use of animal blood may also be covered by the policies of the University's research animal care facilities).

IV. DEFINITIONS

A. Bloodborne pathogens shall refer to pathogenic micro-organisms that are present in human blood and can cause disease in humans. These pathogens shall include, but not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

B. Engineering Controls shall mean controls, which by design, isolate or remove the bloodborne pathogen hazard from the workplace (e.g. sharps disposal containers, self-sheathing needles).

C. Occupational Exposure shall be used to refer to reasonably anticipated or inadvertent skin, eye, mucousmembrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

V. POLICY

A. Requirements:

The primary focus of this policy is to establish procedures, in accordance with OSHA's "Bloodborne Pathogens Standard" (29 CFR 1910.1030), that will protect RUTGERS Robert Wood Johnson Medical School staff and employees from the hazards related to occupational exposures to bloodborne pathogens and other potentially infectious materials. As such, this policy will supplement, not supersede, the existing University Policy on HIV, HBV and HCV (00-01-40-40:00) developed to provide a safe work and learning environment for University staff, students, faculty, and house staff.

1. Each RUTGERS Robert Wood Johnson Medical School school and patient care facility shall be responsible for developing standard operating procedures which will establish compliance with this policy. For the purposes of this policy, these standard operating procedures shall be known as an “exposure control plan”.

2. This policy shall be reviewed on an annual basis, or more frequently as new information arises.

B. Procedures:

1. Exposure Control Plan:

a. Each school and patient care facility shall ensure that a written "Exposure Control Plan" is developed and implemented. This plan will function as a standard operating procedure; describing the procedures and/or programs established by that specific school or unit to eliminate or minimize employee exposure to bloodborne

pathogens and other potentially infectious materials. In some cases, departmental "exposure control plans" may have to be developed. This would especially be the case for those departments whose risk of exposure is moderate, high and/or unique. In those cases where departmental “exposure control plans” are developed, it is recommended that they be modeled after the school/facility plan.

b. The Exposure Control Plan shall minimally consist of the following components:

(1.) An Exposure Determination for those titles within that school/facility:

(a.) including a list of all job titles in which all employees have occupational exposure (as defined in this policy).

(b.) including a list of all job titles in which some employees in that title have occupational exposure. For these titles, a list of all tasks and procedures (or groups of closely related tasks and procedures) in which occupational exposure occurs shall also be included.

(2.) Descriptions or copies of specific programs, policies, or procedures implemented at each school or patient care facility to address the requirements in this policy.

c. Each school/unit shall ensure that the Exposure Control Plan is accessible to its employees for examination.

d. The Exposure Control Plan shall be reviewed and updated, by representatives of the schools/units (e.g., school/unit safety committee) at least annually and, whenever tasks, procedures, or titles are modified such that risk of exposure to bloodborne pathogens change.

2. Universal Precautions:

a. As required by the existing University Policy on HIV, HBV, and HCV each school and patient care facility and all employees shall comply with the Universal Precautions Guidelines as established by the Centers for Disease Control and the New Jersey Department of Health Infection Control Standards for Hospitals (NJAC 8:43G-14.1(b)2).

3. Engineering Controls:

   a. Each school/unit will be responsible for reviewing and implementing available engineering controls. Engineering Controls refer to controls, which by design, isolate or remove bloodborne pathogen hazard from the workplace (e.g. sharps disposal containers, self-sheathing needles). In those cases where engineering controls have been implemented to the extent feasible and occupational exposure risk remains, other methods of controlling or minimizing occupational exposure, including personal protective equipment shall also be used.

   b. Engineering controls shall be maintained and evaluated periodically to ensure their continued effectiveness.

4. Work Practices and Hygiene: Each school/unit shall establish general work practices that will eliminate or minimize employee exposures. These may include, but not limited to:

   a. Hand washing techniques and requirements;

   b. Procedures for handling and disposal of contaminated needles and sharps;

   c. Lists of prohibited activities. (For example, eating, drinking, and handling contact lenses in those work areas where there is potential for exposure, or storage of food in locations where blood or other potentially infectious material are present.);

   d. Procedures to minimize splashing, spraying, spattering, generation of droplets, etc. during tasks which involve blood or other potentially infectious materials; and

   e. Procedures for decontamination of contaminated equipment before servicing, shipping or disposal.

5. Personal Protective Equipment:

   a. Each school/unit shall identify the specific procedures and/or tasks where personal protective equipment is required to prevent exposure to bloodborne pathogens. Specific descriptions of the personal protective equipment required for each task or procedure shall be included in the school's or patient care facility's Exposure Control Plan. For example, employees who transport specimens from clinics or patient care areas to laboratories may be required to wear gloves and laboratory coats. This requirement should be specified in the facility's Plan.

b. Each school/unit shall be responsible for providing personal protective equipment identified as essential to job performance at no cost to the employee. Personal protective equipment may include, but not limited to, gloves, gowns, laboratory coats, face shields and eye protection, mouthpieces, and resuscitation bags.

c. Each school/unit shall ensure that personal protective equipment is accessible and available in sufficient quantities and appropriate sizes.

d. Each school/unit shall be responsible for cleaning, laundering, replacing and disposing of personal protective equipment as necessary.

6. Housekeeping:

a. Each school/unit shall ensure that an appropriate written schedule for cleaning and decontaminating different work areas and surfaces, based upon the location within the facility, type of surface to be cleaned, types of contamination present, and tasks or procedures being performed in the area, is established and implemented in each of their departments.

b. Each school/unit shall ensure that all equipment and environmental and working surfaces are cleaned and decontaminated appropriately after contact with blood or other potentially infectious materials.

c. Each school/unit shall ensure that regulated waste is maintained, labeled, and disposed of in accordance with the University Regulated Medical Waste policy (00-01-45-15:00).

7. Hepatitis B Vaccination and Post-Exposure Evaluation:

a. As required by the University Policy on HIV, HBV and HCV (00-01-40-40:00), all house staff, faculty and staff who have direct patient contact, (as defined in the University Policy on HIV, HBV and HCV), or who have contact with potentially infectious body fluids or laboratory materials must be immunized against hepatitis B or be able to demonstrate immunity. In accordance with the standard, each school/unit shall be responsible for establishing procedures such that all employees who have occupational exposure can obtain hepatitis B vaccinations at no cost to them. The vaccination shall be made available after the employee has received training in accordance with this policy (see Section 9 of this policy) and, within 10 working days of assignment to duty, unless immunity has been established or the vaccine is contraindicated for medical reasons.

b. Confidential medical evaluation and follow-up shall be made immediately available to employees after an exposure incident is reported.

8. Labels and Signs:

a. Warning labels in accordance with the PEOSH/OSHA Bloodborne Pathogens standard shall be affixed to containers or regulated waste, refrigerators and freezers containing blood or other potentially infectious materials Exhibit A.

b. PEOSH/OSHA bloodborne pathogens labels/signs must also be posted at the entrances to work areas conducting HBV and HIV research.

9. Training:

a. Each school/unit shall ensure that all employees with occupational exposure participate in a training program on Bloodborne Pathogens with the following frequency:

(1.) At initial assignment;

(2.) Annually;

(3.) When changes that affect the employee's occupational exposure occur.

b. Training shall include as a minimum:

(1.) An explanation of the contents of the PEOSH/OSHA Bloodborne Pathogens Standard and information on how a copy of the standard may be obtained if requested;

(2.) A general explanation of the epidemiology and symptoms of bloodborne diseases;

(3.) An explanation of the modes of disease transmission;

(4.) A review of the school's/unit's Exposure Control Plan and the steps that the employee can take to obtain a copy of it;

(5.) An explanation of the appropriate methods that can be used to recognize and evaluate tasks and activities with potential exposure;

(6.) An explanation of the use and limitations of the different methods of control including, but not limited to, engineering controls, work practices and personal protective equipment;

(7.) Information on the types, proper use, location, removal, handling and disposal of personal protective equipment and the basis for selection of the different types of equipment;

(8.) Information on the appropriate actions and procedures to follow if an exposure occurs;

(9.) Information on the hepatitis B vaccine including efficacy, safety, and that the vaccine will be free of charge;

(10.) An explanation of the signs and labels required by the standard;

(11.) An opportunity for interactive questions and answers; and

(12.) Additional training for employees in HIV and HBV research laboratories which is specific to the practices and operations of the laboratory.

10. Recordkeeping:

a. Each school/unit shall ensure that medical records for each employee with occupational exposure are maintained for the duration of employment and 30 years thereafter. Each school/unit shall ensure confidentiality of employee medical records. The medical records shall include:

(1.) Hepatitis B vaccination status; including the dates of vaccination.

(2.) A copy of all results of post-exposure medical evaluations.

(3.) Copies of any information provided to the physician(s) performing medical evaluations related to this policy and the PEOSH/OSHA bloodborne pathogens standard.

b. Training records shall be maintained by each school and patient care unit and EOHSS. The records shall include training dates, contents of training, names and qualifications of instructors, and names and titles of the employees attending the training. These training records shall be maintained a minimum of 3 years.

11. HIV and HBV Research:

Each school/unit engaged in the culture, production, concentration, experimentation and manipulation of HIV and HBV shall comply with the requirements outlined for HIV and HBV research laboratories in PEOSH/OSHA's "Bloodborne Pathogens Standard" (29 CFR 1910.1030,

paragraph (e)). These requirements, including mandates for hand and eye washing facilities as well as autoclaves for decontamination of regulated waste, shall be adhered to in addition to the requirements already outlined in this policy.

VI. EXHIBITS

A. Occupational Exposure to Bloodborne Pathogens

By Direction of the President:

_____
Vice President for Administration

University Policy Code: 00-01-45-50:00

Adopted: 07/15/94

Amended: 01/21/00

ATTACHMENT I

POST EXPOSURE PROTOCOL

I. In all instances wash exposure site thoroughly with soap and water or water only for mucous membranes.

II. If incident occurs between 8:00 a.m. and 4:00 p.m. weekdays:

Call RWJMS Employee Health Services at (732) 445-0123 ext. 600 and speak to:
Iris G. Udasin, MD, Medical Director or
Mary Lou Mills, RN, Nurse Manager

If incident occurs after 4:00 p.m. and before 8:00 a.m. or on the weekend or holiday:

Call the Infectious Disease (ID) Fellow at (732) 828-3000. Press "0" and ask the operator to page the ID Fellow on call. The fellow will help determine if chemoprohylaxis is needed and instruct in obtaining it.

Call RWJMS Employee Health for follow-up care.

III. Complete an incident report.

Information provided by Employee Health Services January 2001

Attachment Approved by GMEC 4/10/01

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.7
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: STANDARDS OF CONDUCT IN THE TEACHER-LEARNER RELATIONSHIP

I. PREAMBLE

RUTGERS Robert Wood Johnson Medical School is committed to the highest standards of behavior concerning the teacher-student relationship. It is important to provide members of the medical school community an environment where teaching and learning takes place in a climate of mutual respect. RUTGERS Robert Wood Johnson Medical School maintains its commitment to preventing student abuse through education, by providing support for victims and by responding with corrective action. This policy addresses the behaviors required from all teachers, which include faculty members, residents, staff, or students in a teaching role. It is intended to assure an educational environment in which students, staff, volunteers, and faculty may raise and resolve issues without fear of intimidation or retaliation.

II. STANDARDS

Student mistreatment, abuse, or harassment will not be tolerated in the course of the teacher-learner relationship. Examples of inappropriate behavior or situations that would be unacceptable include:

a. Unwelcome physical contact, including any physical mistreatment or assaults such as hitting, slapping, kicking, or threats of the same nature;

b. Verbal abuse (attack in words, to speak insultingly, harshly, and unjustly);

c. Inappropriate or unprofessional criticism intended to belittle, embarrass, or humiliate a student;

d. Requiring a student to perform menial tasks intended to humiliate, control, or intimidate the student;

e. Unreasonable requests for a student to perform personal services;

f. Grading or assigning tasks used to punish a student rather than to evaluate or improve performance;

g. Sexual assault (refer to Sexual Assault Policy #00-01-10-85:00);

h. Sexual harassment (refer to Sexual Harassment Policy #00-01-35-25:00);

i. Discrimination based on race, religion, ethnicity, sex, age, sexual orientation, and physical disabilities.

While criticism is appropriate in certain circumstances in the teacher-learning process, it should be handled in such a way as to promote learning, avoiding purposeful student humiliation. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

III. PROCEDURES TO ADDRESS AN INFRACTION OF THE STANDARDS

Students who believe that a violation of this policy has taken place should immediately contact:

a. The Dean for Student Affairs or his/her designee or

b. The Office of Affirmative Action – Equal Employment Opportunity (AA-EEO).

If a formal complaint is reported to the Dean for Student Affairs or his/her designee, several options may be pursued;

a. Discuss the allegations with the consent of the accuser, among all involved parties in attempting to reach resolution among the parties. The mediation of the matter may involve contacting the chairperson of the relevant department, administrator, or Clerkship or Residency Program Director.

b. Refer the matter through the Dean to the Hearing Body for Student Rights and Responsibilities if the abuse is student to student, or

c. Refer the matter to the office of AA-EEO.

If the complainant wishes to remain anonymous, no formal action will be taken. However, the anonymous complaint will be filed in the Office of Student Affairs and reviewed to monitor for patterns of abuse. All reports of incidents will be held in confidence and will be dealt with quickly.

If the student goes directly to the office of AA-EEO or is referred from the Student Affairs Dean to the Office of AA-EEO that office will follow its guidelines and procedures to reach resolution (Complaint Policy #00-01-35-55:00).

Approved by the GMEC on October 10, 2000.

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.8
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: DRUG-FREE ENVIRONMENT

I. PURPOSE

To promote a drug-free workplace and learning environment for students, residents, faculty and staff in all University owned, leased and operated facilities. This policy is intended to implement the 1988 Drug-Free Workplace Act (Public Law 100-90, Title V, Subtitle D) and the 1989 Drug-Free Schools and Communities Act Amendments (Public Law 101-226, 34 CFR Part 86).

II. ACCOUNTABILITY

Under the direction of the Senior Vice President for Academic Affairs, the Deans shall ensure compliance with this policy with regard to students, residents and faculty, and the Vice President for Human Resources shall ensure compliance with this policy with regard to staff members.

III. BACKGROUND

A. The federal Drug-Free Workplace Act and the Drug-Free Schools and Communities Act Amendments require that, as a condition of receiving funds or any other form of financial assistance under any federal program, the University must certify that it has adopted and implemented a program to prevent the unlawful possession, use or distribution of illicit drugs and alcohol by all students and employees on University premises or as part of any University activities.

B. The University has implemented various assistance programs for individuals who have impairment problems, i.e., those who are unable to perform their duties with reasonable skill and safety due to substance abuse or alcoholism. A listing of drug and alcohol treatment centers is available from the campus assistance programs and at the campus libraries.

C. Drug and alcohol abuse jeopardizes the success of the University's programs and negatively impacts operations in terms of productivity, safety and attendance. The University is committed to a drug-free workplace and learning environment through the development of several policies and the availability of various assistance programs.

IV. REFERENCES

A. Impaired Faculty 00-01-20-55:00

B. House Officer Impairment 00-01-20-86:00

C. Impaired Students 00-01-25-35:00

D. Staff Impairment 00-01-30-45:00

E. Employee Assistance Program 00-01-30-45:05

V. POLICY

A. Maintaining a Drug-Free Workplace and Learning Environment

No student, faculty member, resident or staff member is permitted to unlawfully Manufacture, distribute, dispense, possess or use a controlled substance in any RUTGERS Robert Wood Johnson Medical School facility or while conducting official University business. Individuals who violate this policy will be subject to appropriate disciplinary action up to and including expulsion or termination from the University and referral for prosecution. A disciplinary sanction may include the completion of an appropriate rehabilitation program.

B. Drug Prevention Program

1. There shall be an annual distribution in writing by the end of September of each year to each student, resident, faculty and staff member:

   a. Standards of conduct that clearly prohibit the unlawful possession, use or distribution of illicit drugs and alcohol on University property or as part of any University activity;

   b. A description of the applicable legal sanctions under state and federal law for the unlawful possession or distribution of illicit drugs and alcohol;

   c. A description of the health risks associated with the use of illicit drugs and the abuse of alcohol;

   d. A description of available drug or alcohol counseling, treatment, rehabilitation or re-entry programs that are available;

   e. A clear statement and description of the disciplinary sanctions that the University will impose for violations of the standards of conduct required by this policy.

2. There shall be a biennial review by the University in August of every other year beginning in 1992 of this drug prevention program in order to:

   a. determine the effectiveness of the program and implement changes to the program if needed; and

b. ensure that the disciplinary sanctions described in section V.A. of this policy are consistently enforced.
this biennial program review shall be based upon the following types of information:

- the number and kinds of cases that are brought to campus impairment committees, assistance programs, department chairpersons, program directors and/or supervisors;
- the number and kinds of sanctions, if any, recommended by campus impairment committees and/or assistance programs;
- the number and types of disciplinary sanctions taken against individuals who violated state or federal drug laws or who resisted professional help when referred by a campus impairment committee, assistance program and/or supervisor; and
- the number and types of referrals for treatment of drug or alcohol abuse.

C. Submission of Written Certification

The Senior Vice President for Academic Affairs has signed and submitted to the U.S. Department of Education a drug prevention program certification (copy on file).

D. Reporting Conviction Resulting from Violation of Criminal Drug Statutes

When a faculty member or a staff member is convicted for violating any criminal drug statute for an act occurring on University premises, he or she must report this incident to the cognizant department chairperson or the immediate supervisor within five (5) days.

In an incident involving a faculty member, the department chairperson must apprise the Dean and contact the Office of Legal Management. In an incident involving a staff member, the supervisor must apprise the appropriate department head and Vice President as well as contact the Office of Legal Management. The Office of Legal Management will ascertain and carry out additional reporting requirements under state or federal law.

By Direction of the President:

Vice President for Academic Affairs

University Policy Code: 00-01-10-60:00
Adopted: 08/18/89 Amended: 03/14/02

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.9
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: IMPAIRED HOUSESTAFF

I. PURPOSE

To set RUTGERS Robert Wood Johnson Medical School policy in the event of impairment among housestaff, to provide assistance to impaired housestaff, and to protect the health and safety of patients, students and employees of RUTGERS Robert Wood Johnson Medical School.

II. ACCOUNTABILITY

Under the President and the Senior Vice President for Academic Affairs, the medical/dental School Deans shall implement and the Deans' designees responsible for graduate medical education at each School shall ensure compliance with this policy, including provision of the housestaff assistance committees with the resources needed to carry out their responsibilities under this policy.

III. DEFINITION

An impaired house officer is one who is unable to participate within the University community with requisite skill and safety. This impairment may be due to substance and/or alcohol abuse or dependency, mental disorder or other medical disorders. Signs and symptoms of such impairment could include, but are not limited to, a pattern of the following:

- unusual or inappropriate behavior
- negative changes in performance of assigned duties
- frequent or unexplained absences and/or tardiness from duties
- frequent or unexplained illnesses or accidents
- conduct which may constitute violations of law, including citations for driving while impaired
- significant inability to contend with routine difficulties and to act to overcome them.

IV. POLICY

Physical and mental disorders and alcohol and other drug abuse or dependencies are often treatable. It is the policy of the University to assist impaired housestaff (as defined

above) in obtaining treatment, when such assistance does not adversely affect the University's ability to safeguard the public health and effectively discharge its missions.

This policy focuses on the behavior of the impaired house officer and its impact on the house officer and others, not on any underlying medical condition or disability. If an impairment is caused by a disability, it shall be the house officer's obligation to comply with University policy, Individuals with Handicaps/Disabilities, 00-01-35-40:00 with regard to requests for accommodation.

Impairment of housestaff due to substance abuse and other forms of mental and physical disorders adversely affects all aspects of the University's missions. These disorders may impair work performance and/or the provision of patient care. Conduct related to impairment may be sufficient grounds for disciplinary action, including dismissal, and may require immediate action to protect the health and safety of others.

The program director of the impaired house officer's training program shall be responsible for restricting and monitoring patient care duties and privileges. In the event that the impairment poses a risk for patient care, clinical practice privileges and clinical duties shall be suspended immediately pursuant to existing University procedures.

Where an incident may involve a violation of federal, state or local law, the Office of Legal Management may be consulted to determine whether there is an affirmative duty to report the violation or take other action.

Confidentiality of all referred and identified housestaff and of individuals making referrals shall be maintained to the extent possible and permitted by law.

V. PROCEDURES

A. Each RUTGERS Robert Wood Johnson Medical School medical/dental School shall develop its own housestaff assistance policies and procedures incorporating all existing resources, including the Housestaff Assistance Committees (see below), to identify and, when appropriate, attempt to assist impaired housestaff.

B. In order to supplement existing University and School resources, bring previously unidentified impaired housestaff into treatment and accomplish identification and treatment earlier in the course of these disorders when the prognosis for successful rehabilitation is likely to be better, the Schools shall separately or in combination with other Schools, and/or patient-care units of the University and/or clinical affiliates establish Housestaff Assistance Committees which will have the following basic functions:

- assessment of reports of impairment;
- presentation of concerns to identified housestaff;
- referrals for diagnosis and treatment;

- monitoring of impaired housestaff until final disposition;
- referral of housestaff who are not cooperative or who are non-compliant in the evaluation, referral and/or treatment to the appropriate program director for possible disciplinary or other action.

Details of the functions, composition and procedures of these committees can be found in item D below.

The Housestaff Assistance Committees are only one of several options available to a School for identifying impaired housestaff and bringing them into treatment, and are meant to be utilized by the School administrators responsible for graduate medical/dental education in concert with other resources at the University and/or its clinical affiliates, and other appropriate procedures which may include disciplinary action and leaves of absence.

C. A summary of this policy and of the assistance available through the Housestaff Assistance Committees and other existing resources shall be incorporated into housestaff informational materials and housestaff orientation programs.

D. Each medical/dental School shall separately or in combination with other Schools, patient-care units and/or clinical affiliates establish a Housestaff Assistance Committee:

1. Composition of the Housestaff Assistance Committee

a. The Dean(s)of the medical/dental School(s) shall appoint the members of the committee. The committee shall have representation by the School's administrator of graduate medical/dental education, program directors, faculty/attendings and senior housestaff. One or more individuals with expertise in mental health and in addiction/substance abuse should be included on each committee. Each committee shall name a chair and establish its own procedures and meeting schedule.

b. A list of the Housestaff Assistance Committee members shall be available at the education office of each patient-care facility participating in RUTGERS Robert Wood Johnson Medical School housestaff programs.

c. Each health care facility participating in the graduate medical or dental program shall identify a contact person to administer the policy at that institution, report to the committee and the program director as indicated, and assume other duties including assuring appropriate reporting to the Board of Medical or Dental Examiners.

2. Functions of the Housestaff Assistance Committee

a. Publicizing the Housestaff Assistance Committee

The committees shall annually publish and disseminate to housestaff and pertinent administrators a statement summarizing the University's Housestaff Impairment policy, including the names, locations and telephone numbers of the members of the committees to whom reports of potential impairment are to be made and a description of other resources for dealing with impairment. The committees shall ensure that a statement regarding the Housestaff Assistance Committee is incorporated into the housestaff informational materials and housestaff orientation programs, and that Campus forums on substance abuse include reference to the Housestaff Assistance Committee.

b. Advocacy for preventive activities

The committees shall develop and recommend to the School and University administrations preventive activities aimed at housestaff.

c. Assessment of reports of impairment

Sources of referrals and reports concerning housestaff impairment may include:

- self referral
- spouse, other family or household members
- students, other housestaff and colleagues
- faculty and housestaff committees
- School administrators and other staff of the School or patient-care facility
- health professionals with knowledge of the house officer from other treatment programs, especially when the house officer has failed to follow or complete the previous program
- patients

The committees are responsible for the preliminary assessment of the validity of reports and referrals made to them prior to presenting their concerns to the house officer.

The committees shall consider reports of behavior or incidents which may be indicative of impairment and which occur within and/or outside the University premises

d. Presentation of concerns to identified housestaff

Once the committee has concluded that there is a likelihood of impairment in a referred house officer, two members of the committee shall be selected to privately present the committee's concerns to the house officer. Where appropriate, individuals possessing first-hand experience with the house officer's impaired behavior or status shall be asked to voluntarily take part in the presentation of concerns to the house officer. Those members of the committee who will perform interventions should have received specialized training in handling such presentations (intervention training). (If desired by a committee considering a referred medical house officer, the Physicians Health Program of the Medical Society of New Jersey may be asked to perform or assist in the intervention.)

Four possible outcomes of the initial presentation are:

i. The presenters conclude that based on additional information given to them by the house officer, there are no grounds for concluding that the house officer is impaired and that no intervention is required.

ii. Further assessment and/or additional information is required. This may include referral of the house officer for a clinical evaluation.

iii. The house officer is convinced of the need for help and assents to enroll in an appropriate treatment program; the presenters will begin the referral process for evaluation and treatment.

iv. Treatment is indicated and the house officer resists help, either by refusing treatment or refusing evaluation to determine if treatment is necessary. The presenters shall report back to the committee which shall convey the information concerning the house officer to the appropriate program director. The program director, after his/her own assessment of the available information, may make additional attempts to get the house officer into treatment or evaluated for the need for treatment. If the program director is convinced that the house officer is impaired and the house officer continues to refuse treatment or evaluation, then the program director shall initiate the appropriate steps to discipline or dismiss the house officer from the institution in accordance with the School's bylaws, policies and procedures and any applicable union contracts.

e. Referral for evaluation, diagnosis and treatment

The committee shall refer housestaff for clinical evaluation to those resources identified by the committee as appropriate.

Referred housestaff will be allowed to choose an approved resource from among those identified by the committee or be able to utilize an alternative resource that meets the committee's approval. A specially trained professional at the resource shall evaluate each referred house officer, make all diagnoses, and, if needed, recommend a treatment program which may be outpatient or inpatient.

If, after receiving the evaluation report, the committee sees the need for additional information or evaluation, or for a second opinion, the committee may refer the house officer to another resource.

When referring a house officer for clinical evaluation/treatment, the committee shall transmit to the provider information describing conduct by the house officer which suggests or indicates potential impairment. When referring a house officer, the committee shall not transmit any individually identifiable health information or medical records directly to the provider except with the written authorization of the house officer.

Treatment, if indicated, may be conducted at the resource performing the evaluation or at an alternative resource selected by the house officer subject to committee approval.

f. Monitoring of impaired housestaff

The committee shall monitor the treatment and rehabilitation of referred impaired housestaff as appropriate. This will include newly hired individuals with a previous impairment that was identified at the time of initial hire and whose employment is contingent upon such monitoring. The committee will also be responsible for monitoring housestaff whose impairment becomes identified through a mechanism other than those identified in Section D.2.c. If a house officer is enrolled in a treatment program, the committee may delegate the monitoring function to the treatment program, and, in that event, shall receive regular reports on the house officer’s progress. The house officer shall be required to permit the treatment provider to provide relevant information to the committee and to inform the committee if the house officer drops out of treatment, relapses or shows other

evidence of deterioration liable to result in significant functional impairment. Failure of the house officer to permit the treatment provider to provide relevant information may result in action by the School, including possible dismissal.

The committee shall determine in each case the appropriate duration of monitoring. In making this determination, consideration should be given to the practice of the New Jersey State Medical Society's Physicians Health Program to monitor practitioners who are impaired due to substance abuse or other physical or mental disorders that may impact on the safe care of patients. Monitoring by the committee may need to be maintained for an indefinite period, or until the house officer leaves the University.

A house officer on medical leave of absence because of an impairment that is being monitored by the committee should be considered for reinstatement by the School administration only after consultation with the committee. The committee's recommendation in this regard will be based upon the current evaluation by the house officer's treatment provider and upon any independent evaluation requested by the committee.

g. Consultation with New Jersey State Assistance Programs

The committee shall maintain open communication with the Directors of the Physicians Health Program of the Medical Society of New Jersey and the Dental Association's Assistance Program for exchange of information and advice and for consultation. Assistance with intervention with referred housestaff may be requested from these programs at the discretion of the committee.

h. Upon completion of the residency training program, the committee may refer the house officer to the state program where the house officer relocates.

i. Submission of annual reports to the Deans and to the Senior Vice President for Academic Affairs

The committees shall each submit an annual report to the respective Deans, School Administrators responsible for graduate medical/dental education and the Senior Vice President for Academic Affairs. These reports will summarize the activities of the committees (referring to individuals by case number only), report on the status of individuals under committee supervision or monitoring, and make recommendations for improving the role of the Housestaff Assistance Committee. The committee chairperson is responsible for the preparation and submission of the reports.

E. Urine and/or blood testing for drugs

There shall be no mandatory, routine use of urine or blood testing for drugs. However, where there is a reason to believe that impairment is the result of substance abuse and the house officer refuses to submit to drug testing, the University reserves the right to take disciplinary action or other action as may be

deemed appropriate to protect the health and safety of patients, students, other house officers and employees. Testing may be performed by the selected treatment program. The committees may also recommend drug testing to a house officer to help rule out the existence of a substance abuse problem. Drug testing may be required to verify a drug-free state during treatment and as part of the follow-up and monitoring after the conclusion of formal therapy.

F. Confidentiality

The Housestaff Assistance Committees shall make every effort to maintain the confidentiality of referred individuals to the extent possible and permitted by law. Only case numbers rather than individuals' names shall be used during meetings and in records. Files involving impaired housestaff shall be stored under lock separately from personnel records. Inactive files and files of housestaff who have left the University shall be sealed and stored separately. If a house officer is referred to a state assistance program, the appropriate files shall be shared with that program, and a notation of the sharing kept at the University.

By Direction of the President:

_____
Vice President for Academic Affairs

University Policy Code: 00-01-20-86:00
Adopted: 05/25/95
Amended: 08/29/02

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.10
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: EXCLUDED INDIVIDUALS AND ENTITIES

I. PURPOSE

To establish a policy governing the RUTGERS Robert Wood Johnson Medical School employment of and entering into contracts with, individuals or entities who are currently excluded by the Office of Inspector General (OIG) and/or the General Service Administration (GSA) from participation in Federal health care programs.

II. ACCOUNTABILITY

Under the direction of the President, the Deans, Senior Vice President for Administration and Finance, Senior Vice President for Academic Affairs, Vice President for Legal Management, Vice President for Human Resources, Presidents/CEOs of the Healthcare Units, and Executive Director for Materials Management shall ensure compliance with this policy. The Department Chairs in each School, Department Directors of University Hospital and Department Directors of all RUTGERS Robert Wood Johnson Medical School Units shall implement this policy.

III. APPLICABILITY

This policy applies to all RUTGERS Robert Wood Johnson Medical School employees and all individuals/entities entering into a contract with RUTGERS Robert Wood Johnson Medical School.

IV. POLICY

In accordance with Federal law, RUTGERS Robert Wood Johnson Medical School will not employ or enter into contracts with any individual or entity who is currently excluded by the Office of Inspector General (OIG) and/or the General Service Administration (GSA) from participation in Federal health care programs.

V. PROCEDURE

Prior to hiring an individual, entering into contracts with any individual or entity, or extending clinical privileges at RUTGERS Robert Wood Johnson Medical School, the Department of Human Resources must verify that the individual or entity does not appear on the OIG or GSA listing of excluded parties. Prior to entering into any contracts or purchasing agreements with any individual or entity, Purchasing Services must verify that the individual or entity certifies through an ownership disclosure statement that same does not appear on the OIG or GSA listing of excluded parties.

These listings can be accessed on the Internet in a searchable format:

(For OIG) http://exclusions.oig.hhs.gov/

(For GSA) http://epls.arnet.gov/

1. If the above searches indicate that the individual or entity is on either the OIG or GSA list of excluded individuals and entities, this individual or entity cannot be employed or have any contractual relationship with RUTGERS Robert Wood Johnson Medical School, including the granting of clinical privileges.
2. To protect RUTGERS Robert Wood Johnson Medical School against individuals or entities excluded subsequent to their employment, during the duration of the contract, during the duration of the employment, or after the granting of clinical privileges, these searches also need to be performed by the Office of Business Conduct periodically, at a minimum of semi-annually.
3. If it is determined that a current employee, entity with a current contract, or non-employee physician with current clinical privileges is an excluded individual or entity, the Office of Business Conduct must be notified immediately. The Office of Business Conduct will perform an investigation to ascertain if in fact the current employee, entity with a current contract, or non-employee physician with current clinical privileges is on the exclusion list. If it is determined that the individual and/or entity is on the exclusion list, the employment and/or contractual relationship shall be immediately terminated.
4. If a person in a supervisory capacity learns that a member of his/her staff and/or an entity being utilized is on the excluded list, he/she must notify the Office of Business Conduct immediately. Failure to notify the Office of Business Conduct may result in sanctions being imposed, up to and including termination.
5. If an individual learns that he/she is on the excluded list, or if an entity he/she is utilizing is on the excluded list, he/she must notify the Office of Business Conduct immediately. Failure to do so will result in sanctions being imposed, up to and including termination.

By Direction of the President:

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Senior Vice President for Administration and Finance

University Coding: 00-01-10-08:00
Adopted: 11/19/99
Amended: 06/07/02 & 01/03/05

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.11
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: GRADUATE MEDICAL, DENTAL AND PODIATRY EDUCATION

I. PURPOSE

To specify minimum standards of the University for the eligibility, selection, evaluation, promotion and dismissal of housestaff in all postgraduate programs sponsored by RUTGERS Robert Wood Johnson Medical School and/or core teaching hospitals. Each School and postgraduate program shall establish its own requirements which may be more stringent but shall not be less stringent than the requirements specified herein.

II. ACCOUNTABILITY

Under the direction of the President, the Senior Vice President for Academic Affairs shall ensure compliance with this policy. The appropriate Deans or their designees shall implement this policy through the Graduate Medical Education and Graduate Dental Education Program Directors.

III. DEFINITIONS

A. Housestaff: Interns, residents and clinical fellows.

B. House officer: Individual intern, resident or clinical fellow.

C. Postgraduate program: Internship, residency or clinical fellowship program.

IV. REFERENCES

A. Outside Employment 00-01-30-10:00

B. Housestaff Immunizations and Health Requirements 00-01-40-45:00

V. POLICY

A. Requirements for Admission to RUTGERS Robert Wood Johnson Medical School postgraduate programs:

It is the policy of RUTGERS Robert Wood Johnson Medical School to obtain a consumer report or investigative consumer report, as those terms are defined in the federal Fair Credit Reporting Act, on all applicants to the University's postgraduate programs. In order to be admitted to a RUTGERS Robert Wood Johnson Medical School postgraduate program, the applicant must receive a consumer report and/or investigative report deemed favorable by RUTGERS Robert Wood Johnson Medical School.

B. Other requirements for admission are as follows:

1. Graduate Medical Education Programs

a. For admission to the first postgraduate year (PGY1), the applicant must qualify for registration with the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners Regulation 13:35-1.5(c) (EXHIBIT A).

b. For admission to PGY2 and subsequent years, the applicant must qualify for a permit issued by the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners Regulation 13:35-1.5 (EXHIBIT A).

c. For admission to PGY3 and subsequent years, the applicant must have passed United States Medical Licensing Exam (USMLE) Step 3, National Board of Osteopathic Medical Examiners (NBOME) Part III or Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level III (which replaced NBOME Part III in February 1995).

d. For admission to any postgraduate year after the applicant has used up his or her five (5) years of eligibility for registration/permit in the State of New Jersey, the applicant must have a New Jersey license.

e. International Medical Graduates (IMGs) must, in addition to the above:

i. be U.S. citizens, U.S. permanent residents or holders of J-1 Exchange Visitor visas issued by the Education Commission on Foreign Medical Graduates (ECFMG); and

ii. hold a currently valid ECFMG certificate.

iii. In rare instances under special circumstances, the University may sponsor an IMG for an H-1B Temporary Worker visa. Such sponsorship must be approved by the School's Associate Dean for GME, the Dean and the Vice

President for Academic Affairs following justification from the Dean.

2. Graduate Dental Education Programs

a. For admission to PGY1 or PGY2 of a RUTGERS Robert Wood Johnson Medical School graduate dental education program, the applicant must:

i. be a graduate from an institution approved by the Commission on Dental Accreditation of the American or Canadian Dental Association (EXHIBIT B), and

ii. hold a resident permit from the New Jersey State Board of Dentistry unless already licensed to practice dentistry in New Jersey (EXHIBIT B), and

iii. have passed Parts I and II of the National Board of Dental Examiners (NBDE) (EXHIBIT B).

b. For admission to an Oral & Maxillofacial Surgery Program, the applicant must fulfill the requirements in section V.B.2.a above plus have U.S. citizenship or permanent residency status with associated proofs thereof.

3. Graduate Podiatry Education Programs

a. For admission to the first postgraduate year (PGY1), the applicant must qualify for registration with the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners Regulation 13:35-1.5 (EXHIBIT A) and must have passed the examination of the National Board of Podiatry Examiners.

b. For admission to PGY2 or PGY3, the applicant must qualify for a permit issued by the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners regulation 13:35-1.5 (EXHIBIT A).

C. Housestaff Selection

Postgraduate programs should develop selection criteria appropriate to the discipline and to the goal of producing caring and competent practitioners.

D. Housestaff Contracts

The contract for each house officer in a graduate medical, dental or podiatry program shall:

1. specify the specialty and sub-specialty, where applicable, and the level or Postgraduate Year (PGY), e.g., Internal Medicine PGY 1, 2, 3, or Internal Medicine-Cardiology PGY 4, 5, etc., and the term of the contract;

2. have an attachment describing assigned duties including patient care and teaching, and the program's overall work schedules;

3. specify that the pertinent registration/permit/licensure requirements of the New Jersey State Board of Medical Examiners must have been met as a precondition of the contract;

4. contain an attachment for medical or podiatry housestaff defining scope of practice of registration or permit holders as per regulations of the New Jersey State Board of Medical Examiners; and for dental housestaff, contain and define New Jersey State Board of Dentistry regulations regarding scope of practice;

5. describe benefits including vacations, professional and/or sick leave, family leave, liability insurance, health insurance and other insurance for housestaff and their families, and meals and laundry or their equivalent, consistent with hospital or University policies or the collective bargaining agreement between the Committee of Interns and Residents (CIR) and the University, where applicable;

6. specify whether or not extramural employment (moonlighting) is permissible; and, where moonlighting is permissible, specify that malpractice coverage is not provided by the University for moonlighting and additionally specify that the house officer must (a) have approval of the Program Director and (b) must give assurance that this activity will not interfere with responsibilities to the postgraduate program (see University policy, Outside Employment, 00-01-30-10:00);

7. have as attachments copies of Sections V.E (Academic Evaluation of Housestaff) and V.F (Promotion) of this policy;

8. specify that compliance with the University's Housestaff Immunizations and Health Requirements policy is required as a condition of the contract; and

9. state that "the house officer agrees that this agreement is contingent upon receipt by RUTGERS Robert Wood Johnson Medical School of a consumer report or investigative report, as those terms are defined in the federal Fair Credit Reporting Act, deemed favorable by RUTGERS Robert Wood Johnson Medical School."

E. Academic Evaluation of Housestaff

1. Evaluation System

Each postgraduate program must have in place a system of evaluation used to assess the academic performance of housestaff on a continuing basis; this system must be followed uniformly for all housestaff in the program. There shall be timely feedback to housestaff, particularly with regard to any deficiencies noted. Evaluations shall be documented in each house officer's academic record.

2. Requirement of Satisfactory Progress

In order to continue in a postgraduate program a house officer must make satisfactory academic progress as determined in accordance with the postgraduate program's evaluation system.

3. Scope of Academic Evaluations

All academic matters shall be considered in determining whether a house officer is making satisfactory academic progress. Academic matters include acquisition of knowledge related to the discipline as well as all aspects of the development of clinical and professional skills necessary for effective functioning as a health care professional. Of particular importance as academic issues are such areas of professional development as professional ethics and maintaining professional relationships with patients and with other health care professionals, including subordinates, colleagues and superiors.

4. The University's Model Statement on Academic Evaluation of Housestaff and Procedures for Academic Dismissals of Housestaff (EXHIBIT C) should be used as a guide in the academic evaluation of housestaff.

F. Promotion

1. Criteria for promotion in each postgraduate program shall be specified, updated, documented and communicated to housestaff at the beginning of each academic year.

2. In general, a housestaff's postgraduate level is determined by the Program Director, the Department Chair and the Dean on the basis of previous training and experience.
3. In addition to fulfilling the requirement of satisfactory academic progress as specified in Section D above, housestaff must satisfy the following requirements:

a. Graduate Medical Education Programs

i. For promotion to PGY2 through PGY5, the house officer must either have a New Jersey medical license or obtain and maintain a permit issued by the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners Regulation 13:35-1.5 (EXHIBIT A); an unlicensed house officer who does not obtain or make application for such a permit shall automatically be terminated at the conclusion of PGY1; an unlicensed house officer who fails to maintain such a permit shall be terminated upon the loss of the permit.

ii. For promotion to PGY3, the house officer must also have passed USMLE Step 3, NBOME Part III or COMLEX Level III (which replaced NBOME Part III in February 1995); a house officer who has not passed USMLE Step 3, NBOME Part III or COMLEX Level III shall automatically be terminated at the conclusion of PGY2.

iii. For promotion to any postgraduate year after a house officer has used up the five (5) year limit for registration/permit eligibility (as specified in NJSA 45:9-21d), the house officer must have a New Jersey license; a house officer whose eligibility for a permit has expired and who has not obtained a New Jersey license shall automatically be terminated at the conclusion of the last academic year of eligibility for a permit; and

iv. Postgraduate programs have the option of requiring housestaff to obtain New Jersey licensure as a condition of promotion to PGY3 if eligible at that time, or to any succeeding postgraduate year. (For IMGs, there can be no requirement for licensure until PGY4 as they are ineligible for New Jersey licensure until they have completed three (3) years of graduate medical education).

b. Graduate Dental Education Programs

For promotion to PGY3 and beyond, a house officer must have a dental license from New Jersey or a dental license from another U.S. jurisdiction plus a New Jersey State Board of Dentistry resident permit. A house officer who has not obtained a dental license from New Jersey or from another U.S. jurisdiction plus a New Jersey State Board of Dentistry resident permit shall automatically be terminated at the conclusion of PGY2. (A house officer who has a New Jersey dental license does not need to have a resident permit).

c. Graduate Podiatry Education Programs

For promotion to PGY2 and beyond, a house officer must qualify for a permit issued by the New Jersey State Board of Medical Examiners as defined in State Board of Medical Examiners Regulation 13:35-1.5 (EXHIBIT A).

G. Dismissal for Academic Cause

Each school shall develop, maintain and follow a defined, written process for dismissal for academic cause. The process must satisfy the requirements of fundamental fairness and must apply equally to all housestaff. The process description should include details of determination of cause for dismissal, notification, and the right to be heard. The University's Model Statement on Academic Evaluation of Housestaff and Procedures for Academic Dismissals of Housestaff should be followed as a guide in all dismissals for academic cause (EXHIBIT C).

H. Inclusion of Policy in Housestaff Manuals

Policies and procedures regarding the eligibility, selection, evaluation, promotion and dismissal of housestaff shall be included in housestaff manuals of each teaching facility sponsoring postgraduate training under the aegis of a RUTGERS Robert Wood Johnson Medical School and affiliated teaching hospital, or included in written materials distributed to all housestaff.

VI. EXHIBITS

A. Regulations of the New Jersey State Board of Medical Examiners governing postgraduate training, and registration and permit requirements for graduate medical education programs in medicine or podiatry (13:35-1.3 and 1.5)

B. Statutes and regulations of the New Jersey State Board of Dentistry governing licensure requirements to practice dentistry (13:30-1.1 through 13:30-1.3)

C. Model Statement on Academic Evaluation of Housestaff and Procedures for Academic Dismissals of Housestaff

By Direction of the President:

_____

Vice President for Academic Affairs

University Coding: 00-01-20-87:00
Adopted: 07/27/95
Amended: 05/15/03

EXHIBIT A
Regulations of the New Jersey State Board of Medical Examiners

13:35-1.3 Postgraduate training

Postgraduate training shall be taken under the auspices of a hospital or hospitals accredited for such training by the Accreditation Council for Graduate Medical Education (ACGME) or by the American Osteopathic Association (AOA) or by the American Podiatric Medical Association (APMA), as applicable to the profession. The program shall further be acceptable to the Board, which shall take into account the standards adopted by the Advisory Graduate Medical 13:35-1.4 Military service in lieu of M.D. or D.O. internship or postgraduate training.

The Board may grant a license to practice medicine and surgery to any person who shall furnish proof, satisfactory to the Board, that such person has fulfilled all of the formal requirements established by law, and who has served at least two years in active military service in the United States Army, Air Force, Navy, Marine Corps, Coast Guard or the U.S. Public Health Service as a commissioned officer and physician and surgeon in a medical facility which the Board determines constitutes the substantial equivalent of the approved internship or residency training program required by law; provided, however, that such military service actively occurred subsequent to graduation from an approved medical school.

13:35-1.5 Registration and permit requirements for graduate medical education programs in medicine or podiatry

(a) The following terms shall have the following meanings unless the context in this section indicates otherwise:

"Applicant" means a graduate of a medical or podiatric school, unlicensed in this State, seeking authorization to engage in the practice of medicine or podiatry as a resident in a graduate medical education program. A registration applicant is seeking authorization to participate in the first year of a graduate medical education program. A permit applicant is seeking authorization to participate in his or her second year (or beyond) of a graduate medical education program.

"Director" means a physician holding a plenary license to practice medicine and surgery in New Jersey who is responsible for the conduct of a graduate medical education program at a hospital licensed in this State and whose responsibilities shall include generally overseeing the selection, training and evaluation of residents. With respect to graduate medical education programs in podiatry, the director shall be a podiatric physician licensed to practice podiatry in New Jersey.

"Graduate Medical Education Program" means an education program, whether denominated as an internship, residency, or fellowship, which is accredited by the Accreditation Council on Graduate Medicine Education

(ACGME) or by the American Osteopathic Association (AOA) in which the graduates of medical schools participate for a limited period of time under the supervision of plenary licensed physicians. With respect to podiatry, "Graduate Medical Education Program in Podiatry" means an education program, whether denominated as an internship, residency, or fellowship, which is accredited by the Council on Podiatric Medical Education of the American Podiatric Medicine Association (APMA) in which the graduates of podiatric schools participate for a limited period of time under the supervision of a licensed podiatric physician.

"Master list" means a list prepared by the director setting forth the name of each person seeking to practice medicine or podiatry in that graduate medical education program in New Jersey, designating the date of birth and medical or podiatric schools attended.

"Permit" means a document issued by the New Jersey State Board of Medical Examiners authorizing the holder to engage in the practice of medicine or podiatry in the second year of a graduate medical education program (or beyond) in medicine or podiatry in this State, subject to the limitations set forth in this rule.

"Permit holder" means a person authorized to engage in the practice of medicine or podiatry, as appropriate, while in the second year or beyond of a graduate medical education program in medicine or podiatry in the State of New Jersey, subject to the limitations set forth in this rule.

"Registered Resident" means an applicant granted authorization to engage in the practice of medicine or podiatry in the State of New Jersey in the first year of a graduate medical education program, subject to the limitations set forth in this rule.

"Registration" means authorization to engage in the practice of medicine or podiatry in this State in the first year of a graduate medical education program subject to the limitations set forth in this rule.

"Resident" means a participant in training in a graduate medical education program in podiatry at a licensed hospital in this State. For purposes of this rule, persons serving in internships and fellowships shall be deemed residents.

(b) No unlicensed person shall engage in the practice of medicine or podiatry in the first year of a graduate medical education program unless and until he or she is registered with the Board. No unlicensed person shall engage in the practice of medicine or podiatry in the second year of graduate medical education or beyond unless or until he or she has been issued a permit by the Board.

(c) A registration applicant shall certify that he or she:

1. Has attained the preliminary educational prerequisites for licensure, including:

i. Completion of at least 60 undergraduate level credits, at a college or university attained prior to medical or podiatric school. With respect to medical residents, the credits shall include at least one course each in biology, chemistry and physics.

ii. With respect to medical residents, graduation from a medical school which, during each year of attendance, was either accredited by the Liaison Committee on Medical Education (LCME) or the AOA or listed in the World Directory of Medical Schools. If the applicant has attended more than one medical school, he or she shall certify that each school attended was accredited or listed in the World Directory during the same time he or she was matriculated. With respect to podiatry residents, graduation from a podiatric school accredited by the Council on Podiatric Medical Education of the American Podiatric Medicine Association (APMA). If the applicant has attended more than one podiatric school, he or she shall certify that each school attended was accredited or listed.

iii. Attendance at medical or podiatric school for at least 32 months prior to graduation.

iv. With respect to medical students, where clinical clerkships have been completed away from the site of a medical school not approved by the LCME or the AOA, satisfactory completion of clinical clerkships of at least four weeks duration each in internal medicine, surgery, obstetrics and gynecology, pediatrics and psychiatry at hospitals which maintained at the time of the clerkship a graduate medical education program in that field.

2. Has never been the subject of an administrative disciplinary proceeding by any state professional licensing agency, has never been convicted of a criminal offense of any grade or admitted to a pre-trial diversionary program, has never been denied licensure eligibility to sit for an examination or eligibility to participate in a postgraduate training program in this or any other state, has never had privileges at a hospital terminated or curtailed for cause, has never been asked to resign from a graduate medical education program or hospital staff, has never had privileges to prescribe controlled dangerous substances curtailed or limited by any

regulatory authority, has never had privileges to participate in any State or Federal medical assistance program (Medicare, Medicaid) curtailed or limited by any regulatory authority.

3. Is not, at the time that the certification is executed, the subject of an administrative disciplinary proceeding by any State professional licensing agency, or other regulatory authority (that is, Drug Enforcement Agency, Medicare, Medicaid), or the subject of any criminal proceeding (under arrest, indictment or accusation).

4. Is not physically or mentally incapacitated to a degree which would impair his or her ability to practice medicine or podiatry, as applicable, and is not at the time of application habituated to alcohol or a user of any controlled dangerous substance except upon good faith prescription of a physician.

5. Has obtained ECFMG or Fifth Pathway certification, if he or she is a graduate of a foreign medical school.

(d) The Director shall obtain a registration form from each registration applicant and shall retain those forms, which may be subject to review by the Board. The Director shall certify that he or she has personally reviewed the registration form of each registration applicant who has accepted an offer of employment to ascertain that the registration applicant has certified that he or she has attained the prerequisites set forth in (c) above and that the Director is unaware of any information which would contradict any of the representations contained in that registration application form. If the Director shall have reason to question the veracity or reliability of those representations, he or she shall direct the registration applicant to supply the supporting documentation. The Director shall prepare a master list including all registration applicants and shall submit it to the Board, along with his or her certification, no later than one month before the registration applicants are to begin participating in the graduate medical education program.

(e) The Board shall review the Director's certification, and shall issue to the Director a list of residents registered to engage in the practice of medicine or podiatry in the first year of the graduate medical education program conducted by that hospital. The Board shall provide to the Director a permit application for dissemination to each registered resident.

(f) A registration applicant unable to certify that he or she has attained the prerequisites set forth at (c) above shall state on the registration application form the reason that he or she is unable to so certify. The Director seeking to offer employment to a registration applicant unable to certify that he or she has attained all the prerequisites may seek from the Board a waiver which would enable the applicant to participate in the first year of a graduate medical education program. The Board, in its

discretion, may grant or withhold such waiver for good cause. However, in no event may the applicant begin participating until the waiver for good cause request has been granted and the individual's name included on the list of registered resident or temporary authorization has been granted pursuant to (g) below.

(g) In the event that a registration applicant has been unable to submit the required certification in a timely manner, the Director may grant that applicant temporary authorization to participate in the first year of a graduate medical education program, which will allow him or her no more than 30 days to complete the application process, provided that notice of such a grant is provided to the Board within five working days.

(h) A registered resident may engage in the practice of medicine or podiatry provided that such practice shall be confined to a hospital affiliated with the graduate medical education program and outpatient facilities integrated into the curriculum of the program, under the supervision of licensed plenary physicians or licensed podiatric physicians, as appropriate. All prescriptions and orders issued by registered residents in the inpatient setting shall be countersigned by either a licensed physician or a licensed podiatric physician, as applicable; or a permit holder at the minimum upon the patient's discharge, or sooner if the Director so requires. All prescriptions issued by registered resident in the outpatient setting which are to be filled in a pharmacy outside a licensed health care facility shall be signed by either a licensed physician or licensed podiatric physician, as appropriate.

(i) The Board may refuse to register a registration applicant if he or she has not certified that the prerequisites set forth in (c) above have been satisfied or if the Board is in possession of any information contradicting the representation made in the registration application form. The Board shall give the Director and the registration applicant notice of its refusal, allowing the submission of documentary evidence in rebuttal. Upon a showing of good cause the applicant will be granted an appearance before a committee of the Board.

(j) In addition to any practice declared to be a basis for sanction, pursuant to P.L. 1978, c.73 (N.J.S.A. 45:1-14 et seq.), the practices listed below, upon proof, shall also provide a basis for the withdrawal of the authorization to engage in the practice of medicine or podiatry as a registered resident. Upon receipt of the notice of proposed withdrawal, the registered resident may request a hearing, which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

1. Termination or withdrawal from the graduate medical education program.

2. Failure to advise the Board of a termination or withdrawal from a graduate medical education program.

3. Engaging in any act or practice beyond the scope of those authorized pursuant to (h) above.

(k) Upon a duly verified application of the Attorney General, alleging a violation of any act or regulation administered by the Board, which palpably demonstrates that the resident's continued practice would constitute a clear and imminent danger to the public health, safety and welfare, upon notice, the Board may enter an order temporarily suspending the resident's authority to engage in the practice of medicine or podiatry pending a plenary hearing on the charge.

(l) A permit applicant shall submit to the Board a permit application form certifying that he or she has attained the prerequisites set forth in (c) above, and in addition, shall forward to the appropriate individuals requests for the production of the documentation listed below. The documentation sought by the permit applicant shall be sent directly to the Director by the certifying individual. The permit applicant shall also submit to the Director a check or money order in the sum of $50.00 made payable to the New Jersey State Board of Medical Examiners.

1. Registrar's certification of attendance or college transcript from each college attended;

2. Registrar's certification of attendance or school transcript from each medical or podiatric school attended;

3. With respect to medical residents, ECFMG or Fifth Pathway certification, if applicable;

4. Certification of successful performance during the first year of a graduate medical education program to date.

(m) The Director shall obtain from the permit applicant the application form and the $50.00 fee and shall also receive and retain certified documentation, set forth in (1) above. No later than four months before the date on which the applicant is scheduled to begin participating in the second year of a graduate medical education program (or beyond), the Director shall submit to the Board a complete application packet for each person to whom an offer of employment has been extended. This packet shall include:

1. Permit application, completed by the applicant.

2. Registrar's certification for each college attended or college transcript for each college attended.

3. Registrar's certification for each medical or podiatric school attended, or transcript for each medical or podiatric school attended.

4. With respect to medical residents, ECFMG or Fifth Pathway certification, if applicable.

5. Certification of successful performance during the first year of graduate medical education to date.

6. Permit fee of $50.00 in the form of check or money order made payable to the New Jersey State Board of Medical Examiners.

(n) The Director shall certify that he or she has offered a position to the applicant and has personally reviewed the permit application form and all supporting documentation and is unaware of any information which would contradict any of the representations in that application form or in any of the supporting certifications. If the Director shall have reason to question the veracity or reliability of those representations, he or she shall direct the permit applicant to supply the supporting documentation.

(o) Upon receipt of the permit application packet, the Board shall review each permit packet and if it is satisfied that the permit applicant has the necessary prerequisites, it shall issue to the applicant a permit authorizing that person to engage in either the practice of medicine or the practice of podiatry, as appropriate, in the second year (or beyond) of a graduate medical education program.

(p) A permit applicant unable to certify that he or she has attained the prerequisites set forth at (c) above shall state on the permit application form the reason that he or she is unable to so certify. In addition, if he or she is unable to produce the supporting documentation set forth at (m) above, an explanation must be provided. A permit applicant who has been unable to certify that he or she has attained all the prerequisites, or unable to produce the required supporting documentation, may seek from the Board a waiver which would enable the person to be issued a permit. The Board, in its discretion, may grant or withhold such waiver for good cause shown. However, in no event may the permit applicant begin to participate in the second year (or beyond) of a graduate medical education program until the program waiver request has been granted and the permit issued or a temporary permit issued.

(q) In the event that a permit applicant has been unable to submit the required certification or supporting documentation in a timely manner, the Director may grant the permit applicant a temporary permit, which will allow him or her to participate in the graduate medical education program for no more than 60 days, to allow for the completion of the application process provided that notice of such a grant is provided to the Board within five working days.

(r) A permit holder may engage in the practice of medicine or podiatry provided that such practice shall be confined to a hospital affiliated with the graduate medical education program and outpatient facilities integrated into the curriculum of the program, under the supervision of licensed plenary physicians or licensed podiatric physicians, as appropriate. Prescriptions and orders may be issued by permit holders in the inpatient setting without countersignature. All prescriptions issued by permit holders in the outpatient setting which are to be filled in a pharmacy outside a licensed health care facility shall be signed by a licensed physician or licensed podiatric physician, as appropriate.

(s) The Board may refuse to issue a permit to a permit applicant if he or she has not certified that the prerequisites set forth in (c) above have been satisfied, if the supporting documentation set forth in (1) above has not been produced or if the Board is in possession of any information contradicting the representations made in the permit application form or supporting documentation. The Board shall give the Director and the applicant notice of its refusal, allowing the submission of documentary evidence in rebuttal. Upon a showing of good cause the applicant will be granted an appearance before a committee of the Board.

(t) In addition to any practice declared to be a basis for sanction, pursuant to P.L. 1978, c.73 (N.J.S.A. 45:1-14 et seq.), the practices listed below, upon proof, shall also provide basis for the termination or suspension of a permit. Upon receipt of the notice of proposed termination or suspension the permit holder may request a hearing which shall be conducted pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B- I et seq.

1. Termination or withdrawal from a graduate medical education program.

2. Failure to advise the Board of a termination or withdrawal from a graduate medical education program.

3. Engaging in any act or practice beyond the scope of those authorized pursuant to (r) above.

(u) Upon a duly verified application of the Attorney General alleging a violation of any act or regulation administered by the Board which palpably demonstrates that the resident's continued practice would constitute a clear and imminent danger to the public health, safety and welfare, the Board may enter an order temporarily suspending the

resident's permit to engage in the practice of medicine or podiatry pending a plenary hearing on the charge.

(v) A permit shall be valid for the duration of the graduate medical education program in which the permit holder is participating. If the permit holder seeks to change programs, he or she must submit a transfer application form. All transfer applications must be accompanied by a certification from the Director of the graduate medical education program in which the applicant has been or is currently participating, attesting to successful performance in the program.

(w) Each hospital offering a program(s) in medicine shall designate one physician who would qualify as a Director to fulfill the responsibilities set forth in this rule. Each hospital offering a podiatry program shall designate one podiatric physician who would qualify as a Director of a podiatry program to fulfill the responsibilities set forth in this rule. The Director may delegate to individual program directors these responsibilities, so long as the Director retains ultimate responsibility for the conduct of the program, except that the Director may not delegate the authority to issue temporary authorizations. In addition to the responsibilities placed upon any Director by this rule, he or she shall:

1. Implement procedures to assure that all prescriptions and orders issued by residents are countersigned or signed in accordance with the requirements of this rule.

2. Provide broad oversight of the activities of all program participants.

3. Report to the Board any conduct by a resident which, if proven, would represent cause for the withdrawal of registration or the suspension of a permit.

4. Report to the Board if any resident is granted a leave of absence for any reason, relating to a medical or psychiatric illness or to medical competency or conduct which would represent cause for the withdrawal of the authority to practice, providing an explanation.

(x) The authorization granted to an unlicensed person to participate in the first year of a graduate medical education program shall not be construed to imply that that person will be deemed eligible for the issuance of a permit or a license. The issuance of a permit similarly should not be construed to imply that the permit holder will be deemed eligible for licensure.

(y) This rule shall be effective upon publication as an adopted rule in the New Jersey Register. With respect to the first year during which this rule is in effect, Directors shall be required to submit a master list. Registration application forms and permit application forms will be made available after the publication of the rule. Unlicensed residents intending to

participate in a graduate medical education program on or after July 1, 1988 may, if they so choose, seek registration or a permit, as may be applicable for the year beginning on July 1, 1988. Registration and permits will be required, as applicable, for participants in the second year (or beyond) of a residency training program which begins on or after July 1, 1989.

EXHIBIT B
Statutes and Regulations of the New Jersey State Board of Dentistry

SUBCHAPTER 1. APPLICANTS FOR LICENSE TO PRACTICE DENTISTRY

13:30-1.1 Qualifications of applicants

(a) All persons desiring to practice dentistry in New Jersey must secure a license from the Board.

(b) To qualify as a candidate for dental licensure, an applicant must present satisfactory evidence of successful completion of the following:

1. A dental degree from a dental school, college or department of a university approved by the Board and the Commission on Dental Accreditation;

2. The Northeast Regional Board Examination. The Board will recognize successful completion of the Northeast Regional Board examination for up to five years. After five years, the Board will review each request on a case-by-case basis pursuant to the provisions of N.J.A.C. 13:30-1.3.

3. The New Jersey jurisprudence examination; and

4. All parts of the National Board Dental Examinations.

13:30-1.2 Resident permit

Prior to obtaining licensure, a graduate of an approved dental school who has passed Part I and Part II of the National Board Dental Examination may serve as a resident in an approved hospital upon obtaining a resident permit from the Board. A resident permit shall be renewed annually for the length of the residency program.

13:30-1.3 Recognition of Northeast Regional Board Examination after five years

(a) The Board may, in its discretion, recognize successful completion of the Northeast Regional Board Examination after five years as set forth in N.J.A.C. 13:30-1.1(b) 2 provided that the candidate submits, at a minimum, evidence satisfactory to the Board that the candidate holds a license in good standing in every state where currently licensed.

(b) As part of its review, the Board shall consider and evaluate any prior record of disciplinary action or pending disciplinary action or investigation in any other state and applicant's complete professional employment history.

EXHIBIT C

February 5, 2001

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL

MODEL STATEMENT
ON ACADEMIC EVALUATION OF HOUSESTAFF
AND PROCEDURES FOR ACADEMIC DISMISSALS OF HOUSESTAFF

This document sets forth a model to be used in developing the procedures for evaluation of the academic performance of housestaff at the RUTGERS Robert Wood Johnson Medical School as well as procedures for adverse actions, including dismissal, based on such academic evaluations. (Note that throughout this document the term housestaff is used to refer inclusively to interns, residents and clinical fellows. Similarly, the term postgraduate medical/dental program is used inclusively to refer to internship, residency and clinical fellowship programs.) These procedures are not intended to be applicable to non-academic matters; procedures for dealing with non-academic discipline are specified in the University's contract with the Committee of Interns and Residents (CIR). However, all matters that are academic in nature shall be addressed via this process even if such matters have both academic and non-academic implications.

I. Definition of Academic Matters for Purposes of these Procedures

Academic matters include acquisition of knowledge related to the discipline as well as all aspects of the development of clinical and professional skills necessary for effective functioning as a health-care professional. Of particular importance as academic issues are such areas of professional development as professional ethics and maintaining professional relationships with patients, staff members, students and other health-care professionals, including subordinates, colleagues and superiors. When particular issues are of concern as both academic and employment-related, they should ordinarily be treated as academic issues. Since the academic development of housestaff is the paramount reason for the existence of postgraduate medical and dental programs at RUTGERS Robert Wood Johnson Medical School it is incumbent upon postgraduate program administrators and faculty to give the highest priority to and to place the strongest emphasis upon academic difficulties that housestaff may be experiencing.

II. Academic Evaluation of Housestaff

Each house officer shall be continuously evaluated for his/her academic performance as follows:

A. Evaluations of knowledge and of clinical and professional development shall be prepared periodically by all attending staff members who interact to a significant extent with the housestaff. Evaluation forms for this purpose will be developed by the Schools, departments or programs. Standard forms developed by the appropriate specialty board or college may be utilized for this purpose. The

evaluation interval shall be established by the program and shall, at a minimum, meet accreditation standards.

B. Evaluations are to be completed at the conclusion of each rotation by the house officer's supervising attending, utilizing the School/department/ program evaluation forms.

C. Other measures of performance to be considered in assessing academic growth include but are not limited to the following

1. Standardized examinations
2. Required certifications
3. In-service examinations
4. Quality of research, presentations, publications, etc.
5. Success in achieving assigned goals, including remediation goals.

D. Communications shall be documented between program director and faculty or other persons in a supervisory role. In order for such communications to be used meaningfully in evaluation, oral communications must be documented, with a copy placed in the house officer's file and another copy provided to the individual. However, documentation of such communication may occur for the first time when an evaluation form is completed.

E. Periodic review of each house officer's progress in the program shall be conducted by the program director in which all of the above performance measures are discussed.

III. Remediation of Academic Deficiencies

In the event that academic deficiencies are identified:

A. The program director or designee shall counsel the house officer. If counseling is conducted by a designee, the program director shall be informed in writing.

B. When a house officer is asked to attend a personal interview for the purpose of investigating his/her performance or conduct and such interview may reasonably be expected to lead to actions that could be characterized as disciplinary in nature (such as a formal letter of reprimand, a suspension or a dismissal), written or oral notice of the interview shall be given to the Associate or Assistant Dean responsible for graduate medical/dental education and to the Committee of Interns and Residents (CIR). A CIR representative may accompany the house officer to hear the matter being discussed, but may not interfere with the interview or speak. Upon determining in good faith that the matter is academic in nature, the CIR representative should leave.

C. The program director shall outline corrective measures and shall establish criteria and time frames for the correction of the deficiencies.

D. The program director shall document the above interactions with the house officer in writing, with a copy placed in his or her file.

E. The program director shall re-evaluate compliance with corrective actions as established earlier.

F. If performance is restored to a satisfactory level, the program director will indicate this orally to the house officer as soon as it has occurred. A written notation of this interaction will also be placed in the individual's file, with a copy to the individual.

G. If the house officer fails to correct the identified academic deficiencies to the satisfaction of the program director within the specified time frame, the program director may either extend the remediation period, using the same procedures as for an initial remediation effort, or proceed with termination in accordance with Section IV.

H. For severe deficiencies warranting immediate termination, the program director may proceed in accordance with the steps outlined in Section IV, below.

I. Copies of all documentation regarding academic deficiencies of housestaff should be provided to the Associate or Assistant Dean responsible for graduate medical/dental education.

IV. Termination

A. In the event of severe academic deficiencies or failure to remediate lesser deficiencies, the program director may make the determination that the house officer should be terminated from the program. The program director should consult with a representative group from among the faculty who interacts to a significant extent with the individual.

B. Once the program director has made the decision to terminate a house officer from the program, the director shall notify the individual in writing of the termination. Copies of this notice shall be provided to the associate or assistant dean responsible for graduate medical/dental education and to the CIR. Termination shall ordinarily become effective not less than two weeks after receipt of the written notice. The notification period may be waived at the discretion of the program director if, in the judgment of the program director, continuance of the individual in the program during the notice period would result in a risk of danger to patients or in a risk of other harm or damage either to the program itself or to other University personnel. The notification shall include the following:

1. Reasons for dismissal
2. Effective date of dismissal
3. Process for appealing the dismissal

V. Appeal Process

A. The house officer may appeal the program director's dismissal decision to an Ad Hoc Appeal Committee established as indicated in Section V.B. This appeal must be made in writing to the program director within five (5) working days of having received the notification of termination.

B. If the house officer submits a timely notice of appeal, the director shall convene an Ad Hoc Committee of faculty members of the division, department or group of departments responsible for the program. The faculty members selected for this purpose shall be experienced faculty in the area of graduate medical/dental education. The number of members of the Ad Hoc Committee shall be large enough to be representative of the faculty of the division, department or group of departments responsible for the program but in any case shall not be larger than five (5) faculty members.

C. The house officer may request to meet with the Ad Hoc Committee in person and be accompanied at the hearing by a faculty member or fellow housestaff who may act as an advisor. A CIR representative may be present at the hearing (but may not participate in the proceedings) only if the matter under discussion is disciplinary or has a disciplinary component, but not if the matter is strictly one of academic performance. The program director will also be present at the hearing at which time he or she shall set forth the reasons for which the house officer has been dismissed. Following the presentation, the house officer and/or his or her advisor shall be permitted to set forth whatever information the individual wishes the Committee to consider as reasons to vacate the decision to dismiss him or her.

D. Following the hearing before the Ad Hoc Committee, the Committee will immediately confer and, after deliberations, advise the Department Chair in writing of its recommendation and the reasons for that recommendation. The Department Chair shall render a decision, and the decision of the Chair shall be final. This decision shall be conveyed to the house officer in writing. The Chair shall provide copies of the decision to the Dean of the School and to the Associate or Assistant Dean responsible for graduate medical/dental education.

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: XI.12
SECTION: INSTITUTIONAL POLICIES RELEVANT TO GME
SUBJECT: AFFIRMATIVE ACTION COMMITMENT

Reaffirmation of Policy

The RUTGERS Robert Wood Johnson Medical School (hereafter referred to as the University) reaffirms its commitment to the full realization of Affirmative Action and Equal Employment Opportunity in its employment practices.

It is the policy of the University to:

1. Recruit, hire, train, promote, retain, tenure, and compensate persons in all applicable administrative, classified, faculty, unclassified, and student job titles without regard to age, ethnicity, disability, marital status, national origin, race, religion, sex, sexual orientation, or veteran status unless otherwise prohibited by applicable law.

2. Base decisions of employment so as to further the principles of affirmative action and equal employment opportunity.

3. Ensure that promotion, reappointment and tenure decisions are in accordance with the principles of affirmative action and equal employment opportunity by imposing only valid requirements for promotional, reappointment and tenure opportunities.

4. Ensure that all personnel actions including compensation, benefits, lay-offs, returns from lay-offs, training, education/tuition assistance, social and recreational programs will be administered without regard to age, ethnicity, disability, marital status, national origin, race, religion, sex, sexual orientation, or veteran status unless otherwise prohibited by applicable law.

Policy on Sexual and Other Types of Harassment

The University is committed to creating and maintaining a working environment where all University employees can fulfill their responsibilities and perform work to their fullest potential. All employees shall have the right to work in an environment free from objectionable and disrespectful conduct, discriminatory harassment, intimidation, ridicule and insult whether based on sex, race, religion or national origin, or any other impermissible factor.

The University will not tolerate any form of harassment, including sexual harassment, and will take affirmative action eliminate it from the workplace. Sexual Harassment is defined as unwelcome sexual advances, requests for sexual favors and other conduct of a sexual nature

that interferes with an individual's work performance or creates an intimidating, hostile or offensive working or learning environment.

RUTGERS Robert Wood Johnson Medical School employees are strongly discouraged from engaging in consensual relationships, particularly those occurring between supervisors and staff members or faculty members and students, which can lead to circumstances that can be interpreted as sexual harassment or be interpreted as causing a hostile or offensive work environment or other staff members or students. Any employee, who is found to have engaged in harassment of another employee, patient or student, after appropriate investigation, will be subject to appropriate disciplinary action up to and including termination.

Sex Discrimination Policy

It is the policy of the University to ensure that all recruitment and employment activities are administered without gender or marital status considerations, except where sex is a bona fide occupational qualification for the job. Equal employment opportunities will be assured regardless of sex or marital status in all personnel policies, union contracts, training, terms and conditions of employment and mandatory retirement options. Women will not be penalized for utilizing established leave policy for the purpose of childbearing and will be reinstated to their original job or a position in a like or comparable status and pay. The University is required to take affirmative action to recruit women for jobs where they are underrepresented.

Policy Against Discrimination Because of Religion or National Origin

It is the responsibility of the University to ensure that all terms and conditions of employment are administered without regard to religion or national origin. The University has an obligation to foster internal communication and understanding of protected religious, national origin and ethnic groups. The University will accommodate the religious observance practices of qualified applicants or employees unless precluded by business necessity, financial cost or result in personnel problems.

Disabled Workers Affirmative Action Policy

The University invites employees to provide information on their disability status and employs, advances and retains qualified disabled individuals and ensures that all terms and conditions of employment are made without regard to disability status. Employment procedures and physical/mental job requirements will be reviewed annually, and reasonable accommodations for physical and mental disabilities are to be made where they are not precluded by prohibitive financial cost or create undue hardship on operations.

Disabled Veterans and Veterans of the Vietnam-Era Affirmative Action Policy

The University will allow voluntary self-identification by employees who are disabled or Vietnam-Era veterans. Affirmative steps will be taken to recruit, employ, upgrade, train, retrain and promote qualified protected veterans. Employment practices, procedures, and physical/mental job requirements will be evaluated annually.

Position vacancies will be listed with the State Employment Service.

All personnel concerned with employment and supervision are required to do their part. Each manager and supervisor (i.e. those directly involved with the making of hiring and other

employment decisions) are responsible for carrying out the overall University's Affirmative Action Plan. However, the day-to-day responsibility for establishing reporting procedures, monitoring, and the annual revision and update of the Plan to ensure compliance with continued implementation of the University's affirmative action policy, is vested in the Associate Vice President for Affirmative Action/Equal Employment Opportunity.

Inquiries concerning this policy should be directed to the:

Associate Vice President for Affirmative Action/EEO
RUTGERS
University Heights
Stanley S. Bergen Building
65 Bergen Street - Room #1214
Newark, New Jersey 07107-3000
(973) 972-4855

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI. 13
SECTION: INSTITUTIONAL POLICIES RELATED TO GME
SUBJECT: POLICY ON LIMITED ENGLISH PROFICIENCY AND HEARING/SPEECH IMPAIRED COMMUNICATIONS

I. PURPOSE

To establish policy and procedures to ensure effective and efficient communication with limited English proficient (LEP) and hearing/speech impaired (HSI) persons to ensure their equal access to health, medical, behavioral health and social service programs, benefits and services.

II. ACCOUNTABILITY

Under the direction of the Senior Vice President for Administration, the Associate Vice President for Affirmative Action and Equal Employment Opportunity (AA/EEO) shall ensure compliance with this policy in concert with the Deans and President/CEOs of the Healthcare Units who shall implement this policy.

III. APPLICABILITY

All University patient care service providers and staff, including but not limited to, physicians, dentists, nurses, technicians, and behavioral health counselors.

IV. DEFINITIONS

A. HSI – Hearing/Speech Impaired - An individual who has had a loss of hearing, e.g. is deaf or hard of hearing and/or who is unable to speak or speak clearly enough to be understood.

B. LEP - Limited English Proficiency - An individual of a national origin minority group with limited English proficiency. Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or "LEP," and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

C. TDD - Telecommunication Device for the Deaf – A device which allows conversation to take place over the telephone by sending typed messages through phone lines to the TDD screen.

D. TTY - Teletypewriter - a precursor to the TDD.

V. POLICY

No person shall be denied equal access to services based on his/her ability to communicate in the English language or due to hearing**/**speech impairment. It is the obligation of the University and all of its component schools**/**units to ensure that effective and efficient communication assistance and language services shall be provided to limited English proficient and hearing**/**speech impaired persons so that they have a complete understanding of information regarding medical condition**,** treatment and payment requirements.

A. Patients/clients shall not be required to utilize family members, especially children, friends, or others awaiting services in the waiting areas as interpreters for the following reasons:

1. Family or friends' emotional involvement with the patient/client can jeopardize interpretation of critical medical information.

2. Such persons may not be versed in the medical terminology required for communication between patient/client and health professionals.

3. Such use may compromise confidentiality.

B. At the request of the patient/client, his/her own interpreter may be used after being advised that a free service is available and the use of this service would not compromise effectiveness of services or violate confidentiality. This request shall be noted in the patient/client's medical record.

Any available interpreter may be used in the case of an emergency; however, the use of a trained medical interpreter is preferred when and if available.

C. Every patient care service delivery facility shall develop an internal procedure pursuant to this policy and communicate this policy and facility-specific procedures to all staff members who are in direct contact with patients/clients, including nurses, physicians, medical health technicians, receptionists, billing clerks, etc.

1. Each such unit shall translate intake forms and patient assessments into patient languages. Such translations shall be deemed necessary when more than 10% of the identified LEP population is serviced.

2. When possible, service delivery facilities may offer and encourage training for qualified bilingual employees desirous of volunteering their services as medical interpreters.

D. The service delivery facility shall also develop a notification and outreach plan for LEP and HIS individuals. The following may be included in this plan:

1. Posting signs in intake areas and other entry points in appropriate languages so that LEP persons may access language services. Signs in intake offices may state that free language assistance is available. The

signs should be translated into the most common languages encountered and should explain how to access language assistance.

2. Outreach documents may include statements that language services are available at the facility. Announcements of such services may appear in brochures, booklets, and recruitment information.

3. Collaborating with community-based organizations and other stakeholders to inform LEP individuals of the facility's services, including the availability of language assistance.
4. Using a telephone voice mail menu in frequently-encountered languages.

5. Notices in local newspapers in languages other than English.

6. Providing notices of the language assistance services available to non-English language radio and television stations and how to access same.

7. Presentations and/or notices at schools and religious organizations.

E. The mechanisms that will be utilized to provide communication assistance include qualified staff interpreters, trained medical interpreters, appropriate telephone interpreter services, video-assisted technology, sign language interpreters, other qualified community/contract interpreter services, bilingual flash cards, translated forms, computer-based technology programs and patient educational materials. The service-providing unit shall pay all costs involved.

VI. PROCEDURES

A. Upon reception or registration, staff should determine whether a patient/client is limited English proficient (LEP) or hearing/speech impaired (HSI) and as such may require special communication assistance. The following are methods to identify LEP individuals:

1. Language identification cards, such as, I speak Spanish in English and Spanish available at http://www. Usdoj.gov/crt/cor/pubs/ISpeakCards2004.pdf;

2. review records of previously registered patients to identify language spoken by such patients; and

3. posting notices in commonly-encountered languages which informs LEP persons of the availability of language assistance and encourages them to self-identify.

B. If it is determined that communication assistance is necessary, the staff member shall inquire in what language the patient/client best communicates, or prefers. For patients/clients utilizing sign language, it is important to ascertain the type of sign language with which the patients/clients are familiar. This information shall be noted in his/her record. Patients/clients shall be made aware at each service entry point that they may request any of the communication services listed in

Sections V.D. and VI.C.3.

C. If the patient/client requests communication services:

1. The staff member shall check the volunteer interpreter's roster to identify an appropriate interpreter, preferably a trained medical interpreter. If no volunteer interpreter for the necessary language is available, another appropriate communication mechanism, described in V.D. shall be used.

2. This information shall be noted in the patient/client record.

3. For hearing/speech impaired patient/clients, either a text telephone (TTY or TDD) relay can be used at 1-800-852-7899 or 1-800-852-7897 or sign language interpreters can be obtained. This will require advance notice unless there is a staff member available who can interpret. Referral services can be obtained through the NJ Division of Deaf and Hard of Hearing (DDHH) at (609) 984-7283 to schedule an interpreter to be present for a patient/client's examination and/or treatment.

By Direction of the President:

_____
Senior Vice President for Administration

University Coding: 00-01-35-42:00

Adopted: 08/18/00

Amended: 09/19/06

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XI.14
SECTION: INSTITUTIONAL/MED SCHOOL POLICIES RELEVANT TO GME
SUBJECT: INDIVIDUALS WITH HANDICAPS/DISABILITIES

I. PURPOSE

To establish a policy which ensures employment and educational opportunities and the provision of services are extended to individuals with handicaps and disabilities in accordance with the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.

II. ACCOUNTABILITY

Under the direction of the President, the Associate Vice President for Affirmative Action and Equal Employment Opportunity (AA/EEO) shall ensure compliance with this policy. The Associate Vice President for Affirmative Action and Equal Employment Opportunity in concert with the Deans and Vice Presidents shall implement this policy.

III. DEFINITIONS

A. Handicapped or disabled person:

1. having a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

2. having a record of such an impairment; or

3. being regarded as having such an impairment.

IV. POLICY

A. Requirements:

1. Educational and employment opportunities and the provisions of any and all public services are administered without discrimination against individuals with handicaps and disabilities in compliance with the Rehabilitation Act of 1973 as amended thereof, and the Americans with Disabilities Act (ADA) of 1990.

2. Qualified individuals with handicaps and disabilities shall be treated without discrimination because of the handicap or disability in all aspects

of employment such as: hiring, advancement, demotion or transfer, recruitment, advertising, layoff or termination, rates of pay or other forms of compensation, benefits, and selection for training including apprenticeship.

3. Affirmative action steps shall be taken to employ and advance in employment individuals with handicaps and disabilities.

4. Reasonable accommodations to the known physical or mental limitations of otherwise qualified employees or job applicants with disabilities shall be made, except where such accommodations are determined to be precluded by business necessity and/or imposes an undue hardship.

5. All facilities will be reviewed to ensure they are accessible in accordance with the ADA requirements. Any barriers to accessibility shall be eliminated through readily achievable methods as defined by the ADA Act. All newly constructed facilities will be made accessible in accordance with the requirements specified in the ADA Act.

6. Employment

    a. Physical and mental job qualification requirements shall be related to the specific job or jobs and shall be consistent with business necessity and the safe performance of the job.

    b. No qualified individual with a disability will be denied employment because of the disability.

    c. Job qualification requirements will be reviewed periodically to ensure they do not tend to screen out individuals with handicaps or disabilities and any physical and mental job qualifications are job related and consistent with the safe performance of the job.

    d. Compensation to handicapped or disabled individuals will not be reduced because of disability income, pension or any other benefit due to a physical or mental disability.

7. Examinations and courses will be offered in ways and places that are accessible to persons with disabilities or alternative arrangements will be offered.

8. Periodically, all individuals shall be invited to take advantage of the RUTGERS Robert Wood Johnson Medical School AA/EEO program for individuals with handicaps and disabilities. Such information shall be confidential except that:

    a. Supervisors and managers may be informed regarding any accommodations and restrictions on the work or duties of handicapped individuals.

b. First aid and safety personnel may be informed, where appropriate, if the condition may require emergency treatment.

c. Governmental officials investigating compliance with the ADA and Rehabilitation Acts will be provided information upon request.

9. Reasonable Accommodations

a. Employees, applicants and students, etc. desiring reasonable accommodations under the handicap plan shall make a request to the supervisor, Human Resources Department or Student Affairs Office, or AA/EEO Office, whichever is appropriate. All such requests will be discussed with the AA/EEO Office.

b. All reasonable accommodation efforts shall be documented with the AA/EEO Office. An explanation of the reasons for any reasonable accommodation requests precluded by business necessity or undue hardship shall be provided by the responsible individual to the AA/EEO Office.

10. Determination of Handicapped or Disabled Status

a. The AA/EEO Office after consultation with the Office of Legal Management shall determine handicapped or disabled status. The AA/EEO Office shall consult with appropriate agencies and review relevant material in making this determination and ensure the determination meets the requirements of Section 503 of the Rehabilitation Act and the definition of disability as defined by the Americans with Disabilities Act of 1990.

b. The applicant or employee may be required to provide medical documentation of the impairment and their ability to perform work or, in the alternative, the University may require the applicant or employee to undergo a medical examination at University expense. These arrangements will be made by the department in consultation with the AA/EEO Office.

c. Any determination of handicap or disability must meet the requirement of Section 60-741.5(c) of the Rehabilitation Act and the requirements as indicated in the Americans with Disabilities Act of 1990 and must be for the purpose of affirmative action and proper job placement. Information obtained shall not be used to exclude or otherwise limit the employment opportunities of qualified handicapped or disabled individuals.

B. Responsibilities:

1. The AA/EEO Office is responsible for:

a. providing an annual program for individuals with handicaps and disabilities;

b. notifying in confidentiality, the managers and supervisors of handicapped/disabled individuals, in order to coordinate the annual program; and

c. determining handicapped or disabled status after consultation with the Office of Legal Management.

2. Individuals with handicaps and disabilities are responsible for:

a. requesting reasonable accommodations.;

b. providing medical documentation of their impairment and their ability to perform work, if necessary; and

c. taking a medical examination, at the University's expense, if necessary.

3. Supervisors of handicapped and disabled individuals are responsible for:

a. making and documenting reasonable accommodations and notifying the AA/EEO Office of these arrangements;

b. documenting and communicating to the AA/EEO Office any reasons why accommodations could not be made;

c. coordinating medical examinations, if necessary; and

d. retaining records of reasonable accommodations requested, made and refused.

4. The Office of Legal Management is responsible for assisting the AA/EEO Office in determining handicapped or disabled status.

_____

President

University Policy Code: 00-01-35-40:00
Adopted: 02/24/81
Amended: 11/01/97

Approved by the GMEC 10/09/07

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: XI. 15
SECTION: INSTITUTIONAL/ MEDICAL SCHOOL POLICIES RELEVANT TO GME
SUBJECT: PLANS TO ADDRESS A DISASTER THAT SIGNIFICANTLY ALTERS RESIDENCY EXPERIENCE AT ONE OR MORE RESIDENCY PROGRAMS, AS MANDATED BY THE ACGME

I. PURPOSE

a. To comply with ACGME mandate that the institution have a plan to address a disaster that significantly alters the residency experience at one or more residency programs.

II. SCOPE

a. All GME programs sponsored by the institution

III. DEFINITIONS

A. A disaster is an event or set of events causing significant alteration to the residency experience at one or more residency programs. Hurricane Katrina is an example of a disaster.

B. The ACGME, when warranted, will make a declaration of a disaster. This decision will be made by the ACGME Chief Executive Officer, with consultation of the ACGME Executive Committee and the Chair of the Institutional Review Committee, and will be posted on the ACGME website.

IV. STATEMENT OF PRINCIPLES

RWJMS will comply with the "ACGME Plan to address a disaster that significantly alters the residency experience at one or more residency programs" as noted in the ACGME Policies and Procedures, Section II H, effective February 9, 2009 (below)

II. ACCREDITATION POLICIES AND PROCEDURES
H. ACGME Plan to Address a Disaster that Significantly Alters the Residency Experience at One or More Residency Programs

1. Overview
ACGME is committed to assisting in reconstituting and restructuring residents' educational experiences as quickly as possible after a disaster.
2. Definition of Disaster
An event or set of events causing significant alteration to the residency experience at one or more residency programs. Hurricane Katrina is an example of a disaster.
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3. ACGME Declaration of a Disaster when warranted, the ACGME Chief Executive Officer, with consultation of the ACGME Executive Committee and the Chair of the Institutional Review Committee, will make a declaration of a disaster. A notice of such will be posted on the ACGME website with information relating to ACGME response to the disaster.

4. Resident Transfers and Program Reconfiguration Insofar as a program/institution cannot provide at least an adequate educational experience for each of its residents/fellows because of a disaster, it must:
a) arrange temporary transfers to other programs/institutions until such time as the residency/fellowship program can provide an adequate educational experience for each of its residents/fellows, or
b) assist the residents in permanent transfers to other programs/ institutions i.e., enrolling in other ACGME accredited programs in which they can continue their education.

If more than one program/institution is available for temporary or permanent transfer of a particular resident, the preferences of each resident must be considered by the transferring program/institution.

Programs must make the keep/transfer decision expeditiously so as to maximize the likelihood that each resident/fellow will complete the year in a timely fashion. Within 10 days after the declaration of a disaster (see above), the designated institutional official of each sponsoring institution with one or more disaster-affected programs (or another institutionally designated person if the institution determines that the designated institutional official is unavailable) will contact the ACGME to discuss due dates that the ACGME will establish for the programs:
(1) to submit program reconfigurations to ACGME, and
(2) to inform each program's residents of resident transfer decisions. The due dates for submission shall be no later than 30 days after the disaster unless other due dates are approved by ACGME.

If within the 10 days, the ACGME has not received communication from the designated institutional official(s), ACGME will attempt to establish contact with the designated institutional official(s) to determine the severity of the disaster, its impact on residency training, and next steps.

5. ACGME Website
On its website, ACGME will provide, and periodically update, information relating to the disaster.

6. Communication with ACGME from Disaster Affected Institutions/Programs

On its website, the ACGME will provide phone numbers and email addresses for emergency and other communication with the ACGME from disaster affected institutions and programs. In general, *Designated Institutional Officials* should call or email the Institutional Review Committee Executive Director with information and/or requests for information.

Program Directors should call email the appropriate Review Committee Executive Director with information and/or requests for information.

Residents should call or email the appropriate Review Committee Executive Director with information and/or requests for information. On its website, the ACGME will provide instructions for changing resident email information on the ACGME Web Accreditation Data System.

7. Institutions Offering to Accept Transfers
Institutions offering to accept temporary or permanent transfers from programs affected by a disaster must complete a form found on the ACGME website. Upon request, the ACGME will give information from the form to affected programs and residents.

Subject to authorization by an offering institution, the ACGME will post information from the form on its website. The ACGME will expedite the processing of requests for increases in resident complement from non-disaster affected programs to accommodate resident transfers from disaster affected programs.

The Residency Review Committees will expeditiously review applications, and make and communicate decisions.

8. Changes in Participating Sites and Resident Complement
The ACGME will establish a fast track process for reviewing (and approving or not approving) submissions by programs relating to program changes to address disaster effects, including, without limitation:
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a) the addition or deletion of a participating site;
b) change in the format of the educational program; and,
c) change in the approved resident complement.

9. Temporary Resident Transfer
At the outset of a temporary resident/fellow transfer, a program must inform each transferred resident of the minimum duration and the estimated actual duration of his/her temporary transfer, and continue to keep each resident informed of such durations. If and when a program decides that a temporary transfer will continue to and/or through the end of a residency fellowship year, it must so inform each such transferred resident/fellow.

10. Site Visits
Once information concerning a disaster-affected program's condition is received, ACGME may determine that one or more site visits is required. Prior to the visits, the designated institutional official(s) will receive notification of the information that will be required. This information, as well as information received by ACGME during these site visits, may be used for accreditation purposes. Site visits that were scheduled prior to a disaster may be postponed.

Approved by the GMEC on June 9th, 2009

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY #: XI.16
SECTION: INSTITUTIONAL/MEDICAL SCHOOL POLICIES RELEVANT TO GME
SUBJECT: PLANS TO ADDRESS DISASTER AND LOCAL EXTREME EMERGENT SITUATIONS

I. Purpose

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL and affiliated institutions have adopted emergency plans to guide the institutional response to specific disasters. This policy is intended to augment these plans and specifically addresses the clinical duties, education, and the working environment of House Officers during disasters or local extreme emergent situations. It provides guidance to program leadership, in the event that a disaster or local extreme emergent situations occur, to assure House Officer safety, continued administrative support for GME programs and residents, as well as other issues that may result from significant alternations to the residency experience in one or more training programs.

II. Scope:

This policy is intended to augment existing disaster plans that are applicable to the institutions affected, focusing specifically on House Officers in graduate medical education programs sponsored by RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL.

III. Definitions:

A disaster is an event or set of events (e.g., natural disaster, human generated, etc.) which impacts an entire community or region for an extended period of time causing significant alternation to the training experience at more than one institution involved in the education of RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL House Officers.

A local extreme emergent situation is an event, such as an epidemic, that impacts the clinical duties, education, and working environment of one sponsoring institution, participating institution, or other similar setting, and causes the institution to implement its disaster plan.

POLICY:

1) Within RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL a formal disaster declaration or local extreme emergent situation will be made only in accordance with existing RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL Disaster Plans.

2) If the disaster or local extreme emergent situation occurs in an affiliate site of training, the GME Office will work with that training site to determine whether a formal disaster declaration has been made based on the policies of that institution.

3) When warranted, and after consultation with the Graduate Medical Education Committee (GMEC) if possible, the Designated Institutional Official (DIO) may ask the ACGME to make a formal declaration of a disaster or local extreme emergent situation for particular programs or the entire institution according to ACGME policies and procedures. This information will be posted on the ACGME website. This formal declaration under ACGME policy creates significant flexibility for trainees to transfer to other institutions if that becomes necessary.

4) RUTGERS Robert Wood Johnson Medical School and affiliated institutions are guided by the following principles relative to GME:
   a) RUTGERS Robert Wood Johnson Medical School is committed to ensuring a safe, organized and effective environment for training of its House Officers;
   b) RUTGERS Robert Wood Johnson Medical School is committed to maintaining full administrative support for GME programs and residents during a disaster or local extreme emergent situation.
   c) RUTGERS Robert Wood Johnson Medical School recognizes the importance of physicians at all levels of training in the provision of emergency care in the case of a disaster of any kind;
   d) House Officers must be expected to perform according to society's expectations of physicians as professionals and leaders in health care delivery, taking into account their degree of competence, their specialty training, and the context of the specific situation.
   e) House Officer Involvement in a disaster or local extreme emergent situation should not exceed expectations for their scope of competence as judged by program directors and other supervisors. House Officers should not be expected to perform beyond the limits of self-confidence in their own abilities.
   f) Expectations for performance under extreme circumstances must be qualified by the scope of licensure, as determined by the New Jersey Board of Medical Examiners and the House Officer's level of post-graduate education specifically regarding specialty preparedness.
   g) Decisions regarding initial and continuing deployment of House Officers in the provision of medical care during an emergency will be made taking into consideration the importance of providing emergency medical care; the continuing educational needs of House Officers; board certification eligibility during or after a prolonged disaster or local extreme emergent situation and the health and safety of the House Officers and their families.
5) Upon the occurrence of the emergency situation and immediately following up to 72 hours:

a) House Officers will be deployed as directed by the leader of the disaster command center at the hospital to which they are assigned. Ongoing decision-making regarding utilization of House Officers to provide needed clinical care will be based on both the clinical needs of the institution and the safety of House Officers.
b) Those involved in making decisions in this period are:
    i) Leader of the disaster command center
    ii) Department Directors, program directors
    iii) Senior Associate Dean for Education
    iv) Dean
    v) Associate Dean for Graduate Medical Education & DIO

6) By the end of the first week following the occurrence of the emergency situation, if the emergency is ongoing:

a) An assessment will be made of:
    i) The continued need for provision of clinical care by House Officers; and
    ii) The likelihood that training can continue on site
b) The assessment will be made by:
    i) DIO /Associate Dean for GME
    ii) Program Directors and Department Chairs
    iii) Senior Associate Dean for Education
    iv) Dean
    v) Leaders of disaster command center
    vi) Chair, Graduate Medical Education Committee

7) By the end of the second week following the occurrence of the emergency situation, if the emergency is ongoing:
a) The Associate Dean for GME will request an assessment by individual program directors and department chairs regarding their ability to continue to provide training; this may be facilitated by the RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL- GMEC
b) The Associate Dean for GME, with assistance from the GMEC, will request suggestions for alternative training sites from program directors who feel they will be unable to continue to offer training at the involved sites.
c) The Associate Dean for GME will contact the RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL-Vice President Academic Affairs to alert other RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL sponsoring institutions of the disaster or local extreme emergent situation.
d) The Associate Dean for GME will contact the Executive Director, ACGME Institutional Review Committee (ED-IRC) to provide a status report if an extreme emergent

situation causes serious, extended disruption to resident assignments, educational infrastructure or clinical operations that might affect the Sponsoring Institution's or any of its programs' ability to conduct resident education in substantial compliance with ACGME Institutional, Common, and specialty-specific Program Requirements.

e) The Associate Dean for GME will receive electronic confirmation of this communication with the ED-IRC, which will include copies to all Executive Directors of RRC's.

f) upon receipt of this confirmation by the Associate Dean for GME, program directors may contact their respective RRC Executive Directors, if necessary, to discuss any specialty-specific concerns regarding interruptions to resident education or effect on educational environment.

g) Those involved in decision making in this period are:

i) Associate Dean for GME/ DIO
ii) Individual Program Directors
iii) Individual Department Chairs
iv) Senior Associate Dean for Education
v) Chair, GMEC

8. During the third and fourth weeks and beyond following the occurrence of the emergency situation, if the emergency is ongoing:

a) The Associate Dean for GME will work with RUTGERS Robert Wood Johnson Medical School to ensure that the Associate Deans for GME at other schools are informed, and when applicable, work for a common solution for RUTGERS residency training programs system-wide.

b) The RUTGERS Robert Wood Johnson Medical School GMEC's andProgram Directors will contact their counterparts at alternative training sites to determine feasibility of temporary transfers until the institution can provide an adequate educational experience for the House Officer; such transfers will also be coordinated with the ACGME;

c) To the extent possible, the program will inform the House Officer being transferred the minimum duration of the transfer and the anticipated total duration of the transfer.

d) RUTGERS Robert Wood Johnson Medical School Program Directors will have the lead responsibility for contacting other program directors and notifying the Associate Dean for GME and the GMEC of the transfers; and

e) The Associate Dean for GME will be responsible for coordinating the transfers with the ACGME.

f) Continuation of financial support in the event of a disaster will be dependent on the short-term and long-term impact on each program and the institution overall. Also, it will be dependent on current policies related to reimbursement.

i. For House Officers temporarily relocated to an affiliated training site, RUTGERS Robert Wood Johnson Medical School will work with the site to sustain resident salary and benefits.

ii. For residents temporarily assigned to a program at another institution:

(1) RUTGERS Robert Wood Johnson Medical School will work with the University, CMS and the receiving institution to provide resident salary (according to the RUTGERS Robert Wood Johnson Medical School stipend schedule) through the end of the current academic year.

(2) As soon as possible prior to the end of the PGY contract, the program will inform the House Officer of his/her status within the program for the next academic year.

iii. For residents permanently transferring to another institution, RUTGERS Robert Wood Johnson Medical School will typically not cover salary and benefits.

iv. If the RUTGERS Robert Wood Johnson Medical School training program closes permanently, some transitional funding may be provided by RUTGERS Robert Wood Johnson Medical School to the accepting institution.

v. If the program is not permanently closed but a resident decides to permanently transfer to another institution, the costs of salary and benefits will be covered by the accepting institution as of the date of transfer.

9) \When the emergency situation is ended:

a)Plans will be made with the participating institutions to which House Officers have been transferred for them to resume training at RUTGERS Robert Wood Johnson Medical School

b)Appropriate credit for training will be coordinated with ACGME and the applicable Residency Review Committees; and

c)Decisions as to other matters related to the impact of the emergency on training will be made through the RUTGERS Robert Wood Johnson Medical School - GMEC.

d)The Associate Dean for GME will notify the ED-IRC when the institutional disaster or local extreme emergent situation is resolved.

Approved by the GMEC on 10/12/10

SECTION TWELVE

RUTGERS ROBERT WOOD JOHNSON MEDICAL SCHOOL
NEW BRUNSWICK, NEW JERSEY

GRADUATE MEDICAL EDUCATION MANUAL

POLICY#: XII.1
SECTION: RESTRICTIVE COVENANTS
SUBJECT: RESTRICTIVE COVENANTS

I. PURPOSE

To provide housestaff with a policy on Restrictive Covenants.

II. SCOPE

This policy will apply to all of the postgraduate training programs at the RUTGERS Robert Wood Johnson Medical School.

III. DEFINITIONS

Housestaff - refers to all interns, residents and subspecialty residents (fellows) enrolled in a RUTGERS Robert Wood Johnson Medical School postgraduate training program. An individual member of the housestaff may be referred to as a house officer.

IV. RESPONSIBILITIES/REQUIREMENTS

The Medical School specifically prohibits the creation and enforcement of any Restrictive Covenant as a condition of housestaff participation in Graduate Medical Education Programs.

Approved by the GMEC on October 10, 2000.