West Virginia University
SCHOOL OF MEDICINE
DEPARTMENT OF UROLOGY

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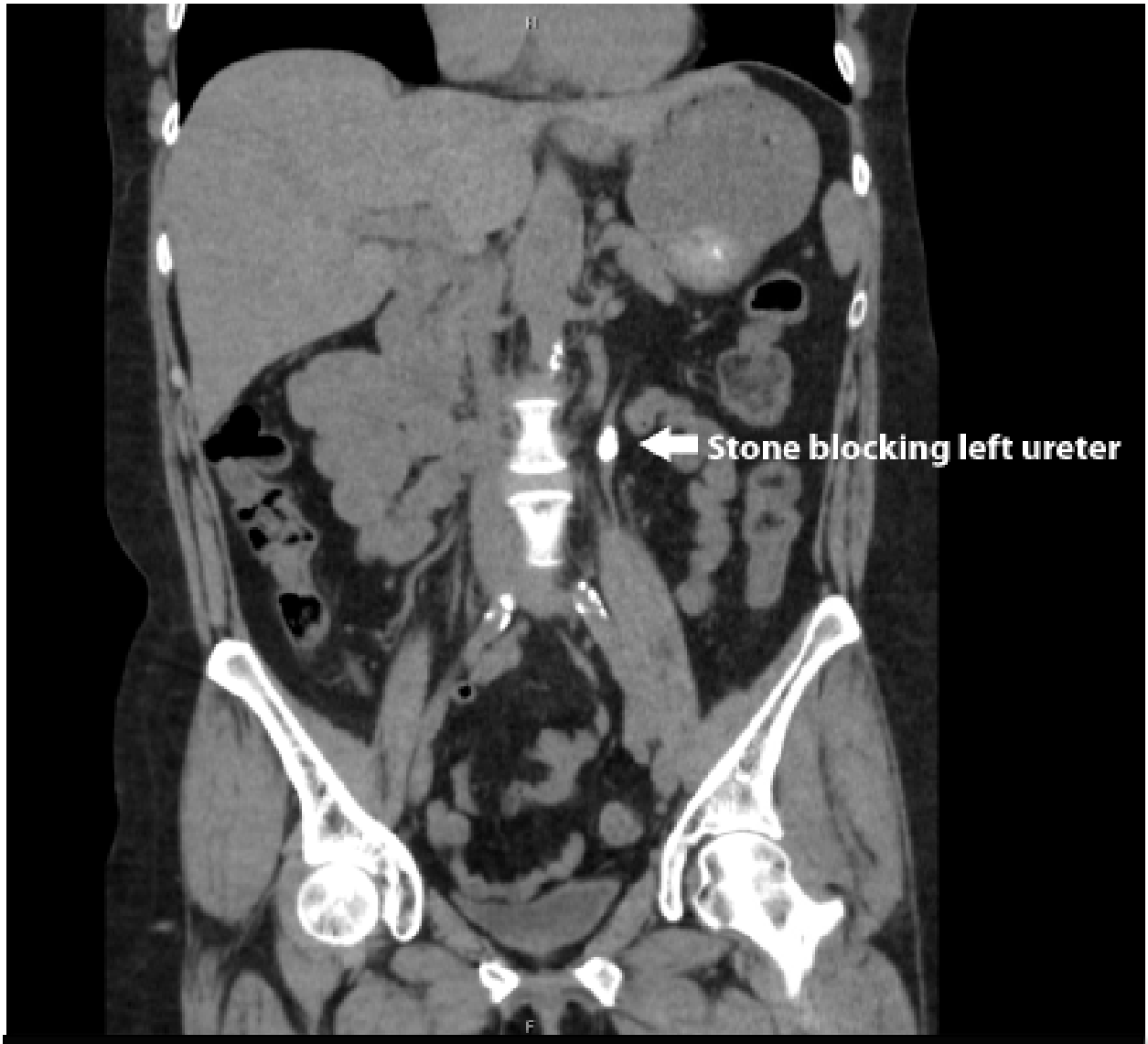

2017-2018 RESIDENT MANUAL

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Welcome and Introductory Statements

Welcome to the West Virginia University School of Medicine, Department of Urology, Morgantown, West Virginia. You are about to embark on an experience that you will remember for the rest of your life. You will have the opportunity to learn the art and science of urology, an amazing discipline of which we feel being a member is a privilege.

This manual is designed to clarify what is expected of residents at each stage in the training program. In addition to the information in the manual, a few things need to be conveyed:

- Residents are **not to wear** WVU imprinted scrubs outside the hospital. This is in violation of an OSHA regulation and significant sanctions can be placed on both the department and institution. Scrubs with a protective outer covering (white coat or anesthesia coverlet-gown) are permitted in the Emergency Department, OR, fifth floor ICUs and Same Day Surgery Center, and Clinics. Residents are to wear the hospital provided "green" scrubs to be used when entering and leaving the hospital.
- Computers are provided in the Department of Urology, Physician's Office Center (POC) Clinics, and 2 West and 5 North OR Work Stations. These are linked to the internet and to the electronic medical record system (EPIC); however, residents are not at liberty to bring in games to play on these computers.
- Health Information Management (HIM, or Medical Records) records are to be kept up-to-date. This includes current dictations of operative notes and discharge summaries.
- **Eleni Spirou** serves as the Residency Manager and is your available resource guide. She will discuss with you the daily activities of the residency, which include meal tickets, laundry, benefits, vacation requests, and certification courses in ATLS and ACLS, as well as the USMLE Step III.
- You must take and pass USMLE Step 3 by the end of your PG-2 year. However, the most optimal time to take this examination is at the end of your PG-1 year. We **strongly suggest** you follow this recommendation. Residents will not be advanced to the PG-3 year unless they have passed all steps of the USMLE and have applied for and obtained a West Virginia license to practice medicine.
- Your operative cases **must be kept up-to-date weekly** on the ACGME website. The Program Manager will provide you with your user name, password, and instructions on completing the information. It is your responsibility to complete the information in the website and keep it up-to-date weekly. You must log all cases, regardless of whether or not you are the primary surgeon. If you are helping a chief or senior resident with a major case, you should log the case as assistant surgeon. Case logs will be monitored quarterly.
- Your duty hour logging through the E-Value system **must be kept up-to-date by Sunday of each week**, unless directed to update sooner by the Program Director or coordinator. Please review the department duty hour policy for further guidance.

Again, welcome to the Department of Urology and Morgantown, West Virginia. If you have any questions, please contact us at any time.

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The Robert C. Byrd Health Sciences Center

The Robert C. Byrd Health Sciences Center is devoted to patient care, education, and research. It is a major regional referral center, and more than three-quarters of its inpatients are from outside the Morgantown area. It serves an area of approximately 1.9 million people. With a total of 645 licensed patient beds and a range of specialty clinics, the Health Sciences Center serves an estimated 250,000 patients annually.

The Health Sciences Center includes four schools that award undergraduate, graduate, and professional degrees in health-care fields. The Schools of Medicine, Dentistry, Pharmacy, and Nursing currently enroll 1,600 students and residents in 25 degree and post-degree programs.

The Health Sciences Center campus encompasses federal, state, and private facilities, but views its mission of statewide service as a central responsibility. It is a regional leader in primary care, and residents in specialty areas have opportunities to gain experience in rural areas of the state. WVU's innovative rural health programs have earned national praise. Faculty physicians in the School of Medicine see patients in outpatient facilities at more than 28 sites across the state and inpatients at several locations, in addition to the Health Sciences Centers in Morgantown and Charleston.

A tertiary care center, West Virginia University Hospitals, Inc. is a non-profit corporation. Although associated with WVU, it operates solely from patient services revenues and receives no tax support. In December 1996, it became affiliated with United Hospital Center in Clarksburg — one of West Virginia's most successful community hospitals — to form the regional West Virginia United Health System. Within the system is United's 209-bed hospital; the 450-bed Ruby Memorial Hospital; the new Ruby Day Surgery Center; the Level I Jon Michael Moore Trauma Center, with an emergency air transport system; and WVU Children's Hospital, which comprises the entire sixth floor at Ruby Memorial Hospital. The WVUH Child Development Center supports WVU Healthcare employees by providing high-quality child-care services on site.

WVU Healthcare
University Health Associates is the faculty practice plan of the WVU Schools of Medicine and Dentistry. Faculty and residents see patients in UHA's modern, $24.5 million outpatient facility—the Physician Office Center. It is West Virginia's largest multi-specialty group practice. With more than 200 physicians and dentists in over 60 different primary and specialty practices, up to 1,000 patients per day are seen at the POC. UHA also owns Cheat Lake Physicians, a family health center located a few miles outside of Morgantown, which offers a small private-practice setting.

To provide more patients the option of outpatient surgery for some conditions, WVU recently added a new $3.1 million Day Surgery Center with $1.5 million in medical equipment.

The Mary Babb Randolph Cancer Center and Robert C. Byrd Research Laboratory provide the people of West Virginia with an integrated, high-quality system of cancer care. The facilities and a multidisciplinary team of providers bring together a variety of resources for patient care, education, and research. Approximately 11,800 West Virginians were diagnosed with cancer in 1996. Of those, 2,200 had prostate cancer; 1,700 had lung cancer, a number well above the national average; 1,300 were diagnosed with breast cancer; 1,200 with colorectal cancer; and 630 with bladder cancer. In 1990, the rate of mortality from heart disease for both sexes was 21% higher in West Virginia than in the rest of the U.S.

Also on the WVU Health Sciences Center Campus are the Chestnut Ridge Psychiatric Hospital, a private, 70-bed psychiatric and chemical- dependency hospital staffed by WVU behavioral medicine and psychiatry residents and physicians, as well as Health South Regional Rehabilitation Hospital, a private, tertiary facility that provides care to persons disabled by accident, injury, illness, or congenital problems. Nearby is the Ronald McDonald House, which provides a home away from home for families of critically

ill children being treated in Morgantown. The Rosenbaum Family House has recently been opened to provide the same services for families of adult patients. A new and expanding NIOSH/CDC facility also is adjacent to the campus.

To assist in providing excellent and highly sophisticated tertiary care to the patients it serves throughout the region, WVUH provides the most modern technology. From computerized radiography and Positron Emission tomography to specially equipped surgical suites, it has the tools to ensure the best in health care and medical education.

WVU has a relatively traditional medical curriculum, with an emphasis on rural medicine and a commitment to producing excellent doctors who know the "art" of medical practice. The WVU facilities and their faculty and staff provide comprehensive clinical experiences and opportunities for medical research and advancement for residents in all disciplines. Residents are full participants in medical education, research, and patient care; and the exchanges between mentors and house staff create an exciting and supportive intellectual environment.

In the area of research, the institution fosters interdisciplinary projects, with basic sciences and clinical departments working together. Cardiovascular/renal and oncological research are areas of particular strength, which were identified for research during the 1990s by the School of Medicine Research Council. Other areas are the neurosciences and occupational/environmental health and oncology.

Numerous core research facilities (mass spectrometry, recombinant DNA, EM, and image analysis, etc.) are available to all investigators. The Mary Babb Randolph Cancer Center conducts research into the causes and treatment of cancer, and a new PET scanning center is in operation. Research focusing on improving health care in rural areas is strongly emphasized at WVU.

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Parking Information

The following are some helpful hints and information that address many of the more common questions we receive regarding parking:

- Do not use patient/visitor parking lots. This practice does not reflect the patient priority values of our organization.
- Do not park illegally anywhere on WVUH property. Permit parking spaces are always available. If you cannot find a space, approach one of the Parking Officers and they will direct you to a space.
- If you have more than one vehicle and you forget to transfer your permit, please obtain a staff temporary good for one day. You will need to go to the Parking Office on the 4th floor of Ruby.
- If you lose your parking permit, please see the Parking Office for replacement. A nominal fee is charged to replace a lost permit.
- Please be aware that warning tickets stay on record for 3 months. After a vehicle is issued a minimum of 3 warnings, the next notice given will be a pink final notice sticker in effect for 6 months. If the vehicle is parked illegally after receiving a pink sticker within the 6-month period, it will be towed at the owner's expense. A tow authorization being issued extends the period a vehicle can be towed again to 6 months from the date of the tow. The same vehicle could potentially be towed multiple times.
- Please be aware that it does not matter in which WVUH lot or lots you receive the warnings and final notice. The effect is cumulative. If you park illegally anywhere on WVUH property within 6 months of a pink final sticker, your vehicle will be towed, even if it is an area in which you had never before parked illegally.

- If you have been towed, your vehicle will be taken to Summers Towing, Van Voorhis Road, phone number: 304-599-3133.
- Please note that the C-6 off-shift parking was intended to provide spaces for afternoon shift parking. If you are working midnight shift and think you may be asked to work past 8:00 am the next day, you should park in lot D, an employee lot very close to C-6. There should always be space available, and you have the same degree of safety at night without risking violation if your times run over into day shift. (Remember to use your security escort at night any time you are not comfortable walking to or from your vehicle).
- Please note that the on-call lot is designated for persons with a special on-call permit. It is not intended for all of those in an on-call status.
- Lot K-2, the gravel lot between the stadium and Ronald McDonald House, is not a WVUH lot. If you are towed from this area, you will need to contact DPS at: 304-293-5502.
- Remember that F-2 (gravel lot next to paved F-1) is now an employee permit parking lot and spaces are always available in that lot. F-2 is newly graveled, has parking curbs, and is monitored by our Parking Officers.
- If you do not understand where you should park, or if you have any other questions about lot designations, ticketing, or anything related to parking, please call the parking office at 304-598-4029 any time between 7:00 am and 3:30 pm.

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Policies of Physician Health Committee

The Physicians Health Committee serves as a resource in management of impaired physicians. Impairment includes any physical, psychiatric, or emotional illness that may interfere with the physicians' ability to function appropriately and provide safe patient care. In an effort to ensure consistency in our approach to these difficult problems, the Physician Health Committee has formulated the following guidelines.

New Residents/Faculty

Substance Abuse

Any resident or faculty member who requests an appointment to practice at WVUH and has a reasonable suspicion of substance abuse, or a history of substance abuse and/or treatment of substance abuse, must be referred initially to the Practitioner Health Committee. The Practitioner Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person who specializes in substance abuse.

After receiving an evaluation and consulting with the Department Chair, the Practitioner Health Committee will make a recommendation concerning:

- Advisability of an appointment to WVUH
- Need for restriction of privileges
- Need to monitor
- Need for consent agreement concerning rehabilitation, counseling, or other conditions of appointment

The decision to grant hospital staff privileges or allow residents to treat patients at WVUH, and under what terms, are at the discretion of the WVUH Board of Directors through the Joint Conference Committee and are based on the recommendation of the Department chair, Vice-President of Medical Staff Affairs, and the Practitioner Health Committee.

These recommendations will be communicated to the House Staff Coordinator (for residents), Vice-President for Medical Staff Affairs, and Practitioner Health Committee.

If it is agreed that the resident or faculty is to have an appointed position at WVUH, the resident/faculty member must sign an agreement that upon granting privileges he/she will submit to a blood and urine drug screening before assuming any patient-care responsibilities.

If the circumstances dictate a need for monitoring, the resident/faculty must sign an agreement that he/she will meet with a member of the Practitioner Health Committee and agree to random blood and urine drug screenings, as well as other conditions the Committee determines are appropriate in their sole discretion, as requested by the Practitioner Health Committee, Vice-President of Medical Staff Affairs, and other supervisors.

All conditions of privileges and test results will be communicated in writing to the House Staff Coordinator (for residents) and the Vice-President of Medical Staff Affairs.

Practicing Residents/Faculty

The responsibility of all faculty, residents, or any other person is to immediately report any inappropriate behavior or other evidence of substance abuse/health problems that could impact on professional/ clinical performance in the Hospital. In addition, a resident or faculty member can, and is, required to self-refer to the Physician Health Committee in the event he/she experiences any substance abuse/ health problem that could impact on professional/clinical performance in the Hospital.

All such reported information shall be kept confidential except as limited by law, ethical violation, or when patient safety is threatened.

If a Department chair or Vice-President of Medical Staff Affairs receives a report suggesting impairment of a physician (faculty or resident), or observes behavior that suggests impairment, the following actions are required:

- The Department chair or Vice-President of Medical Staff Affairs will do the best of his/her ability to ensure the allegation of impairment is credible.
- The Department chair or Vice-President of Medical Staff Affairs must notify the Dean, Vice-President of Medical Staff Affairs (or the Section Chief), and Practitioner Health Committee (within 24 hours or within the next business day) in writing of any reported incidents or observed behavior that suggest impairment.
- The Department chair or Supervisor must immediately send the physician to Employee Health or the Emergency Department for blood and urine drug screening, as set forth in WVUH policy. Refusal to cooperate with testing is grounds for dismissal from the medial staff for faculty, and removal of residents from providing any patient care within the hospital.
- The Department chair or Supervisor must remove the physician from patient care or patient contact immediately.
- The Department chair or Supervisor must make a mandatory referral to the Employee Assistance Program (EAP) immediately, based on the possibility of impaired performance.

The EAP will require the physician to sign a release authorizing exchange of medical information between the EAP, Chief, WVUH, and Physician Health Committee. EAP will provide a report of their evaluation and treatment recommendations in a timely manner to the Dean, Physician Health Committee, Chief, and Vice-President of Medical Staff Affairs of WVUH.

The Physician Health Committee will review the report from the EAP and provide a recommendation to the Vice-President of Medical Staff Affairs who will be responsible for the final decision concerning return to work and monitoring. The Physician Health Committee will participate in the monitoring of physicians until rehabilitation or any disciplinary process is complete. All instances of unsafe treatment will be reported to the Medical Executive Committee.

Other Impairments (Physical, Emotional, or Psychological)

Any resident or faculty who requests an appointment to practice at WVUH where a physical, emotional, or psychological impairment that may interfere with the physician's ability to function appropriately and provide safe patient care exists, must be referred initially to the Practitioner Health Committee. The Practitioner Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person who specializes in the specific condition.

The same process will apply as above, however, there may be different or additional monitoring required besides random blood and urine drug screenings.

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Patient-Care Responsibilities

Description of How the Urology Service is Conducted

Chief Resident

The responsibility of the Chief Resident is to assign each resident his/her operative or clinical duties daily. Distribution of operative cases will be in accordance with level of training and at the discretion of the Chief Resident or Attending Urology Faculty. Cases are to be distributed in an equitable fashion. If a resident does not agree with the Chief Resident's distribution of cases, a formal written complaint must be given to the Chief Resident and a copy to the Residency Program Director.

The Chief Resident also will assign clinical duties to each resident daily. If a resident is assigned to clinical duties, that resident should not expect to have operative assignments on that particular day; however, a resident may be assigned operative duties for a portion of the workday and clinical duties for another portion of the workday. Clinical duties will be distributed in an equitable fashion.

The Chief Resident also may assign research days to each resident in the event clinical and operative duties will be covered by the other residents, which will depend on the case load and variety for a particular day. The resident will check in with the designated faculty member to discuss their project(s).

It should be understood that resident assignments may be changed in accordance with emergency situations or unforeseen events. Should a change in a resident's daily duty occur, that change will be taken into account when daily assignments are made in the future. An equitable distribution of duties may not be possible on a given day; however, over the course of 1 week or 1 month, resident assignments will be fair and equitable.

The Chief Resident also will assign conference responsibilities and is expected to take the lead in discussions both in conference and regarding patient care. The Chief Resident also will assign articles to be reviewed during Journal Club.

Senior and Junior Residents

The Senior and Junior Residents are considered to be any resident not in a Chief Resident position. Senior and Junior Residents will have clinical and operative duties assigned to them daily. The Senior and Junior

Residents are expected to comply with these assignments. Furthermore, the Senior and Junior Residents are expected to fulfill their conference and Journal Club assignments in a timely fashion. The Senior and Junior Residents are expected to comply with the directives of the Chief Resident(s). Any complaints should be given as a formal written letter to the Chief Resident(s) in question and the Residency Program Director.

Patient Admissions & Procedures

The Urology Service at WVU is a state and regional resource, and all patients with Urologic disorders are candidates for admission. The appropriate on-call faculty member should be called if a question regarding admission of anyone arises.

Emergency Admissions: Appropriate patient's faculty or on-call faculty must be notified when an emergency or unscheduled admission occurs.

All residents are responsible for preparing themselves for any surgeries in which they may be participating. The Administrative Chief Resident will be responsible for preparing a schedule for resident participation in those procedures and care of particular patients.

Patients admitted the day of surgery should have a preliminary admission history and physical provided by the Medical Officer from the pre-testing area and by the Anesthesiologist. The Operating Chief Resident or designee will be responsible for providing a preliminary note as to the particular Urologic problem and rationale for the procedure being performed.

Patients admitted the day before surgery should be fully evaluated by the on-call resident. This evaluation should include a Urologic symptoms history, pertinent illnesses in other systems, a list of medications, allergies, prior surgeries, and a problem-oriented summation. Proposed plans for diagnostic tests or proposed surgical procedures should be included. Laboratory results also should be included as part of the admission evaluation. Urinalysis is of particular importance in this regard. If any evidence exists of pyuria (>4-5 white cells per high power field), a urine culture should be sent and the Attending Physician contacted. Antimicrobial coverage for the procedure may be important in this setting and in patients with a history of urinary infection. The Attending physician should be alerted to any other abnormalities in the admission laboratory evaluation.

The Chief Resident or designee should write a brief summary admission note on each patient following review with the admitting resident and/or responsible Attending Physician.

Patient Surgery and Clinic Coverage

The Chief Resident will determine coverage by the resident staff on all surgeries performed. Any conflicts in coverage shall be discussed with the service Attending Physician.

Any resident not scrubbed on cases when Clinics are ongoing will be in the Clinic. The resident's responsibility for patient management will vary from one Clinic to another at the discretion of the Attending staff. Part of caring for the patient is completing the necessary charting and other patient care paperwork in EPIC.

All patients being seen for endoscopic procedures should have had a urinalysis performed in the Outpatient Clinic. If any indication of infection was noted, a urine culture should have been plated and checked before the procedure. If the patient is already on appropriate antibiotic coverage for treatment of a known infection, or a negative urinalysis has been performed and documented in the most recent Outpatient Clinic, the resident may proceed with the planned procedure.

Routine inpatient floor work and consultations should not be done while patients are being seen in the clinic. If there is an emergency in the hospital that requires immediate attention during the clinic, the resident must notify the faculty in clinic about the emergency as well as the faculty responsible for the patient requiring emergent care.

Inpatient Follow Up

Documentation of the need of each patient's stay in the hospital shall be made daily. This documentation should include an EPIC-entered progress note on the patient's current status, plans for additional testing that day or on future days, and an indication that the patient's status has been discussed with the Attending staff member responsible for that patient's care.

Work rounds are scheduled daily by the Chief Resident with the resident team and faculty member, typically the faculty member on call. Work rounds are to be completed prior to the beginning of conferences, clinics, and cases.

Discharge summaries are the responsibility of the Junior House Officer involved in the care of the patient and dictated within 1 day of discharge. All charts must be in completed form according to hospital guidelines. Notification to the office of incomplete charts without subsequent timely correction will result in suspension from OR privileges, as per hospital guidelines.

Intensive efforts must be made to minimize a patient's length of stay and are the responsibility of the Chief Resident in consultation with the Attending physician. Discharge planning and use of home-care resources should facilitate this process.

Consults

Again, consult rounds are daily with the Chief Resident and Faculty on-call.

Urgent consults must be communicated to the Chief Resident by way of the paging system, and will be seen as soon as possible by the Chief or his/her designee. All consults must be seen by the faculty and documented in EPIC.

Chart Documentation

Computer based EPIC notes must be spell-checked for accuracy. Always include the referring/consulting physician in the initial operative note and discharge summary so records can be sent as appropriate. Dictate operative notes immediately following the case. Also, referring physicians must be included in subsequent admissions. Referring physicians must receive a letter at the initial office visit, when procedures or hospitalization are required, and whenever significant changes in outpatient management occur. Referring physicians must be kept informed!

When documenting the history portion of the note, documentation must be made on the following elements: location, quality, severity, duration, timing, context, modifying factors, and signs & symptoms. The examination portion should have at least 4 areas of examination (heart, lungs, abdomen and genitourinary examination).

The residents must make sure to state "consult" in Clinic and inpatient notes, as well as the referring physician.

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Conferences

Residents are expected to attend all conferences listed below unless involved with an emergent patient situation, attending an out-of-town meeting, on vacation, or on sick leave.

The Wednesday Morning Conference begins at – 6:30 am (or earlier per Program Director or Chief Resident) – in the Health Sciences Center on the ground floor in Room G252.

Topics will consist of the following: Campbell's Urology Review, Pediatrics Conference, and Complications in Urology Conference, and General Urology topic review. A brief indications conference is also included during this block conference time. Residents must be punctual to attend this Conference, and sign the attendance sheet. Lectures also are given by Urology Department faculty members, as well as invited speakers from other departments in the School of Medicine.

Residents presenting material at these conferences must provide a handout of the material to serve as a teaching guide for their peers and faculty. Residents will be evaluated periodically by faculty on their presentations throughout the academic year. Results of these evaluations will be shared with residents during their semi-annual progress meetings.

Additional conferences may be scheduled as well such as radiology, pathology and robotic simulation sessions. Informal Friday Morning Conferences may be used to catch up on material not covered completely in the Wednesday Conference.

Residents will be assigned topics in each of the urologic disciplines to present at these Conferences, which will be led by faculty and guest lecturers from the respective departments. Residents will be evaluated periodically by faculty on their presentations throughout the academic year. Results of these evaluations will be shared with residents during their semi-annual progress meetings.

Journal Club is held monthly and announcements are sent by e-mail. Residents must attend this Conference. The Chief Resident or designee will be responsible for selecting articles from the Urologic literature for presentation and discussion. Each resident will review all articles and be asked to present information in an informal fashion from a particular article(s).

CALL SCHEDULE

The call schedule will be made by the chief resident with oversight by the Residency Program Director. Each resident will have at least 2 weeks off each month from primary (first) call responsibility. The majority of primary call responsibility will be shared equally by the PGY-2 and PGY-3 residents when averaged over the course of the year, and the remainder of primary call duties will be taken by the PGY-4 resident. A PGY-1 resident will be allowed to take call but will require additional supervision by senior residents as per ACGME guidelines. All call is considered to be "at-home" call.

An example of the call schedule for a 30 day calendar month is as follows:
PGY-2: a total of 12 days of call/month with either one or two weekends (Friday at 7 am until Monday at 7 am) on call
PGY-3: a total of 12 days of call/month with either one or two weekends (Friday at 7 am until Monday at 7 am) on call
PGY-4: a total of 6 days of call/month with one weekend on call

An example of the call schedule for a 31 day calendar month is as follows:
PGY-2: a total of 12 days of call/month with either one or two weekends (Friday at 7 am until Monday at 7 am) on call

PGY-3: a total of 12 days of call/month with either one or two weekends (Friday at 7 am until Monday at 7 am) on call
PGY-4: a total of 7 days of call/month with one weekend on call

The chief resident is expected to be physically present (i.e. in the local area) to provide “back-up” or second call responsibility to the primary resident on call. With approval by the responsible faculty on call, second call may be provided by faculty while the PGY-4 resident is on call.

Any questions about call schedule arrangements/assignments must be addressed with the responsible faculty on call. In the event that an agreement cannot be reached regarding the call schedule, the issue should be presented to the residency program director.

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ACGME Core Competencies and Assessment

At the February 1999 meeting of the ACGME, general competencies for residents were endorsed. Suggested was that Residency Programs incorporate these competencies into their Training Programs. Each Program would then develop methods of assessment and evaluation in each of these core competencies. In the next several paragraphs, each core competency and our methods of assessment and evaluation are described. https://medicine.hsc.wvu.edu/gme/gme-policies/acgme-core-competencies/

Patient Care

Residents must be able to provide compassionate, appropriate, and effective patient care for treatment of health problems and promotion of health.

Residents are expected to communicate effectively with staff and patients, gather essential/accurate information about patients, and make informed decisions regarding diagnostic and therapeutic interventions based on their assessment. They also are required to develop/carry out patient-management plans, counsel and educate patients/families, and use technology to support patient-care decisions in a competent fashion. The residents must provide health-care services aimed at preventing health problems and maintaining health. They must work with health-care professionals, including those from other disciplines, to best care for the patients.

In our Residency Training Program, this ACGME competency will be assessed in the following manner: First, faculty will provide a formal evaluation of the residents on a semi-annual basis. Questions regarding this evaluation specifically evaluate the resident's performance in this competency assessment. Second, the patient-satisfaction surveys done periodically in the institution will be reviewed; these are geared toward enhancing patient satisfaction with the general hospital experience. If a Urology resident is mentioned in this survey, that information can be used in their evaluations.

Interpersonal and Communication Skills

This competency assessment requires residents demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates. Residents are expected to create and sustain a therapeutic and ethically sound relationship with patients. They also are expected to use listening skills effectively, and elicit and provide information using effective nonverbal, explanatory questioning and writing skills. Faculty will review resident operative, hospital, and Clinic notes with residents periodically to ensure they achieve success in the area of written communication. Finally, they must work effectively with others as a member of a health-care team or professional group.

In our Residency Training Program, this ACGME competency will be assessed in the following manner: First, faculty provides a formal evaluation of the residents semi-annually. Questions related to this evaluation specifically evaluate the resident's performance in this competency assessment. Second, the resident is evaluated by faculty and their peers semi-annually when they are the main presenter at the Urology Conference. A standard evaluation form is used and the results are reviewed with the resident during their semi-annual meetings with faculty. Third, the patient-satisfaction surveys done periodically also are used in the institution. These surveys are geared toward enhancing patient satisfaction with the general hospital experience, and can be applicable in assessing resident competency if residents are mentioned by name regarding their performance. Finally, the resident is assessed semi-annually by the support staff that may include the following: administrative staff, clinical support staff and nurses, and OR support staff and nurses. A composite evaluation is generated, reviewed with the resident at their semi-annual meeting, and then placed in the resident's permanent file with the Department of Urology.

Medical Knowledge

In this competency assessment, residents must demonstrate knowledge regarding established and evolving biomedical, clinical, and cognate sciences, as well as application of this knowledge to patient care. Residents are expected to demonstrate an investigatory and analytic thinking approach to clinical situations, as well as be knowledgeable of, and apply, the basic and clinical supportive sciences appropriate to their discipline.

In our Residency Training Program, this ACGME competency is assessed using several methods. As mentioned previously, faculty evaluation of residents takes this competency into consideration on our standardized evaluation form. Second, residents are assessed on their performance on 3 written examinations. The first is the USMLE Step III Examination. Residents must achieve a passing score on this examination to continue beyond the first-year in the Urology Residency Program. The next examination is the Annual AUA In-Service given in November. Residents receive a full score report from this examination given to them at their semi-annual meetings with faculty. Specific guidelines regarding performance criteria on this examination are provided in the Urology Resident Manual and remediation guidelines also are reviewed. The third examination—the AUA SASP examination is given annually via computer in June of each academic year. This AUA constructed examination of approximately 100 to 150 questions serves to update the resident on their strengths/weaknesses since the November examination. A score report from this test is given to residents at their semi-annual meeting with faculty. Finally, residents are evaluated on their research presentations, written and oral, and critiqued on their performance.

Practice-based Learning and Improvement

This competency assessment requires that residents are able to investigate and evaluate their patient-care practices, appraise and assimilate scientific evidence, and improve their patient-care practices. Residents are expected to analyze practical experience and perform practice-based improvement activities using a systematic methodology. They must locate, appraise, and assimilate evidence from scientific studies, as well as obtain and use information from their patient population and the larger population from which patients are drawn. They must apply knowledge of study designs and statistical methods to the appraisal of clinical studies, as well as use information technology to manage information, access on-line medical information, and facilitate the learning of students and other health professionals.

In our Residency Training Program, this ACGME competency is assessed primarily through the use of faculty/peer evaluations. Residents are evaluated on a standardized evaluation form during their presentations at Journal Club, regional and national scientific meetings at which they were asked to present, and an informal review of their billing and coding knowledge through a review of the patients' charts. In addition, the general faculty/peer evaluation forms provide some specific insight into the resident's competency in this area.

Professionalism

In this competency assessment, residents must demonstrate a commitment to carrying out professional responsibilities, adhering to ethical principles, and having sensitivity to a diverse patient population. Residents are expected to demonstrate respect, compassion, and integrity. They must demonstrate a responsiveness to the needs of patients and social interests that supersede self-interest, as well as accountability to patients, society, and the profession. They must demonstrate a commitment to excellence and ongoing professional development. Residents must demonstrate a commitment to ethical principles that pertain to provision or withholding of clinical confidentiality of patient information, informed consent, and business practices.

In our Residency Training Program, this ACGME competency is assessed using evaluations of the resident's performance by faculty, office support staff, Clinic staff and nurses, OR staff, and nurses, as well as patients. A composite evaluation is generated and reviewed with residents at their semi-annual meeting with the faculty. Informal evaluations from the above areas also are requested when the situation warrants.

Systems-based Practice

In this competency assessment, residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care and the ability to effectively call on system resources to provide care of optimal value. Residents are expected to understand how their patient care and other professional practices affect other health-care professionals, the health-care organization, and the larger society. Residents must know how types of medical practice and delivery systems differ from one another. They must be able to practice cost-effective health care and resource allocation that does not compromise the quality of care. They must be an advocate for quality patient care and assist patients in dealing with system complexities. Finally, they must know how to partner with health-care managers and health-care providers to assess, coordinate, and improve health care, as well as the way in which these activities can affect system performance.

In our Residency Training Program, this ACGME competency is assessed primarily by the resident's ability to obtain a license to practice medicine in West Virginia. This process must be complete by the end of the second year of Urology residency. In addition, evaluations by Clinic support staff and nurses, operating support staff and nurses, as well as floor nurses and administrators also may be used.

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Resident Case Logs

It is the responsibility of the resident to keep his/her case logs up-to-date weekly. Case logs will be monitored quarterly for log entries. If cases are not logged weekly, the resident will have his/her meal card suspended and/or a suspension from the clinic and any Operating Room cases until in compliance. All cases are logged into the ACGME website at https://apps.acgme.org/connect/login. Please see the Program Manager if you have forgotten your password or have questions regarding the site. Residents must log all cases that they participate in. If two residents are participating in a major urologic case where both residents perform a significant portion of the case, the chief/senior resident may code the case as teaching resident and the second resident can code the case as surgeon.

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Clinical Competency Committee

With the implementation of the Next Accreditation System (NAS) by the ACGME, all residency programs must establish a Clinical Competency Committee (CCC). For this reason, this Statement of Purpose is created to assist the CCC with their mission.

The WVU Department of Urology Residency Program's CCC officially commenced functioning on July 1, 2013. The committee is chaired by Dr. Henry Fooks, Associate Residency Program Director and

Assistant Professor of Urology. Additional members of the committee include all full-time urology faculty. Residents are not formally considered to be part of the committee. However, the chief resident or senior resident may be asked to provide insight to the committee as requested. The goal of the committee is to make recommendations to the Program Director based on data available. Decisions will be linked to the competencies and milestones.

Members of the WVU Department of Urology Clinical Competency Committee

- **Henry Fooks, MD**, Committee Chair, Associate Professor Director, Division of General Urology
- **Stanley Zaslau, MD**, Professor, Chair, Residency Program Director
- **Adam Luchey, MD**, Associate Residency Program Director
- **Osama Al-Omar, MD**, Associate Professor, Director, Division of Pediatric Urology, Associate Residency Program Director, Pediatric Urology Education
- **Mohamad Salkini, MD**, Associate Professor, Director, Division of Urologic Oncology, Director, Urologic Simulation and Robotics
- **Chad Morley, MD**, Assistant Professor, Director, Minimally Invasive Urology and Stone Disease
- **Michael Ost, MD, MBA, FACS**, Professor, Associate Chairman, Department of Urology, Associate Surgeon in Chief, West Virginia Medicine Children's Hospital
- **Stanley Kandzari, MD**, Professor

The committee will meet semiannually in December and June of each academic year to review evaluations and provide information regarding successful completion of the milestones. Additional meetings may be scheduled at the discretion of the CCC Chairman Dr. Henry Fooks or Dr. Stanley Zaslau, Department chair and Urology Residency Program Director. All decisions will be made by consensus. The committee will use (but not be limited to) the following evaluation tools to assist in the decision making process for competency assessment:

WVU Department of Urology Resident Assessment Tools

1. Annual AUA ISE Performance Report – November
2. Annual AUA SASP Performance Report - June
3. ACGME Case Log Completion – monthly
4. Duty Hours Logging – monthly
5. Attendance at weekly Urology Resident Conference
6. Self-Evaluation of Milestone Performance
7. Mock Oral Examination Score Sheet
8. Completion of Robotics Simulation Training – semiannually
9. Case Presentation at M & M conference
10. Resident Presentation at Teaching Conference
11. General Competencies Evaluation of Resident by Faculty
12. Patient Care Evaluation

The Clinical Competency Committee meets biannually to review each resident and assign milestones levels. The milestones are then reported to the ACGME through the ADS (Accreditation Data System). Residents are presented with their milestones metric at the end of each 6 month rotation and discussed with the Program Director. The Program Director and the resident sign off on the official Milestones Narrative Report which is then uploaded to the resident's E-Value resident portfolio.

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Resident Salaries

2017-2018 Salary schedule **http://medicine.hsc.wvu.edu/gme/salaries-and-benefits/**

- PG 1 - $54,062
- PG 2 - $56,068
- PG 3 - $57,878
- PG 4 - $59,632
- PG 5 - $61,408

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Narrative Description of the Urology Residency Program

Goals and Objectives and Competencies/Evaluation of Outcomes

The goal of the Urology Residency Training Program is to train excellent Urologic surgeons, by providing flexibility to pursue either an academic or private-practice career path. Pursuit of excellence in clinical care, discovery in research, and integrity of character are stressed. The resident will be competent in clinical science, practice-based learning, interpersonal skills and communication, professionalism, and systems-based practices.

In addition, each resident will, by the end of the residency attain sufficient knowledge of etiology and management of Urologic disease in the following domains: andrology, infertility, impotence, sexuality, calculus disease, Neurourology, obstructive diseases, Oncology including laparoscopic and robotic urology, Pediatric Urology, Endourology, ESWL, Female Pelvic Medicine and Reconstructive Surgery, infectious diseases, renovascular diseases, surgery of the adrenal gland, trauma, and urodynamics.

The resident will be able to provide total care to the patient with graded responsibility by level of training, which include initial evaluation, diagnosis, use of information technology, selection of appropriate therapy, performance of high-caliber surgical technique, management of any adverse events, delivery of service aimed at preventive Urologic care, and collaboration with all health-care professionals for patient-focused care.

1. The resident will learn basic and clinical Urologic research.
2. The resident will demonstrate competency as defined by faculty review in patient care, teaching, leadership, organization, and administration.
3. The resident will learn to evaluate their patient-care practices in light of new scientific evidence.
4. The resident will learn to develop productive and ethically appropriate relationships with patients and families.
5. The resident will learn to work effectively as a member of the entire health-care team.
6. The resident will learn to be sensitive to patients' culture, age, gender, and disabilities.
7. The resident will learn to demonstrate integrity and responsibility in their professional activities.
8. The resident will learn to understand the multiple modalities of health-care delivery systems and strive to be cost effective in their selections of care.

Educational Goals and Objectives by Discipline

The PGY-1 year is the preliminary year of General Surgery in the Department of Surgery General Surgery Residency Program. The first year of Urology (PGY-2) focuses on General Urology. Basic Pediatric Urology cases are also introduced. The second year of Urology (PGY-3) focuses Endourology/Minimally invasive surgery. Advanced Pediatric Urology cases are taught. The third year of Urology (PGY-4) focuses on advanced cases in Endourology/minimally invasive surgery and female Urology/Neurourology. Introduction to Urologic Oncology and Advanced cases in Pediatric Urology are also provided. The fourth year of Urology (PGY-5) focuses on Urologic Oncology with significant exposure to robotic urology and advanced cases in all other disciplines.

PGY-1 YEAR – 12 months

PGY-1 residents will obtain the knowledge and skills required for preoperative evaluation of surgery patients, perioperative care, and basic surgical techniques. General abdominal surgery, critical care, and trauma are essential components of education in General Surgery. Rotations in Urology, General Surgery, Night Float, Vascular Surgery, Surgical Intensive Care Unit, Surgical Oncology, and Trauma are provided. Rotations are 1-month blocks.

The educational goals of this year include: expand knowledge of basic perioperative surgical care, critical care and fluid and electrolyte balance, learn basic principles of general, trauma, and vascular surgery, gain preliminary skills in surgical techniques, and refine interpersonal skills with support personnel.

The educational objectives of this year include: (1) conduct proficient preoperative evaluations of general surgical patients;(2) provide postoperative care for general, vascular, and trauma patients, which includes fluid and electrolyte management; (3) master techniques of insertion and evaluation of invasive monitoring of postoperative or critically ill patients; (4) assist or perform surgical procedures in general, vascular, and trauma; (5) develop surgical skills in minor procedures, and opening/closing surgical wounds; (6) initiate personal surgical log of cases; and (7) work effectively with support staff in pre-operative, operative, and postoperative settings.

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PGY-2 YEAR – 12 months

PGY-2: General Urology. The goals of this experience are to develop a knowledge base of general Urologic diseases such as BPH, erectile dysfunction, and evaluation of hematuria and urinary tract infection. The resident will gain outpatient experience with the medical management of common Urologic diseases. They will gain surgical skills associated with treatment of General Urologic diseases as described above. They will gain experience in the spectrum of postoperative care and long-term follow up of patients after surgical procedures. By the end of this rotation, residents will be able to: evaluate and treat patients in the outpatient setting who present with General Urologic problems, as well as patients who have erectile dysfunction and infertility. They will demonstrate competency in basic Urologic procedures such as cystoscopy and prostate needle biopsy. They also will demonstrate competency in the area of urodynamics.

Pediatric Urology. Residents in this formative year will have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. Residents will demonstrate competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain exposure to some of the more complex cases such as hypospadias, congenital anomalies, and major urinary tract

reconstruction. Pediatric urology is taught over all four years of the urology residency with a gradation of complexity of cases as the resident's knowledge and skills grow.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of General Urology. They will learn basic Urologic procedures such as cystoscopy and prostate needle biopsy, as well as ureteral catheterization, and how to counsel patients and families. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the General Urology patient. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in General Urology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-2: Introduction to Endourology: An introduction to Endourology is provided in the PGY-2 year. This experience is incorporated into the PGY-2 year for approximately 2 to 3 months. Residents will develop a knowledge base for decision-making regarding the use of Endourology therapies for stone disease. Residents will learn basic cystoscopic Endourologic procedures and introductory exposure to ureteroscopy. By the end of the year, residents will be able to evaluate patients at the time of presentation for possible Endourologic therapies. Residents will demonstrate competency in basic ureteroscopy, which includes stone manipulation. They will be able to identify potential postoperative complications and management thereof.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Endourology/minimally invasive surgery. They will learn basic ureteroscopic techniques, including stone manipulation. They will learn to counsel patients and families. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate patients who require Endourologic/minimally invasive surgery. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records, and work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.

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PGY-3 YEAR – 12 months

PGY-3: Advanced Endourology/Minimally Invasive Surgery. Residents will further their knowledge base for decision-making regarding the use of Endourology therapies for stone disease. Residents will advance their basic cystoscopic Endourologic procedures and further their exposure to ureteroscopy. They will learn basic principles of Urologic laparoscopic surgery. They will be introduced to basic principles of access to the kidney, and percutaneous Endourologic procedures. By the end of the year, residents will be able to evaluate patients at the time of presentation for possible Endourologic therapies. Residents will demonstrate competency in basic ureteroscopy including stone manipulation. They also will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. Residents will demonstrate competency in ureteroscopic treatment of the ureteropelvic junction and ureteral strictures. They will further their knowledge of percutaneous treatment of stone disease, obstruction, and urothelial neoplasms. They will be able to identify potential postoperative complications and management thereof.

Pediatric Urology. Residents in this second year of urology will again have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. Residents will demonstrate their previously acquired competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain operative experience with increasing participation in some of the more complex cases such as hypospadias, congenital anomalies, and major urinary tract reconstruction. As mentioned previously, Pediatric urology is taught over all four years of the urology residency with a gradation of complexity of cases as the resident's knowledge and skills grow.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Endourology/minimally invasive surgery. Residents will advance their basic cystoscopic Endourologic procedures and further their exposure to ureteroscopy. They will learn basic principles of Urologic laparoscopic surgery. They will be introduced to basic principles of access to the kidney, and percutaneous Endourologic procedures. They will learn to counsel patients and families. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs advanced Endourological surgery. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

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PGY-4 YEAR – 12 months

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Pediatric Urology. Residents will demonstrate competency in surgical management of common Pediatric Urologic surgical problems such as vesicoureteral reflux and cryptorchidism. Residents will obtain surgical skills in treatment of complex Pediatric problems such as hypospadias, congenital anomalies, and major urinary tract

reconstruction. They will learn to counsel patients and families. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the Pediatric Urologic patient. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Pediatric Urology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with children, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records, and work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4: Female Urology/Neurourology.

The goals of this experience are to expand the knowledge of the preoperative evaluation of incontinence and Neurourology. Residents will develop surgical skills in management of female Urologic problems and incontinence. Residents will learn about postoperative management and long-term care of patients with female Urologic incontinence and Neurourologic problems. They will develop a knowledge base of management of patients with neurogenic bladders resulting from a spinal cord injury. By the end of this experience, residents will be able to evaluate patients at the time of presentation to the Clinic with an emphasis on history taking, examination, and evaluation of women with Urologic diseases, including incontinence, pelvic-floor strengthening exercises, endometriosis, interstitial cystitis, neurogenic problems, recurrent UTIs, management of urethral diverticuli and fistulas, pelvic pain, estrogen-replacement therapy, osteoporosis, and urodynamics. Residents will demonstrate competency in the surgical treatment of female incontinence. Residents will be able to follow patients in the Outpatient Clinics and postoperatively after treatment for the above-mentioned conditions. Residents will be able to evaluate spinal-cord injured patients and initiate management. Residents will be able to evaluate and manage Urologic aspects of patients with longstanding lower urinary tract dysfunction secondary to spinal-cord injury.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of female Urology/Neurourology. Residents will demonstrate competency in the surgical treatment of female incontinence. Residents will be able to follow patients in the Outpatient Clinics and postoperatively after treatment for the above-mentioned conditions. Residents will be able to evaluate spinal-cord injured patients and initiate management. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for various causes of incontinence. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in female Urology/Neurourology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues

PGY-4: Advanced Endourology/Minimally Invasive Surgery/Introduction to Robotics. Residents will further their experience in this area. Introductory skills in robotic urology are taught. They will continue to learn principles of access to the kidney, and percutaneous Endourologic procedures. By the end of this year, they will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. Residents will demonstrate competency in ureteroscopic treatment of the ureteropelvic junction and ureteral strictures. They will further their knowledge of percutaneous treatment of stone disease, obstruction, and urothelial neoplasms.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of advanced Endourology/minimally

invasive surgery. They will continue to learn principles of Urologic laparoscopic surgery. They will continue to learn principles of access to the kidney, and percutaneous endourologic procedures. They will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examination, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs advanced Endourology/minimally invasive surgery. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4: Introduction to Urologic Oncology with Introduction to Robotics. Residents will gain knowledge in the pre- and postoperative care, intraoperative technical skills, with an emphasis on Urologic Oncology patients. Introductory skills in robotics are taught to the resident. By the end of this experience, residents will have basic knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate familiarity with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Urologic Oncology with robotic

skill teaching as indicated. Residents will have basic knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will demonstrate familiarity with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for Urologic cancer. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Urologic Oncology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

Pediatric Urology. Residents in this third year of urology will again have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. However, their proficiency with these basic skills is expected to be at a sufficiently high level. Residents will further demonstrate their previously acquired competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain more significant operative experience with increasing levels of participation in hypospadias, congenital anomalies, and major urinary tract reconstruction. Advanced cases in Pediatric Urology Robotics are taught in this academic year.

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PGY-5 YEAR – 12 months

PGY-5: Advanced Urologic Oncology with additional instruction in Robotic Urology. Residents will gain knowledge in pre- and postoperative care, intraoperative technical skills with an emphasis on Urologic Oncology patients. Further knowledge and skills are taught in robotic urology. By the end of this experience, residents will have advanced knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase their knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate surgical competency with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection.

Pediatric Urology. Residents in this fourth year of urology will supervise and teach junior residents in the evaluation and treatment of common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. However, their proficiency with these basic skills is expected to be at a sufficiently high level. Residents will generally participate in advanced pediatric urologic procedures including reconstruction, oncology, laparoscopy and robotics.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Urologic Oncology. Residents will have advanced knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Robotic techniques are taught to residents for the abovementioned procedures as indicated. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase their knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate surgical competency with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph- node dissection. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for Urologic cancer. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Urologic Oncology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with: clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with: clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, including continuity

of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

Interruption of Patient Care

To assure continuity of care and patient safety, ACGME requires a minimum number of patient care transitions and readily available schedules listing residents and attending physicians responsible for each patient's care. In addition to resident-to-resident patient transitions, residents must care for patients in an environment that maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting.

https://medicine.hsc.wvu.edu/media/2575/residentprofessionalismstandardforinterruptionofpatientcare2011revised11-11-11.pdf

West Virginia University School of Medicine GME International Rotation Policy

In order for a resident physician enrolled in any graduate medical education training program sponsored by the West Virginia University School of Medicine to obtain permission to complete an International Health Rotation for academic credit, this approval process must be followed:

https://medicine.hsc.wvu.edu/media/2588/internationalrotationpolicy7-2014.pdf

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Policies & Procedures

The Department of Urology will comply with the following Policies and Procedures derived from the West Virginia University School of Medicine Graduate Medical Education (GME) Office by-laws and the West Virginia University Hospital.

GME Resident Physician Manual available online:
https://medicine.hsc.wvu.edu/media/2569/2016residentphysicianmanual.pdf

Resident Selection

Purpose

To establish a policy that ensures a fair and non-discriminatory process for the selection of residents into the Residency Training Programs.

Criteria for Selection of Candidates

The primary source of candidates for entry into graduate medical education programs will be graduates of Liaison Committee for Medical Education (LCME)-accredited medical schools. Candidates will be evaluated on the basis of their academic credentials, preparedness, aptitude, communication skills, letters of reference and recommendation, by national qualifying examinations when available, and by personal interview if possible. It is strongly suggested that all programs participate in an organized matching program. (http://medicine.hsc.wvu.edu/media/2577/criteria-for-selection-of-candidates-5-2008-nl.pdf)

Residents must be:

1) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME); or
2) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or
3) Graduates of medical schools outside the United States who have received a currently valid certificate from the Education Commission for Foreign Medical Graduates or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction; or
4) Graduates of medical schools outside the United States who have completed a Fifth Pathway Program by an LCME-accredited medical school. [A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who
   a.) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school;
   b.) have studied at a medical school outside the United States and Canada but listed in the World Health Directory of Medical schools;
   c.) have completed all of the formal requirements of the International medical school except internship and/or social service;
   d.) have attained a score satisfactory to the sponsoring medical school on a screening examination; and

e.) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

5) WVU only accepts J-I Visa Status for Resident Physician positions. Exceptions to this would require approval from the DIO and the GME Taskforce.

6) DO's participating in residency programs at WVUH are required to be licensed by the State of West Virginia prior to beginning their allopathic PGY1 year.

Recruitment

The Department of Surgery programs will sponsor activities such as student interest groups, continuing education conferences and receptions for students at the Schools of Medicine in West Virginia. They will maintain web pages that will provide basic information and recruitment information for students outside West Virginia.

Application Process

- All applications are accepted through ERAS. Applicants must apply through ERAS with their application.

- All applications must contain the following:
    - Application with ERAS
    - Three letters of reference
    - Personal Statement
    - USMLE Scores
    - Dean's letter
    - Transcripts
    - CV
    - Valid ECFMG for international graduates
    - Visa Status

- Completed application will be reviewed by the program director. The program director, or designee, will evaluate and select the candidates he/she believes to be the most qualified for the positions available within the training program.

Interview

- The program director will select candidates to be offered an interview. The candidates will be notified by ERAS email that they have been invited for an interview.

- All candidates invited for interview will be sent a packet including the following:

    - Salary information
    - Benefits information
    - Information about the area
    - Lodging information
    - Morgantown pamphlets

- All candidates will interview with the program director, two or three members of the Education Committee and the chief resident or his/ her designee.

- Candidates will be evaluated on:
    - Contents of the application materials (Dean's Letter, Personal Statement, Transcripts, USMLE scores, Letters of Reference)
    - Overall interview

- Interviews will be conducted in November and December.

Requirements

The Department of Urology has the following criteria's for residency selection.

- The residents for Urology will enter under the General Surgery Program at the PGY 1 level.
- The Urology applicants must have completed the clinical General Surgery year at WVU prior to beginning their training under the Urology Department at the PGY II level.
- The applicant for Urology is selected through the American Urological Association (AUA) match.
- A candidate will not be ranked on the match lists for either program unless he/she has had a formal interview.

Conditions of Employment

Three to four months before the resident is ready to begin, training, requests for contracts shall be prepared and forwarded to the Graduate Medical Education (GME) Office for preparation. Before training begins the resident should submit the following information to the program coordinator:

- Copy of medical school diploma
- A copy of an up to date certificate of BLS, ACLS and ATLS training
- Copy of social security card
- Immunization records
    - Hepatitis B
    - Tetanus
    - MMR 1 and 2
    - History of Varicella (chicken pox) or immunization series
    - TB skin testing within the last 12 months
    - Serological testing for Hepatitis B
    - MMR and Varicella for positive antibody levels is required
- Must receive RADNET training
- Must attend a benefits session
- Must attend new resident orientation (both Hospital and Department)

West Virginia University is an equal opportunity/affirmative action institution and will not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran status.

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Supervision of Residents

Purpose

To establish a policy to ensure all residents are provided increasing amounts of supervision. https://medicine.hsc.wvu.edu/media/2572/supervision-policy-nl.pdf

Responsibilities/Requirements

- A urology faculty is always assigned to supervise the residents. A printed and/or emailed call schedule is sent out monthly to residents, faculty, and the hospital paging office. Faculty are notified with change in condition of patients following evaluation by the resident. Faculty are notified of elective admissions as soon as possible. When the residents are called for emergency department admissions and consults, the attending faculty are notified immediately following the residents evaluation.

- In the event of unforeseen circumstances, such as illness, the resident will be informed by the program director who the supervising urology faculty will be.

- All clinical work is done under the supervision of attending faculty. While the degree of supervision in any given examination will vary with the particulars of the examination as well as the level of training of the resident, the ultimate responsibility for the written report created is that of the attending surgeon.

- All faculty are available during the day and when on call via telephone and/or beeper.

- In all cases, the ultimate responsibility rests with the attending physician who supervises all resident activities.

Lines of Responsibility for Resident Supervision:

- Outpatients – All residents will see patients in the outpatient setting. Every patient seen as an outpatient has a designated staff member responsible for all care provided in their respective clinic. Direct communication with the attending staff occurs prior to any procedure undertaken in the outpatient setting. Faculty are present in the clinic procedure room when a procedure is performed. All residents will discuss cases with the supervising attending staff.

- Inpatients – All residents participate in the care of inpatients. The junior residents have the primary responsibility for taking calls from the wards and entering orders in the EMR for patients on the Urology service. Junior residents are expected to see consultations and inform senior residents and/or attending staff for any question that may arise, or when any significant change in patient's status occurs. Each inpatient has an attending staff member who is responsible for all care provided. Attending staff will round on all inpatients either in person or through communication with the resident staff at least once per day.

- Consultation/Emergency Department – All residents participate in the care of emergency department patients and consultations from other services. The junior resident will usually see the patients first and then discuss the findings and plans with the more senior resident team members. Usually, the resident on-call will see the patient first. Each patient seen in consultation will either be seen by, or discussed with, one of the attending staff, typically the urology faculty member on call.

- Operating Room – All residents participate in the care of patients in the operating room. A graded experience is provided to allow residents to assume a greater role as their operative skills develop. The chief resident will determine the assignment to residents to operative case based on staffing needs to match the complexity with level of training. Each operative procedure is covered by one of the attending staff, and that staff member is present for the key portions of the procedure.

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Resident Evaluation

Purpose

To establish a policy for the evaluation and structural feedback that will enhance the residency training programs and institute quality improvement mechanisms.

Responsibilities/Requirements

A. Evaluation of Residents

Formal evaluation will be based on the following criteria:

- Evaluation forms
- Input from faculty
- In-service and end year examinations
- Professionalism
- Attendance and participation in conference
- Evaluations will be completed for each resident semi-annually.
- Any negative evaluations will be brought to the resident's attention and measures to correct the problem will be addressed.
- The program director will evaluate each resident a minimum of twice a year for a formal evaluation of his/her progress.
- All formal evaluations are kept as part of the resident's personnel file.
- The program director is always available for discussion and the residents are strongly encouraged to seek guidance for any perceived difficulty or problem.
- Residents may have access to their academic files at any time. The file can be obtained from the residency program coordinator but is not to leave that office.
- At the conclusion of each resident's training, a formal written final evaluation summarizing their years of training will be completed by the program director and maintained in the resident's permanent file.
- Faculty evaluations of the resident will be kept in the resident's permanent file.
- Evaluations will be one of the tools utilized in determining promotion to the next level of training.

B. Evaluation of Faculty by Residents

- Faculty evaluations will be completed by each resident at least annually through the E-Value program.
- These evaluations will be anonymous and confidential which will assure each resident is free to comment frankly and openly without fear or intimidation or retaliation.
- A final report, of the Urology faculty will be compiled together of the resident's faculty evaluations and will be submitted to the GME Office for the DIO review. If any derogatory comments or complaints are noted, the DIO will consult with the Department Chair and Program Director.

C. Program Evaluation

- Program evaluations will be completed by each resident annually through the E-Value program.
- The program evaluation will be anonymous and confidential which will assure each resident is free to comment frankly and openly without fear of intimidation or retaliation.
- A final report will be compiled together of the Urology resident's program evaluation by the ACGME ADS program. It will be submitted to the GME Office for the DIO review. If any derogatory comments or complaints are noted, the DIO will consult with the Department Chair and Program Director.

Feedback Buttons

If you are a resident who has experienced mistreatment; if you have been demeaned for requesting, or been denied, adequate supervision; or if you have witnessed any of these things happening to a resident, please complete the information online and make a report. Help us stop mistreatment and create and promote a safe learning environment.
Mistreatment Form (https://medicine.hsc.wvu.edu/gme/mistreatment-form/)

Physicians in training must be held to a high standard of professionalism in all areas of their lives. These standards are not intuitive, and must be taught and reinforced both by formal education and by constructive formative feedback. If you have witnessed a resident or fellow displaying either a lapse in professionalism or exemplary professionalism, please complete the information online and provide us with the details. Help us to improve our working and learning environment.
Professionalism Form (https://medicine.hsc.wvu.edu/gme/professionalism-form/)

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Resident Promotion

Purpose

To establish a policy for the Residency Training Programs to use in the promotion of residents to the next level of training.

Responsibilities/Requirements

The decision to re-appoint and promote a resident to the next level of post-graduate training shall be done annually by the Clinical Competency Committee upon review of the resident's performance and with input from the program faculty. The final recommendation of the CCC is given to the Program Director who has the final decision in this process.

The resident is expected to make and maintain satisfactory progress in appropriately developing plans, good communication skills, patient management, effectively and competently assuring the role of consultant to a wide variety of referring physicians, and mastery of technical skills for performing required procedures independently (with technologist support).

The CCC shall consider the successful completion of the Urology Milestones commensurate with their level of training as the major factor in the decision to promote a resident to the next level of training. Additional information may be used in this regard including:

- All evaluations of the resident's performance (refer to the Policy for Evaluation of Residents) – by making satisfactory progress in the program as documented by evaluations on a semiannual basis from faculty and making measurable progress in acquiring didactic knowledge.

- Performance on the In-Service and End-Year Examinations.

- Second year residents must pass Step 3 of the USMLE examination in order to advance to the third year of training.

- Any other criteria deemed appropriate by the Program Director.

Any resident pending promotion due to academic performance will be placed on either departmental remediation or probation. In the event that a resident is on departmental remediation or probation at the time of contract renewal, the program director may choose to extend the existing contract for the length of time necessary to complete the remediation process, not to exceed six months, or to promote the resident to the next level of training. If the resident's performance continues to be unsatisfactory, he/she may either be placed on the next level of discipline or terminated.

A resident may request a Fair Hearing in the case of contract extension or non-renewal.

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Resident Academic Discipline and Dismissal

The Department of Surgery developed this disciplinary system, which was derived from the WVU/GME website by-laws at http://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf to ensure residents are competent, professional and ethical within the standards of care. The Department of Urology will follow the WVU School of Medicine GME and ACGME policies.

The Department of Urology may take corrective or disciplinary action including dismissal for cause, including but not limited to:

- Unsatisfactory academic or clinical performance
- Failure to comply with the policies, rules, and regulations of the House Officer Program, University or other facilities where the House Officer is trained
- Revocation or suspension of license
- Violation of federal and/or state laws, regulations, or ordinances
- Acts of moral turpitude
- Insubordination
- Conduct that is detrimental to patient care
- Unprofessional conduct.

Corrective or disciplinary actions may include but not limited to:

- Issue a warning or reprimand
- Impose terms of remediation or a requirement for additional training, consultation or treatment
- Institute, continue, or modify an existing summary suspension of a House Officer's appointment
- Terminate, limit or suspend a House Officer's appointment or privileges
- Non-renewal of a House Officer's appointment
- Dismiss a House Officer from the House Officer Program; or
- Any other action that the House Officer Program deems is appropriate under the circumstances.

A. Level I Intervention:

Oral and/or Written counseling or other Adverse Action:

Minor academic deficiencies that may be corrected at Level I include i) unsatisfactory academic or clinical performance or ii) failure to comply with the policies, rules, and regulations of the House Officer Program or University or other facilities where the House Officer is trained. Corrective action for minor academic deficiencies or disciplinary offenses, which do not warrant probation with remediation as defined in the Level II intervention, shall be determined and administered by each Department. Corrective action may include oral or written counseling or any other action deemed appropriate by the Department under the circumstances. Corrective action for such minor academic deficiencies and/or offenses are not subject to appeal.

B. Level II Intervention:

Probation/Remediation Plan or other Adverse Action:

Serious academic or professional deficiencies may lead to placement of a House Officer on probation. An academic or professionalism deficiency that is not successfully addressed while on probation, may lead to non-reappointment or other disciplinary action. The Program Director shall notify the House Officer in writing that they have been placed on probation and the length of probation. A corrective and/or disciplinary plan will be developed that outlines the terms and duration of probation **and** the deficiencies for which probation was implemented. Failure of the House Officer to comply with the terms of the plan may result in termination or non-renewal of the House Officer's appointment.

C. Level III intervention:

Dismissal and/or Non-reappointment:

Any of the following may be cause for dismissal or non-reappointment including failure to comply or address the deficiencies within the corrective and disciplinary plan as outlined in the Level II intervention:

A. Demonstrated incompetence or dishonesty in the performance of professional duties, including but not limited to research misconduct.
B. Conduct which directly and substantially impairs the individual's fulfillment of institutional responsibilities, including but not limited verified instances of sexual harassment, or of racial, gender-related, or other discriminatory practices.
C. Insubordination by refusal to abide by legitimate reasonable directions of administrators or of the WVU Board of Governors.
D. Physical or mental disability for which no reasonable accommodation can be made, and which makes the resident unable, within a reasonable degree of medical certainty and by reasonably determined medical opinion, to perform assigned duties.
E. Substantial and manifest neglect of duty.
F. Failure to return at the end of a leave of absence.
G. Failure to comply with all policies of WVU Hospitals, Inc.

A House Officer who is dissatisfied with a Level II or Level III intervention, may appeal that decision by following the Academic Grievance Policy and Procedure in Section XI.

http://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf

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Academic Grievance Policy and Procedure

Purpose. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes and complaints which may arise between postgraduate residents and fellows and their Program Director or other faculty member. The Department of Urology developed this Policy, which was derived from the WVU/GME website by-laws at http://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf

Policy. Postgraduate residents or fellows may appeal disagreements, disputes, or conflicts with the decisions and recommendations of their program regarding academic related issues using the procedure outlined in this section. This grievance procedure does not cover issues arising out of (1) termination of a resident/fellow during an annual contract period; (2) alleged discrimination; (3) sexual harassment; (4) salary or benefit issues. These grievances are covered under the employment grievance procedures for employees of West Virginia University as outlined in section XXV of these bylaws.

Definitions

Grievance: any unresolved disagreement, dispute or complaint a resident or fellow has with the academic policies or procedures of the Residency Training Program or any unresolved dispute or complaint with his or her Program Director or other faculty member. These include but are not limited to issues of suspension, probation, retention at current level of training, and refusal to issue a certificate of completion of training.

Procedure

A. Level 1 Resolution

A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within 10 working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence which supports the grievance. Within ten (10) working days after notice of the grievance is received by the Program Director, the resident/fellow and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days after the meeting between the resident/fellow and Program Director. A copy of the Program Director's final decision will be sent to the Department Chair and to the Designated Institutional Official for GME (DIO).

B. Level 2 Resolution

If the Program Director's final written decision is not acceptable to the aggrieved resident/fellow, the resident/fellow may choose to proceed to a Level 2 resolution, which will begin with the aggrieved resident/fellow notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the Program Director's final decision. If the Department Chairman is also functioning as the Program Director, then the Level 2 resolution will be handled by the DIO. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence which supports the grievance. Within ten (10) working days of receipt of the grievance, the resident/fellow and the Department Chairman or DIO will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Level II of this grievance procedure will be deemed complete when the Department Chairman (or DIO) informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days of the

meeting with the resident/fellow and the Chairman. Copies of this decision will be kept on file with the Program Director, in the Chairman's office and sent to the DIO.

C. Level 3 Resolution

If the resident/fellow disagrees with the Department Chairman's final decision, he or she may pursue a Level 3 resolution of the grievance. The aggrieved resident/fellow must initiate this process by presenting their grievance, in writing, along with copies of the final written decisions from the Program Director and Department Chairman, and any other pertinent information, to the office of the Graduate Medical Education within 5 working days of receipt of the Department Chairman's final written decision. Failure to submit the grievance in the 5 working day time frame will result in the resident/fellow waiving his or her right to proceed further with this procedure. In this situation, the decision at Level II will be final. Upon timely receipt of the written grievance, the DIO will appoint a Grievance Committee and will contact the aggrieved resident/fellow to set a mutually convenient time to meet with them. The Grievance Committee will review and carefully consider all material presented by the resident/fellow and his or her Program Director or the aggrieved party at the scheduled meeting, following the protocol outlined in Section E. The Grievance Committee will provide the aggrieved resident/fellow with a written decision within five working days of the meeting and a copy will be placed on file in the Office of Graduate Medical Education, and with the Program Director and Department Chair.
The decision of the Grievance Committee will be final.

D. The Grievance Committee

Upon request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents, and three Program Directors. No members of this committee will be from the aggrieved resident's/fellow's own department. The DIO will choose a faculty member appointed to the Grievance Committee to be the chair of the committee. The Grievance Committee hearing should occur within 20 working days from receipt of the Level III grievance.

E. Grievance Committee Procedure

1. Attendance: All committee members should be present throughout the hearing. The aggrieved resident/fellow must personally appear at the Grievance Committee meeting.

2. Conduct of Hearing: The chair will preside over the hearing, determine procedure, assure there is reasonable opportunity to present relevant oral or written information, and maintain decorum. The Chair will determine if information is relevant to the hearing and should be presented or excluded. The aggrieved Resident may present any relevant information or testimony from any colleague or faculty member. The Resident is NOT entitled to legal representation during the grievance committee hearing. The Program Director and Department Chair may be requested by the Committee to also be present for oral testimony. The committee chair is authorized to exclude or remove any person who is determined to be disruptive.

3. Recesses and Adjournment: The committee chair may recess and reconvene the hearing by invoking the right for executive session. Upon conclusion of the presentation of oral and written information, the hearing record is closed. The Grievance Committee will deliberate in executive session outside the presence of the involved parties.

4. Decisions: Decisions are to be determined by vote of a majority of members of the Committee and are final. After deliberation, the Chair will prepare a written decision to be reviewed and signed by all of the Committee members. The aggrieved resident/ fellow should be notified within 5 working days of the hearing.

5. Meeting Record: A secretary/transcriptionist may be present for the purpose of recording the meeting minutes. Minutes and the final written decision of the Committee will be placed on file in the Office GME, and by the Department in the resident or fellow's academic file.

F. Confidentiality

All participants in the grievance are expected to maintain confidentiality of the grievance process by not discussing the matter under review with any third party except as may be required for purposes of the grievance procedures.

Conditions for Reappointment:

1. Promotion: Decisions regarding resident promotion are based on criteria listed above, and whether resident has met all departmental requirements. The USMLE is to be used as a measure of proficiency. Passage of the USMLE, step 3 is a requirement for advancement for the 3rd year of residency as indicated in Section VII. Resident Doctor Licensure Requirement.

2. Intent Not to Renew Contract: In the event that WVU School of Medicine elects not to reappoint a resident to the program and the agreement is not renewed, WVU shall provide the resident with a four (4) month advance written notice of its determination of non-reappointment unless the termination is "for cause."

Employment Grievance Procedure for Non-Academic Issues

Resident is encouraged to seek resolution of non-academic employment-related grievances relating to Resident's appointment or responsibilities, including any differences between Resident and WVUH, or WVU School of Medicine with respect to the interpretation of, application of, or compliance with the provision of the agreement, in accordance with the grievance procedures set forth on the WVU website. Forms and procedures are available from the Human Resources Department.
http://grievanceprocedure.wvu.edu/

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Policy for Appropriate Use of the Internet, Electronic Networking and Other Media

Social and business networking Web sites or on-line communities are being used increasingly by faculty, students, residents and staff to communicate with each other, and to post events and profiles to reach external audiences. Resident physicians are expected to act with honesty, integrity, and respect for the rights, privileges, privacy, sensibilities, and property of others.

Resident physicians will be required to review annually the Health Sciences Center Information Technology Security Awareness Training which includes but is not limited to the appropriate usage of information technology resources and various forms of electronic media

Please review the entire policy at
https://medicine.hsc.wvu.edu/media/2590/guidelines-for-appropriate-use-of-internet.pdf .

Resident USMLE/License Policy

Purpose: The Department of Urology will follow the WVU School of Medicine, Graduate Medical Education by-laws which can be found at the WVU/GME website by-laws at https://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf

Responsibilities/Requirements:

Effective July 1, 2005, all new incoming residents (graduates of US, Canadian and International medical schools) are required to take and pass Step 3 before the end of their second year to be eligible to advance to the third year. It is the policy at the Robert C. Byrd Health Sciences Center that all residents obtain a West Virginia Medical License as soon as they are eligible to do so under state law. This means that graduates of US and Canadian medical schools, eligible for licensure after one year of postgraduate education are required to take, and pass, Part 3 of the USMLE by the end of their second year. These residents will not be advanced to the third year unless they have passed the USMLE and have applied for West Virginia licensure. Graduates of medical schools outside the US and Canada (IMGs) are also required to take, and pass Part 3 of the USMLE by the end of their second year. They will not be advanced to the third year unless they have done so. For graduates of osteopathic schools of medicine, a license must be obtained from the Osteopathic Board of Medicine for all training beyond the AOA approved internship.

Information can be obtained regarding licensure from the following:

Doctors of Medicine:
West Virginia Board of Medicine
101 Dee Drive
Charleston, WV 25311
(304) 348-2921 or (304) 558-2921

Doctors of Osteopathy:
State of West Virginia
Board of Osteopathy
334 Penco Road
Weirton, WV 26062
(304) 723-4638

WV State Board of Licensing Eligibility Requirements

Attempt Limit: Unlimited.

Time Limit: Must complete USMLE Steps 1, 2, & 3 within SEVEN (7) years of the first sitting; exceptions for MD/PhDs require board approval.

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Resident Fatigue

Purpose

To establish a policy for the Residency Training Programs concerning resident Fatigue.

Responsibilities/Requirements

The Residency Program Director and Faculty will monitor each resident carefully for signs of fatigue. Faculty will question residents periodically on their level of fatigue. The Program Director also monitors fatigue as it relates to on-call duty hours. If hours on-call appear to be excessive as reported in E-Value submitted by the residents, a discussion will be held with that resident regarding the reasons for the long hours covered. Questions regarding their level of fatigue also will be discussed.

If a resident is known to be exhibiting signs of fatigue or the resident mentions to Faculty or the Program Director that they are fatigued, he/she will be relieved immediately of their responsibilities and sent to rest. If the Program Director does not believe the resident is safe to drive home, they will be asked to rest in the hospital on-call room. They will be checked on to determine how they feel and then sent home for further rest.

Residents also receive articles regarding sleep deprivation. In addition, an annual lecture and video on sleep deprivation is provided for residents.

https://medicine.hsc.wvu.edu/media/2597/alertnessmanagementpolicy1-15-16.pdf

https://sole.hsc.wvu.edu/Site/1296

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Sick Leave, Maternity Leave, and Vacation/Meeting Policy

The resident/fellow leave guidelines of the West Virginia University School of Medicine exist to ensure the safety and general welfare of the residents/fellows and the effectiveness of the training programs. The guidelines are in accordance with the guidelines of West Virginia University, West Virginia University School of Medicine, ACGME, the regulatory and/or accrediting agencies, and the Residency Committee and are approved by the Resident/Fellowship Program Director, the Chair, and the Graduate Medical Education Committee.

The Program Director and the Competency Committee will review resident/fellow leave time to assure that Residency Review Committee requirements are met. Due to the potential for stress and fatigue during residency training, it is expected that residents/fellows will take advantage of whatever amount of annual leave you are able to take each year in accordance with this policy without consequence to your studies. If not requested, annual leave may be assigned at the discretion of the Program Director.

However, use of leave may impact on a resident's/fellow's ability to complete program requirements. Therefore, a resident/fellow who takes all the allowable annual and sick leave may not be able to complete the program requirements in the allotted training time and/or may not be eligible to take the required and/or applicable board examinations at the conclusion of the training period without additional training time. The Department is not responsible for providing additional training time and, in fact, may not be able to do so without requesting permission from ACGME, which permission may or may not be granted. The grant of permission by ACGME is beyond the control of WVUSOM.

In addition to WVU leave policies, the ACGME and the applicable board may have requirements that must be followed in order to obtain your certificate and sit for your boards. Additional training as a resident may be required. The Urology Board has the following requirements with regard to required training time: A minimum of 48 months of clinical urology education is required. Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. The clinical and academic experience as a chief resident should prepare the resident for an independent practice of urology. As such, this Chief Resident experience should include management of patients with complex urologic disease, advanced procedures, and, with appropriate supervision, a high level of responsibility and independence.

ANNUAL LEAVE

Full time residents/fellows will accrue two (2) days of annual leave per month. A day in the leave system is equal to 7.5 hours. **While, as a resident, you are entitled to use, and may request the use of, the entirety of your annual leave, the Urology program recommends that its residents/fellows request no more than 15 days of annual leave per year to ensure that program requirements are met.** PGY 1 residents are scheduled 2 weeks' vacation time during their residency and PGY 2-5 are granted 3 weeks' vacation time per year during their residency. Annual leave must be accrued prior to using it. Annual leave time caps at 24 accrued days which will appear in the leave system as 180 hours. Once you accrue 24 days, you will stop accruing annual leave. Unused accrued annual leave time carries over from year to year, and at the end of your residency or fellowship, beginning from the day following your last day worked, any unused time, up to the maximum allowable accumulation of 24 days (180 hours), will either be paid to you in a lump sum or you may choose to remain on the payroll until your leave is exhausted if you are leaving the institution, or, if you are staying on for fellowship training or as faculty, unused accrued leave will transfer over to your new position or to another qualifying state agency.

Annual leave will be granted on a "first come, first served" basis and is determined by the total number of Department providers present during the time period requested. All annual leave must be approved, in advance, by your Program Director and reported to the Residency Program Manager, as well as the Chief

Resident/Fellow and Service Chief. Program Directors have the right to deny annual leave at the requested time. The amount of time that can be missed on any one rotation is limited by the educational goals of the rotation. Only 1 week of annual leave may be taken on single month rotations, and only 2 weeks of annual leave may be taken on 2-month rotations. No more than 2 days of annual leave time may be taken during a 2 week rotation. Additional weeks may be taken on multi-month rotations, however no block of time greater than 2 weeks may be granted, and only one week of annual leave time may be used in any one calendar month. Extended annual leave or combining annual leave with meetings is discouraged due to prolonged absence from the program. Such requests require special approval from the Program Director and must fall within the requirements of the ACGME and the applicable Board.

A resident does not have the option of reducing the time required for the residency by forgoing annual leave.

In the Urology program, annual leave time may not be used during the following rotations or dates which are considered "blackout" periods:

- To prevent a surplus of vacation days toward the end of the academic year, five days of vacation must be taken every four months; however, no leave will be taken in June or July unless there are extenuating circumstances and the leave is approved by the residency program director. The chief resident will be allowed to use remaining vacation days (NOT sick leave) in June to allow for "early" graduation with prior approval from the residency program director. Resident vacations must not overlap. The below Resident – Training Day Out request form **must be completed and signed** prior to taking vacation.

- If the resident will require air travel during vacation, it is expected that the resident will return 2 days prior to returning to clinical duties to help prevent problems that may occur due to delays with air travel.

SICK LEAVE

Full time residents/fellows will accrue 1.5 sick days per month. Sick leave must be accrued prior to using it. Sick leave may be used by an employee who is ill or injured, when a member of the immediate family is seriously ill, or when a death occurs in the immediate family. Immediate family is defined as: father, mother, son, daughter, brother, sister, husband or wife, mother-in-law, father-in-law, son-in-law, daughter-in-law, grandmother, grandfather, granddaughter, grandson, stepmother, stepfather, stepchildren, or others considered to be members of the household and living under the same roof.

If you are sick and need to "call-in" to take a sick day you must do 3 things:

1) Contact the program director,

2) Contact the chief resident,

3) Contact or leave a voice mail message for the Residency Program Manager.

Sick time may be used for:

- Scheduled Dr/Dentist appt for employee

- Non-scheduled appt for employee's child (i.e. called by caretaker or daycare that child is sick and needs medical attention)

- Funeral leave (3 days) for immediate family

- Maternity/Paternity leave

If you have any question regarding whether sick leave can be used, please contact the Residency Program Manager. **Excessive/unexplained absences may affect your competency evaluation and/or your promotion to the next level of training.** Sick leave for more than five (5) consecutive work days cannot be granted to an employee without satisfactory proof of illness or injury as evidenced by a statement of the attending physician or by other proof. An employee who has been absent from work for an extended period because of illness or injury must obtain medical clearance before returning to work. The University may require verification of an illness or other causes for which leave may be granted under this policy regardless of the duration of the leave. A copy of all medical documentation must be sent to the medical management unit.

HOLIDAYS

While the University provides scheduled holidays to its employees as state employees, the requirements of medical coverage do not allow for all these holidays to be taken as scheduled. The Program Director and Residency Program Manager will assist in scheduling and coordination of available holiday time.

If you are on a service where physicians observe a state holiday, you will not be required to work on that holiday. As professionals, you are exempt from overtime or compensatory time, therefore, if a service requires you to work on a state holiday, you will not be compensated additional amounts for that worked holiday.

However, residents/fellows who work on State-defined Holidays (for example, Thanksgiving Day or a service where physicians do not observe a state holiday) may be granted an equivalent number of alternate days to be taken at a time mutually agreed upon by the resident/fellow, the Residency Program Manager, and the Program Director. No grant of an equivalent number of days is required of or owed by WVUSOM.

CONTINUING MEDICAL EDUCATION LEAVE

All CME conferences a resident/fellow wishes to attend must be approved, in advance, by the Program Director and reported to the Residency Program Manager, as well as the Chief Resident and Service Chief. Attendance at CME conferences counts toward duty hours during the actual conference time. As a result, annual leave does not need to be used for CME attendance. One day of travel time, if necessary, will be granted before and after the conference without the use of annual leave.

The following forms **must be completed** by the resident and authorized by the appropriate person **prior** to arranging reservations (flight, hotel, and meetings). If the following forms are not completed, then you will not receive re-imbursement for the trip, hotel or meeting. Prior Planning Prevents Poor Performance, so plan accordingly and ahead of time. Contact the residency program manager for a copy of these forms.

1. **Resident – Training Day Off Request Form**:

Residents requesting travel must ensure all lines are completed on the request form before submission.

Residents presenting a paper/abstract or poster, ensure a copy of the presentation is attached with your vacation and meeting request form.

2. **Request for Authorization to Travel**:

Resident should ensure all lines are filled out.

Residents traveling by automobile to a meeting location can estimate **$0.54** per mile.

Residents can estimate **$30.00** per day for food.

Hotel and registration costs can be obtained off the registration forms. Copies of the meeting and hotel registration forms need to be included with your request.

Interviews

Residents will be granted a total of 5 days off of work during the entire duration of the residency for completing fellowship and/or job interviews. The resident must complete the Resident – Training Day Off request form 2 weeks prior to departing for Program Director approval. If a resident requires more than 5 days off work, they must utilize their Vacation time for completing job interviews. Residents cannot utilize sick time for interviews.

LEAVES OF ABSENCE

A Leave of Absence (LOA), including Family Medical or Military leave, may be requested by a resident/fellow after all applicable leave time has been exhausted. The University policies regarding LOA, WVU BOG 24 regarding leave and the University Human Resources Department provide guidance regarding the procedures and forms that must be completed.

Generally, LOA will be granted based on the need to attend to personal matters such as perinatal care or serious illness. No academic credit may be provided for non-annual leave. Additional months will be added to the training duration if possible, but residents/fellows are advised that LOA may impact a resident's/fellow's ability to complete program requirements. Therefore, a resident/fellow who takes a LOA may not be able to complete the program requirements in the allotted training time and/or may not be eligible to take the required and/or applicable board examinations at the conclusion of the training period without additional training time. The Department is not responsible for providing additional training time and, in fact, may not be able to do so without requesting permission from ACGME, which permission may or may not be granted. The grant of permission by ACGME is beyond the control of WVUSOM. A maximum of 6 months of LOA may be honored before a resident/fellow may be required to reapply to and be reaccepted into the program.

University policy and applicable laws control compensation and duration of leaves for pregnancy, illness, military, or injury. Educational requirements of the residency must be met irrespective of leave. Such leaves may result in the extension of time necessary to complete the residency/fellowship. The Program will make every attempt to meet individual needs created by pregnancy or illness, and LOA will be considered and provided in accordance with University policy and applicable law, but the Program cannot control the potential inability of a resident/fellow to complete the required training if a LOA is taken.

PROCEDURE FOR REQUESTING LEAVE

The Urology Program requires that annual leave requests be submitted in writing for approval 60 days in advance of the requested time off. *AN ANNUAL LEAVE REQUEST FORM MUST BE COMPLETED AND SUBMITTED FOR APPROVAL***.** After all required signatures are obtained, the leave request form must be provided to your designated leave coordinator for entry into the MyAccess system. If prior written approval is not sought for annual leave, disciplinary action may result, and a letter will be placed in your personnel file. Annual leave requests without the required advance notice may not be approved.

Coverage for call schedules, patient care, and other obligations must be adequately arranged for by the resident ***and*** communicated.

See Annual Leave Request Form attached as Exhibit A.

GRIEVANCE, WITNESS, AND JURY LEAVE

Employees who are subpoenaed, commanded to serve as jurors, or required to appear as witnesses or representatives for review proceedings of the Federal Government, the State of West Virginia, or a political subdepartment thereof, or in defense of the University shall be entitled to work release time for such duty and for such period of required absence which overlaps regularly scheduled work time. Employees are entitled to leave with pay for the required period of absence during the regularly scheduled work time including reasonable travel time. For additional information, refer to the WVU Department of Human Resources Policies and Procedures.

When attendance in court is in connection with official duties, time required, including reasonable travel time, shall not be considered as absence from duty.

Return to TOC

Department of Surgery
School of Medicine
P.O. Box 9238, HSC, Morgantown, WV 26506-9238

RESIDENT TRAINING DAY OUT REQUEST

RESIDENT: _____

(Check One):

- ☐ **VACATION**
- ☐ **SICK OR MEDICAL LEAVE**
- ☐ **MEETING (Symposiums, Presentations, Poster, Abstract)**
- ☐ **INTERVIEWS**
- ☐ **OFF SITE ROTATION**

TRAINING DATES OUT: _____

LOCATION: _____

_____

TITLE of (Abstract, Paper or Poster): _____

_____

Sponsoring Faculty Member(s): _____

_____
Chief Faculty Member Signature of Service

_____ _____
Chief Resident of Service Signature **Program Director's Signature**

Please return completed form to:

Eleni Spirou
Residency Program Manager
Department of Surgery
P.O. Box 9183

or

Linda Shaffer
Department Manager &
Residency Program Manager
P.O. Box 9238

Please provide a copy of your abstract, paper, presentation, or meeting brochure, registration and hotel reservation with this form.

REQUEST FOR AUTHORIZATION TO TRAVEL

DEPARTMENT OF SURGERY

DATE: _____

APPLICANT: _____

REQUISITIONER: _____

DESTINATION: _____

PURPOSE (Attach brochure or meeting announcement): _____

_____

_____

DATES OF MEETING/OFFICIAL BUSINESS:

FROM _____ TO _____

DATES OF ABSENCE FROM WORK INCLUDING TRAVEL AND VACATION:

FROM _____ TO _____

ESTIMATED COST:

	(Brief Description:)	
TRANSPORTATION		
AIR	_____	_____
AUTO MILEAGE	_____	_____
OTHER	_____	_____
REGISTRATION FEE	_____	_____
HOTEL	_____	_____
MEALS	_____	_____
OTHER (Specify)	_____	_____
OTHER (Specify)	_____	_____
PRESENTATION MATERIALS	_____	_____
TOTAL ESTIMATE		_____

APPROVAL GRANTED: _____

Dept of Surgery Administration

JC9502

Return to TOC

Transferring Resident

The Department of Urology developed this disciplinary system, which was derived from the WVU/GME website by-laws at http://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf.

To maintain professional relationships, policies, and program stability for residents and program directors, the following procedure must be followed when a resident wishes to transfer between training programs:

It is inappropriate for a Program Director to initiate recruitment with a resident currently in a training program at WVU or elsewhere and discuss specific positions or arrangements with the resident without first receiving written or verbal notification from the current Program Director. It is inappropriate for a resident to seriously pursue a transfer to a training program within WVU or elsewhere without first discussing his/her plans with the current Program Director.

A. There are three types of transfers possible:

1. Transferring from one training program in the WVU SOM to another training program in the WVU SOM:

   a) The resident may request to meet with the Program Director or his/her designee of the receiving program to discuss general information about the training program and careers in that specialty. No information about specific positions should be discussed. The Program Director of the receiving program may refuse to meet with the resident prior to receiving a release from the current Program Director. After this initial general discussion, it is unethical for the resident to pursue a transfer without first discussing the plans with his/her current Program Director. If a resident persists in contacting the Program Director of the receiving program, this Program Director must notify the current Program Director of these activities.

   b) After the initial general discussion between the resident and the Program Director of the receiving program, if a resident wishes to seriously pursue a transfer, the resident must discuss the possibility of leaving the current training program with the current Program Director. In some cases, this discussion might reveal problems or concerns of the resident that can be solved by the Program Director that may prevent the resident's desire to transfer. If the resident decides to seriously pursue the transfer, the resident must obtain written notification from the current Program Director to pursue the transfer.

   c) When the Program Director of the receiving program receives the written or verbal notification for the resident to pursue the transfer, then the Program Director of the receiving program can freely talk with the resident regarding specific position opening within the program.

   d) As much as possible, transfers should be decided before January 1 of the year prior to the transfer, which usually occurs in July or at the end of the current appointment period, so that the current Program Director can interview, recruit and match a resident to fill the vacated position.

2. Transferring from a training program in the WVU School of Medicine to a training program outside the WVU School of Medicine:

   a) When a resident wishes to pursue a transfer to a training program outside of WVUSOM, the resident must discuss the possibility of leaving the current training program with his/her current Program Director. In some cases, this discussion might reveal problems or concerns of the resident that can be solved by the Program Director that may obviate the resident's desire

to transfer. The Program Director may also advise on career planning and/or assist with the transfer. If the resident decides to seriously pursue the transfer, the resident must obtain written notification from the current Program Director to pursue the transfer.

b) It is advisable to obtain a written consent from the transferring House officer which would allow the WVU Program Director to disclose any and all information about the transferring House officer's file to the receiving Program Director, should the receiving Program Director contact WVU for information about the House officer's academic and professional performance.

c) As much as possible, transfers should be decided before January 1 of the year prior to the transfer, which usually occurs in July or at the end of the current appointment period, so that the current Program Director can interview, recruit and match a resident to fill the vacated position.

3. Transferring from a training program outside of WVU SOM:

a) When a resident from a training program outside of the WVU SOM wishes to pursue a transfer to a training program in the WVU SOM, the resident must provide the WVU SOM Program Director with a written or verbal release from the current Program Director for the resident to pursue the transfer. WVU SOM Program Directors shall contact the current Program Director to discuss the academic status of the resident prior to seriously considering the applicant and prior to inviting the resident for an interview.

To determine the appropriate level of education for a resident who is transferring from another residency program the program director must receive written verification of the previous educational experience and a statement regarding the performance evaluation of the transferring resident, including an assessment of competencies in the six areas prior to acceptance into the program. A program director is required to provide verification of residency education for any residents who may leave the program prior to completion of their education.

Return to TOC

Resident Moonlighting

Purpose

This policy is to set the standards for the Department of Surgery residents concerning moonlighting. To ensure that professional activities falling outside the course and scope of the training program are consistent with policies and guidelines set forth by the Accrediting Council for Graduate Medical Education (ACGME) and Graduate Medical Education Committee. Moonlighting is defined as any professional activity not considered an integral part or required rotation of the curriculum for a postgraduate training program, irrespective of remuneration.

Responsibilities/Requirements

The residents in the Department of Urology will not be permitted to moonlight due to the numerous requirements already assigned to them as a resident for patient care through the Physician Office Center and the hospital.

Return to TOC

Resident Duty Hours

The Department of Urology developed this disciplinary system, which was derived from the WVU/GME website by-laws at http://medicine.hsc.wvu.edu/media/2598/gmebylawsrevised1-15-16.pdf.

The primary responsibility for the development of a Duty Hours and On Call Schedule plan resides with the program director and faculty of the Urology program. The Urology program was developed in accordance with the requirements of the American Board of Urology and the Accreditation Council for Graduate Medical Education, and will focus on Urology specific factors, and to the Robert C. Byrd Health Sciences Center and the School of Medicine, while emphasizing the needs of the patient and the education needs of the resident. Duty hours will be entered, by the resident, into the E-Value program each week. Duty hours will be updated by Sunday of each week. The Program Director and Residency Program Manager will monitor the residents' duty hours each Monday and monthly for ACGME, institution and department compliance. On Call schedules will be monitored by the Program Director, Residency Program Manager and the Chief Resident for compliance with the following ACGME requirements:

1. a maximum of 80 hours per week averaged over four weeks;
2. 10 hours off between duties and after call for rest and/or personal activities;
3. 24 hours maximum continuous on–site duty with up to 4 additional hours permitted for patient transfer and other activities to be defined in RRC requirements;
4 no new patients after 24 hours of continuous duty;
5. resident time spent in the hospital during at-home call to be counted toward the 80 hours;
6. program directors and faculty to adopt policies to prevent and counteract effects of fatigue;

Remediation Plan:
Residents who are not in compliance with the weekly duty hour updates will have one or both of the below actions applied until duty hours are updated:

1. Meal card suspended and/or
2. Removed from clinic or the operating room

Copies of this plan will:

1. Be kept on file in Residency Program Manager's office.
2. Be reviewed yearly by the department and updated as may be necessary.
3. Be given to each participant at the beginning of each year of residency beginning on July 1.

Return to TOC

Resident Travel

Purpose

To establish a policy that ensures a fair and non-discriminatory process for the reimbursement of monies for residents travel to meetings and conferences.

Criteria for Reimbursement

1. The resident must be selected by the local, regional or nationally recognized organization to present a paper, abstract or poster.
2. The resident must obtain from the Residency Program Manager, a Training Day Out request form and an Authorization to Travel form. Both forms must be completed and submitted through the appropriate departmental channels for approval (Chief Resident, Program Director, and Department Chairman). The resident must provide the brochure of the meeting and the invitation letter to present with the meeting/authorization request forms. All requests must be submitted at least 30 days before the event or as soon as deemed possible. A copy of the paper, abstract or poster must be submitted with the meeting request form or the travel will be denied. Final decision for travel will come from the Department Chairman.
3. All original receipts (registration, parking, flight and hotel) must be submitted to the Residency Program Manager for reimbursement. Registration, flights and hotel (reservation only) can be prepaid/arranged by the Surgery Department Accountant (Stephanie White) or can be arranged and paid by the resident for reimbursement. If the registration, flights or hotel is purchased by the resident, all receipts turned in must show a zero (0) balance due.
4. All international travel for poster, paper, or abstract presentation must be pre-approved by the Program Director, Department Chairman, and by the Dean.

Reimbursement

A resident in the Department of Urology who is presenting a **paper, abstract or poster** at a local, regional or nationally recognized *meeting or conference* will be fully reimbursed for their travel as long as the criteria for reimbursement, step 1-4 above, has been followed. A resident that is presenting a **poster** at a local, regional or nationally recognized *conference* will be reimbursed up to $1000.00 by the Department of Urology. Chief residents (PGY-5 only) who travel to a once a year nationally recognized meeting/conference will be reimbursed $1,000.00 for attendance.

Return to TOC

Resident Book Funds

Purpose

To establish a policy that ensures a fair and non-discriminatory process for the purchasing of literature (Books) for the residents in the Department of Urology.

Topic

1. Residents in the Department of Surgery (General Surgery and Urology Departments), during their PGY 1-3 year, will be allocated $150.00 a year for the purchase of a book(s).
2. Residents in the Department of Surgery (General Surgery and Urology Departments), during their PGY 4-5 year, will be allocated $500.00 during both years of residency, not each year, for the purchasing of books.
3. Residents in the Department of Surgery (Cardiothoracic Department) will be allocated $500.00 for both years of residency, not each year, for the purchasing of books.

Discussion

1. General Surgery residents, during the PGY-1 year, will have a textbook purchased for them by the Department of Surgery. The purchase of this book will be deducted from the allocated yearly funds.

2. The resident will order the desired literature through the Department Accountant. All orders will be purchased online (if possible) by the department.

Scholarly Activity

The Department of Urology actively encourages and supports residents to present or publish one paper/abstract/poster at a local, regional or national meeting during their residency.

Return to TOC

Program Closure/Reduction

Purpose

To establish a policy for the Residency Training Programs should one of them have to close or reduce their program. This policy will apply to the Departments of Thoracic Surgery, General Surgery and Urology.

Responsibilities/Requirements

In the event that one of the Department of Surgery programs is closed, reduced or discontinued, the department will inform the residents in writing as soon as possible. In the event of such closure, reduction or discontinuation, the department will make reasonable efforts to allow the residents already in the Program to complete their education or to assist the resident in enrolling in an ACGME accredited program in which they can continue their education at the appropriate PGY level.

The department will exercise proper care, custody and disposition of the resident's education records, and appropriately notify licensure and specialty boards.

Return to TOC

Transition of Care

Purpose

To establish a transition of care policy for the Department of Urology. This will be based on effective communication between residents and urology faculty members. By definition, transition of fare assumes that a physician transfers the care of a patient from one urology resident/physician on call to another urology resident/physician on call.
https://medicine.hsc.wvu.edu/media/2589/handoffsandtransitionsofcare7-25-13.pdf

Responsibilities/Requirements

Effective communication is vital to safe and effective patient care. Many errors are related to ineffective communication at the time of transition of care. In order to provide consistent superior patient care, it is vitally important that we communicate with one another consistently and effectively when care of a patient is handed off from one physician to another. This policy is meant to define the expected process involved in transition of care, and applies to all urology residents and faculty members.

I. The Daily Sign-in and Sign-out

- There must be a formal sign out daily by each resident on the inpatient service. Sign out must include direct communication between residents and should be face to face.

- Residents who are directly responsible for patients on the inpatient service who are on call receive access to the urology patient list on the EMR. The resident on call must know, at a minimum, the following information:
  1. Patient name, age, sex, room assignment
  2. Relevant diagnosis
  3. Active urologic problems
  4. Code status
  5. Follow up and/or required actions, e.g. check labs, urinary catheter, stoma, etc.

- Residents that are post-call must communicate the events of the preceding night to the residents coming on that day. All new admissions and consults must be listed on the EMR dashboard. In addition, any significant developments overnight must be shared with the oncoming resident providing care for the service.

II. Transfer to another level of care

- When a patient is transferred from one level of care to another, e.g. the wards to the ICU or vice versa, and a different resident or group assumes the care of that patient, there must be documented communication between the resident physicians that includes the information that summarizes relevant information and provides the information necessary to provide effective care.

- The resident physician that “sends” the patient to the service providing a different level of care must place a note in the EMR that summarizes the clinical events preceding the transfer, and should also communicate verbally with the resident that “receives” the patient. That note in the EMR should include a brief history, relevant examination findings, relevant labs and/or imaging studies, advanced directives, current medications, and a brief assessment and plan.

- The physician that “receives” the patient must place a note in the EMR that summarizes the patient’s condition and includes an assessment and plan that is reviewed and approved by the urology attending responsible for the patient.

- Any decision to transfer a patient from one level of care to another must be made with the knowledge and consent of the attending faculty physician. In the event of an emergency, this may be obtained during or after the transfer.

Any questions regarding this policy should be directed to the Program Director or his designee.

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Policy on Resident Interactions with Vendor Representatives

The purpose of this policy is to establish guidelines for interactions with industry representatives for residents in graduate medical education programs sponsored by the West Virginia University School of Medicine. Interactions with industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and research equipment as well as on-site training of newly purchased devices. Many aspects of these interactions are positive and important for promoting the educational, clinical and research missions of the institution. However, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, and the integrity of our education and training programs.

https://medicine.hsc.wvu.edu/media/3009/medical-student-interactions-with-vendors.pdf

Return to TOC

WEST VIRGINIA UNIVERSITY HOSPITALS ***POLICY AND PROCEDURE MANUAL***	**Policy V.251** **1st Effective 1-1-84** **Revised 9-30-91; 9-15-95** **Reviewed 8-18-03**

HOSPITAL SCRUB SUITS

POLICY

Only authorized personnel are permitted to wear Hospital provided scrub suits in designated areas. Hospital provided scrub suits are not to be taken off hospital premises.

PROCEDURE

A. Medical Staff and Hospital Personnel are authorized to wear Hospital provided blue scrub suits only in the following work areas:

1. Operating Room
2. Recovery Room
3. Radiology (Mobile & Operating Room technicians)
4. Labor and Delivery
5. Cardiac Catheterization Lab
6. Central Processing
7. Pathology Gross Lab(s)
8. Satellite Pharmacy, 5th Floor
9. Pharmacy IV Room
10. Special Diagnostics
11. Bone Marrow Unit

B. It is the responsibility of individual departmental managers to ensure that their employees wear scrub suits only as required in designated areas.

C. The Hospital Security Staff will be available to assist in preventing the unauthorized removal of scrub suits. They may question personnel leaving the hospital wearing hospital provided scrub suits and refer the offender to Hospital Administration.

D. Individual department (not listed above) desiring to wear scrub suits in their respective areas may do so at the employee's expense and in accordance with this policy and departmental policy. Colors chosen must be approved by the respective departmental manager and may not be the designated ceil (light) blue as the standardized color for use in the Hospital. An employee purchasing his/her scrub suits for wear in his/her department will also be responsible for laundering them.

Bruce McClymonds
President

Return to TOC

Urology Resident Quality Improvement Program

Resident Quality Improvement Program

Per the Institute of Medicine's 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, in order to "continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States", all health care constituencies (health professionals, federal and state policy makers, public and private purchasers of care, regulators, organization managers and governing boards, and consumers) must adopt a shared vision of six specific aims for quality improvement:

- Patient-centered – care that is responsive to patient preferences, needs, values
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing to those not likely to benefit
- Equitable – providing care that does not vary in quality because of personal characteristics
- Timely – reducing waits and delays for care
- Efficient – avoiding wastes
- Safe – avoiding injuries to patients from care

The Urology Residency Quality Improvement (QI) Program has been designed to meet two primary goals:

- Fulfill the Residency Review Committee (RRC) requirements that residents learn QI methods and participate in a QI project during their residency
- Provide training that enables residents to address quality of care issues during both their training and in their future careers

Objectives of the QI program are to ensure that all residents:

- Participate in at least one QI project during their residency
- Complete the QI project under the guidance and supervision of a knowledgeable faculty mentor
- Understand and can perform the basic steps of a QI project:
- Identify area, problem, or opportunity for improvement
- Assemble an appropriate QI project team
- Develop an AIM statement
- Identify measurable goals
- Test and implement system changes using plan-do-study-act (PDSA) cycles

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West Virginia University School of Medicine (Updated for 7/1/17)
Graduate Medical Education Policy on Supervision from GME Bylaws

XIV. Supervision and Accountability

Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, and coercion of residents, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory and supportive manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of residents and faculty regarding inappropriate and unprofessional behavior, *especially* when exhibited toward a trainee who is requesting supervision and guidance. *[VI.B.6. – with slight edits]*

Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institution, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. *[VI.A.2.a)]*

Supervision in the setting of graduate medical education provides: safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth. *[VI.A.2.a)]*

Each patient must have an identifiable, appropriately-credentialed and privileged, attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. This information must be available to residents, faculty members, other members of the health care team, and patients. Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. *[Section VI.A.2.a).(1)]*

Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback. *[VI.A.2.b)]*

The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. [The Review Committee may specify which activities require different levels of supervision.] *[VI.A.2.b).(1)]*

<u>Levels of Supervision</u> *[Section VI.A.2.c)]*

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classifications of supervision:

<u>Direct Supervision</u>:

The supervising physician is physically present with the resident and patient.

Indirect Supervision:

…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.

…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 telephonic and/or electronic modalities, and is available to provide Direct Supervision.

Oversight:

The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. *[VI.A.2.d)]*

The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. *[VI.A.2.d).(1)]*

Faculty members functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of each resident. *(Has changed from Detail to Core)* Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. *[VI.A.2.d).(2) & (3)]*

Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). *[VI.A.2.e)]*

Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents may progress to be supervised indirectly with direct supervision available.] [*VI.A.2.e).(1).(a)]*

Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. *(Has changed from Detail to Core) [VI.A.2.f)]*

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West Virginia University School of Medicine
Graduate Medical Education – Clinical/Educational Work Hours & Well-Being – from the GME Bylaws

XV. Clinical/Educational Work Hours & Well-Being – Updated 7-1-17

Compliance with the Clinical & Educational (C&E) Work Hours Standards as outlined in the ACGME Common Program Requirements are expected for all programs.

The primary responsibility for the development of a call schedule that follows the ACGME's C&E Work Hour Standards resides with the program director, the program manager, and the core faculty of each program. In addition to the call schedule, the program manager for each program will regularly monitor their trainees logging of C&E Work Hours in order to: 1) Ensure timely logging; and 2) Monitor hours logged to allow for early intervention in unsafe work hour situations.

The GME Office will also provide monthly central oversight to ensure institutional compliance across all programs with current standards as outlined in the ACGME Common Program Requirements.

Each program must have a written policy that: 1) follows the ACGME's C&E Work Hour Standards; 2) is program and department specific; 3) and is provided to all trainees and faculty on an annual basis. This policy must define an effective program structure that is configured to provide residents with excellent educational and clinical experience opportunities, while also allowing for reasonable opportunities for rest and personal well-being. *[VI.F.2.a)]*

Factors that must be addressed include, but are not limited to: maximum hours per week, and per shift; mandatory time free; frequency of in-house call; frequency of at-home call; night float; guaranteed time off for medical, dental, and mental health appointments; vacation & sick time procedures, as well as other types of leave; rules for inclement weather and/or disaster situations; and the expectation of honest, and timely logging of work hours.

Honest and Timely Logging of Work Hours:

- **Honesty is a cornerstone** of our ethical and professional code here at WVU SOM. Without honesty, there is no trust. **Log your work hours honestly**. *[VI.B.4.f)]*

- Our **institutional standard** for logging of work hours is to **log them daily**.

- **However**, understanding that life is rarely standard – **if necessary, fall back on this one rule – at bare minimum, log every four days**. Beyond that, you will not remember what you actually worked.

Maximum Hours:

- C&E Work Hours **must** be limited to **no more than 80 hours per week**, **averaged** over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. *[VI.F.1.]*

- C&E Work **periods for residents and fellows must not exceed 24 hours of continuous scheduled assignment**. **Up to 4 hours of additional time** may be used for **activities related to patient safety**, such as providing **effective transitions of care**, and/or **resident education**. *Additional patient care responsibilities must not be assigned to a trainee during this time. [VI.F.3.a).(1) & .(a)]*

- **Exception** – In **rare circumstances**, after handing off all other responsibilities, **a resident or fellow, *on their own initiative*, may elect to remain or return to the clinical site** in the following circumstances:
    - To continue to provide care to a single severely ill or unstable patient
    - Humanistic attention to the needs of a patient or family
    - To attend unique educational events.

  All additional hours of care or education will be counted toward the 80-hour maximum weekly limit. *[VI.F.4.a) through VI.F.4.b)]*

Time Free:

- Residents and fellows **should have 8 hours off** between scheduled clinical work and education periods. *[VI.F.2.b)]*

- Residents and fellows **must have at least 14 hours free** of clinical work and education **after 24 hours** of in-house call. *[VI.F.2.c)]*

- Residents and fellows **must be scheduled for a minimum of one day in seven free** of clinical work and required education, when averaged over a 4-week period. *At-home call cannot be assigned on these free days. [VI.F.2.d)]*

Clinical Work Hours:

- **Night float** must occur within the context of the 80-hour week, and one-day-off-in-seven requirements. (Your specialty Review Committee may have further regulations regarding night float.) *[VI.F.6.]*

- Residents and fellows must be scheduled for **in-house call no more frequently than every third night,** averaged over a four-week period. *[VI.F.7.]*

- **At-home call** must not be so frequent or taxing as to preclude rest or reasonable time for personal care, and well-being, and it **must not be assigned on a free day**. **All clinical work** performed while on at-home call, *whether at home or in the hospital*, **must count toward the 80-hour maximum weekly limit**. *[VI.F.8.a) through VI.F.8.b)]*

Moonlighting:

- **PGY-1** residents are **not permitted to moonlight**. *[VI.F.5.c)]*

- **Must not interfere** with the trainee's ability to **achieve the goals & objectives** of the educational program.

- **Must not interfere** with the **trainee's fitness for work**, nor compromise **patient safety.** *[VI.F.5.a)]*

- Whether done at the teaching institution (internal), or at another facility (external), **all moonlighting hours must be counted toward the 80-hour maximum weekly limit**. *[VI.F.5.b)]*

Fatigue Mitigation:

- **Programs must** –
    - **Educate** all faculty, residents, and fellows to recognize the **signs of fatigue and sleep deprivation**; *[VI.D.1.a)]*

- **Educate** all faculty, residents, and fellows in **tools to mitigate fatigue**; *[VI.D.1.b)]*

- **Encourage** faculty, residents, and fellows **to use fatigue mitigation tools** to manage **potentially negative effects** of fatigue on safe patient care, and learning. *[VI.D.1.c)]*

- **Ensure continuity of patient care** by maintaining a back-up system in the event that a resident or fellow is unable to perform their patient care responsibilities due to excessive fatigue. *[VI.C.2 & VI.D.2]*

- Along with the help of the Sponsoring Institution, **ensure adequate sleep facilities** *AND* **safe transportation options** for residents and fellows who may be too fatigued to safely return home. *[VI.D.3.]*

Sick Time, Time Off for Health Care Appointments, & Other Types of Leave:

- **There are circumstances in which residents and fellows may be unable to attend work**, including but not limited to fatigue, illness, and family emergencies. **Each program must have policies and procedures in place** that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These **policies must be implemented without fear of negative consequences for the resident or fellow** who is unable to provide the clinical work. *[VI.C.2.]*

- Residents and fellows **must** be given the **opportunity to attend medical, mental health, and dental care appointments**, *including those scheduled during their working hours*. *[VI.C.1.d).(1)]*

Vacation:

- **Residents and fellows should be encouraged to plan for, and use their allotted vacation time each year.** Programs must provide policies and procedures to their trainees annually. This includes a detailed vacation policy clearly stating all the necessary steps for the correct way to request their allotted time off.

Resident/Fellow Well-Being:

- **Psychological, emotional, and physical well-being** are **critical** in the development of the competent, caring, and resilient physician. **Self-care** is an important component of professionalism; it is also a skill that **must be learned and nurtured** in the context of other aspects of residency training. ***Programs*** *have the same* ***responsibility to address well-being*** *as they do to evaluate other aspects of resident competence.* *[VI.C.]*

- This responsibility must include:
  - Efforts to enhance **the meaning that each trainee finds in the experience of being a physician**, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; *[VI.C.1.a)]*

  - Attention to **scheduling**, **work intensity**, and **work compression** that impacts resident/fellow well-being; *[VI.C.1.b)]*

  - Evaluating workplace safety data and **addressing the safety** of trainees and faculty members; *[VI.C.1.c)]*

- **Policies and programs** that **encourage optimal** trainee and faculty member **well-being**; *[VI.C.1.d)]*
- **Attention to** trainee and faculty member **burnout, depression, and substance abuse**; *[VI.C.1.e)]*
- **Educating** trainees and faculty members in **identification of the symptoms** of burnout, depression, and substance abuse, including **means to assist** those who experience these conditions; *[VI.C.1.e)]*
- **Educating** trainees and faculty members to r**ecognize those symptoms in themselves** and how to seek appropriate care; *[VI.C.1.e)]*
- **Encourage trainees and faculty members to alert** the program director, or the GME Office **regarding concerns** that a resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; *[VI.C.1.e).(1)]*
- **Provide** access to appropriate **tools for self-screening**; *[VI.C.1.e).(2)]*
- **Provide** access to **confidential, affordable mental health assessment**, **counseling**, and **treatment**, including **access to urgent and emergent care 24** hours a day**, seven** days a week. *[VI.C.1.e).(3)]*

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