Written by Dr Ahmad Al-Hashemi, Revised with additions by Dr Hawra Al-Matrouk & Dr Nadia Al-Rasheedi
Date: 30 December 2025

KBIM ONCALL POLICY

A. GENERAL RULES AND SITE OF ONCALL COVERAGE

1.0 Residents in the KBIM program have oncall duties during all rotations of the program, including rotations in all hospitals within and outside the Ministry of Health (MOH) and during all electives including non-clinical electives such as research electives.

2.0 Residents in the KBIM program cover calls with General Internal Medicine (GIM) during all of their rotations except the following rotations in which they cover calls with the same rotation they are in:
- 2.1 Cardiology and CCU rotations
- 2.2 ICU rotations
- 2.3 ER rotations
- 2.4 Electives outside the country

3.0 Residents who are doing a rotation in one of the major hospitals (Adan, Amiri, Farwaniya, Jaber, Jahra, Mubarak Al-Kabeer and Sabah) will cover calls with the General Internal Medicine service at the hospital in which they are rotating.

4.0 Residents who are doing a rotation outside of one of the major hospitals will cover calls with the General Internal Medicine service at their main site for the academic year (i.e. the same site in which they will be doing all of their Medical Teaching Unit (MTU) rotations for that year).

5.0 It is a resident's responsibility to obtain an oncall schedule clearly covering their entire rotation period from the site in which they are expected to do oncalls, read the schedule carefully, and note all days in which they are scheduled to be oncall.

6.0 If a resident does not find their name anywhere in the oncall schedule, it is the resident's responsibility to inform the coordinators of the site in which they will be oncall immediately so they can be added to the schedule.

7.0 If the resident does not receive an oncall schedule or receives an oncall schedule that does not cover the entire period of their rotation, they should assume that they can be oncall on any days that are not covered by an on call schedule.

8.0 The oncall period of a rotation starts on the first working day of the rotation and extends until the day before the first working day of the next rotation.
- 8.1 For example, if there is an official holiday from June 28 until July 3rd; resident oncall duties in the June rotation will extend until July 3rd and their oncall duties in the July rotation will start on July 4th, which is the first working day in the July rotation

9.0 When transitioning from one rotation to another rotation at a different site with a different oncall schedule, the minimum number of days between two calls during this transition is **2 non-call days**.
- 9.1 The resident must inform the tutors and site coordinators of the next rotation at least 14 calendar days before the start of the rotation if they are on call in the last 2 days of their current rotation.
  - 9.1.1 For example, a resident who was oncall on Saturday on the last day of a rotation may be asked to do call on Tuesday on the next rotation, but not earlier than that.

10.0 When transitioning from a rotation with 24-hour calls to a shift-based rotation (e.g. emergency medicine rotation), residents should not be given the morning shift on their first day on the shift-based rotation if they were oncall on the last day of the previous rotation.

10.1 The resident must inform the tutors and site coordinators of the next rotation at least 14 calendar days before the start of the rotation if they are on call on the last day of their current rotation.

11.0 The maximum number of calls in a rotation is the total number of days in the rotation divided by 4 and rounded up.

11.1 Approved leave and leaves of absence days are not counted in the total number of days in the rotation, however weekends, official holidays and sick leave days are all counted.

B. COVERING NON-TEACHING GIM UNITS

12.0 R1 to R5 residents **MUST NOT** cover non-teaching GIM units during calls, with no exceptions.

C. NATURE OF RESPONSIBILITIES

13.0 Role of R1 Residents:

13.1 Residents in R1 as well as residents who are still in the TTD or Foundation stages of training should carry the usual responsibilities of an **"Assistant Registrar".**

13.2 This **must** include a minimum of 1 call per month in which they carry their responsiblities in the Emergency Department (ED), working under the direct supervision of Registrars.

13.3 Residents should only be asked to cover ward-calls exclusively if there are no non-resident physicians to do that (e.g. trainees or elective assistant registrars).

13.4 R1 residents should always cover the wards during the daytime of the oncall and may only cover ER after 2 pm.

13.5 **All calls from the ward MUST be reviewed by an R2 or above during the first 4 months of training.**

13.5.1 Supervision must continue until the resident has completed TTD stage with a minimum duration of 4 months (to include at least 1 MTU rotation).

13.5.2 If the resident has completed 4 months and has not completed TTD, supervision must continue.

14.0 Role of R2 Residents:

14.1 Residents in R2 who are in the Core stage of training are expected to assume the role of a 'Registrar' during their on-call shifts.

14.1.1 Their primary responsibilities include:

- Receiving pre-filtered (in person or by phone)referrals from the ED, which are first assessed by a fellow registrar before being assigned to them.
- Managing initial stabilization, including resuscitation when necessary.
- Making admission decisions in collaboration with the supervising senior.

14.2 Residents in R2 will be asked to cover oncalls as the shift leader for ward calls during the first 4 months of the academic year (October to January) when R1 residents are still in TTD stage.

14.2.1 During shortage in junior staff, this period may extend beyond January especially when R1 residents are still in TTD stage

14.2.2 Priority to cover ER will be for MTU R2 residents; sub-specialty residents may be asked to cover as shift leader during the entire rotation.

14.3 Supervision Protocol for R2 Residents

14.3.1 To ensure patient safety and progressive resident development, supervision during calls will follow this hierarchy:

- Primary Supervision: Preferably provided by a registrar from KBIM (R3/R4).
- Alternative Supervision: If an R3/R4 is unavailable, the supervision shifts to an R5 resident, followed by a Fixed Senior Registrar.

14.4 Progression in Responsibilities for R2 Residents

14.4.1 First 4 Months in Core Stage

- The R2 resident will primarily manage stable cases in the male and female observation units under the supervision of R3/R4/R5 or fixed senior registrars.
- All cases will be pre-filtered by the registrar before being assigned to the R2 resident in the observation unit, ensuring that only stable cases are handled at this stage.
- If the resident has any doubt about case stability or believes the patient requires initial evaluation by a registrar, it is their responsibility to escalate immediately by calling the oncall registrar.

14.4.2 After 4 months (with a minimum of two months in an MTU)

- An automatic transition will occur after four months of observation, provided there are no documented incidents or red flags in their general assessments
    - Residents must have passed the rotations for previous 4 months
    - Decision to transition will be made by the site director in collaboration with clinical tutors from the MTU that the resident has attended
- Upon transitioning: The R2 resident may begin managing cases independently in the observation units, with mandatory case review by the senior registrar oncall to ensure safety and appropriate decision-making.
- The resident may handle cases in the Resuscitation Room (RR) but only under direct supervision of an R3 or R4, who must be physically present during case management.
- Cases will continue to be pre-filtered by a fellow registrar before being assigned to the resident.

14.5 Oncall Workflow and Daytime Coverage

14.5.1 <u>Before 2 pm:</u> R2 resident continues regular ward duties as an assistant registrar.

14.5.1.1 Exception is during R3 or R4 Academic Days, if no MTU Registrar is available during the morning time (7am to 2pm).

14.5.2 <u>After 2 pm:</u> R2 resident works in the ED for the remainder of the shift with supervision by R3/R4/R5.

14.5.3 <u>Morning Rotation Exclusion:</u> Unlike other registrars, the R2 resident will not be included in the morning registrar rotation during workdays. This ensures that ward duties are completed efficiently without interruptions from oncall responsibilities

15.0 Role of R3-R4 Residents:

15.1 Residents in R3 and R4 should carry the usual responsibilities of a **"Registrar"** during calls. Specifically, they should be receving referrals directly from the ED, carrying out initial stabilizing management including resuscitation, and making decsisions regarding admission.

15.2 They should be supervised and supported by physicians with a rank of "Senior Registrar" or above.

16.0 Role of R5 Residents:

16.1 Residents in R5 cover calls at the "Senior Registrar" level and are supervised by tutors in the unit.

16.2 The R5 resident is required to evaluate all newly admitted cases during their oncall shift.

16.3 Any ED discharge initiated by an R3/R4 or an R2 in the CORE stage must be communicated in advance to the R5 or senior registrar prior to completing the discharge.

16.4 The R5 must be consistently supported by clinical tutors during oncall shifts and is encouraged to seek a second opinion or consult on admission and discharge decisions.

16.4.1 To discuss with clinical tutor regarding discharged cases from the ED whenever there is any speculation about a case.

D. ONCALL AND LEAVES

(Please refer to the KBIM Leave Policy for more details.)

17.0 The exact dates of days off work needs to be indicated when you take a leave, this includes the weekends and any official vacations including Eid, National/Liberation Days, Israa & Miraj, the Prophet's Birthdate or any other State Official Holidays.

18.0 Residents are expected to do oncalls on any days outside of the start and end dates indicated on their official approved leave requests, including days that are part of an official holidays and including when the resident hasn't completed their Return-to-Work papers after returning from a leave.

E. ONCALL HOURS

19.0 **On call hours are 24 hours**, with the exact timing depending on the site (e.g. 7am to 7am or 8am to 8am).

20.0 Even after an oncall duty hours end, residents should never leave their posts until:

20.1 All remaining patient issues have been resolved or safely handed over to the next oncall team.

20.2 The next oncall team has arrived and assumed responsibility for any new incoming consults or ward call coverage.

21.0 In some oncall services, when the number of physicians oncall allows, on call duties may be internally distributed by time, responsibility, location etc; however, residents remain responsible for

on call duties throughout the 24 hour period and may be asked at any time to extend their coverage location, time or period depending on needs.

22.0 When work is distributed by time, there should be no more than two coverage periods (or "shifts") during the 24-hour call, regardless of whether the call was on a working day, weekend, or vacation.

23.0 Residents always respond professionally to any calls from nurses, emergency physicians and other colleagues throughout their entire official oncall coverage hours and direct them to the right person within the on call team if the work has been divided in any way; it is not enough to declare "I'm not covering right now" when you get called during the official oncall hours.

24.0 Residents must never leave the country during all or part of any official oncall duty. Doing so is a professional misconduct and will be dealt with accordingly.

25.0 During rotations which are shift-based, such as emergency department rotations, residents will follow the same shift rules as those specified for emergency department physicians or residents.

F. SUB-SPECIALTY GIM COVERAGE

26.0 For sub-specialty residents covering General Internal Medicine (GIM) calls:

- 26.1 On regular working days, residents will work with their subspecialty rotation during the day and with the GIM service after regular working hours.
  - 26.1.1 Residents **will only cover** GIM during oncalls and not their respective sub-specialty; their name shouldn't be placed on any sub-specialty oncall list.
  - 26.1.2 The shift starts from the end of the working day: 2 pm onwards; they are not expected to cover daytime working hours in the ED.
  - 26.1.3 The night shift ends when they assess and complete the plan for the last patient they have; **they shouldn't be expected to cover more ONE hour after the end of the official shift time**.
  - 26.1.4 They shouldn't be expected to receive any new cases **less than ONE hour before the end of their official night shift time** to ensure they see the patients appropriately and carry out any necessary management orders and plans.
  - 26.1.5 Any sick patients or pending issues must be handed over to the GIM staff to follow.

28.0 Residents are expected to attend rounds with the GIM staff during the oncall:

- 28.1 Oncall evening rounds if they're covering the day shift.
- 28.2 Postcall morning rounds if they're covering the night shift (during weekends only).
- 28.3 They will not be expected to attend postcall rounds during weekdays.
- 28.4 If the resident is busy in the ED, they may be given feedback over the phone.