

**GRADUATE MEDICAL EDUCATION PROGRAMS BY LAWS AT
THE ROBERT C. BYRD HEALTH SCIENCES CENTER OF
WEST VIRGINIA UNIVERSITY
SCHOOL OF MEDICINE**

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Introduction

Programs in graduate medical education (GME) have been conducted at the Health Sciences Center since its opening in 1960. The charter of West Virginia University Hospitals, Inc., formulated at the time of its incorporation in 1984, commits the Hospital to continue its high degree of support for GME sponsored by the West Virginia University School of Medicine.

In this document, “Resident” and “Resident Physician” refers to: Intern, Resident, Subspecialty Resident and Fellow at any level of training in any of our programs. Allopathic physicians are defined as graduates of LCME accredited medical schools or residents who have ECFMG certificates.

I. Objectives:

- A. The primary concern of both the West Virginia University School of Medicine and West Virginia University Hospitals (WVUH) will be to maintain and improve the health of the people of West Virginia and the Nation through education, service and research.
- B. **Mission** – The West Virginia University School of Medicine improves the lives of the people of West Virginia and beyond through excellence in patient care, education, research, and service to our communities.

Vision – the West Virginia University School of Medicine, leading the way to a healthier West Virginia.
- C. Special attention will be given to developing and maintaining programs that address the physician manpower needs of West Virginia and the surrounding region.

II. Administration:

- A. The GME programs at the Robert C. Byrd Health Sciences Center (RCBHSC) will be led by an Associate/Assistant Dean of the School of Medicine functioning as the Designated Institutional Official (DIO) with the support of the Chair of GMEC who shall be a member of the faculty appointed by the Dean, Administrative Director of GME and appropriate staff.
- B. The DIO will coordinate the implementation of Accreditation Council for Graduate Medical Education (ACGME) policies as they apply to institutional policies.

- C. The DIO will monitor individual programs at regular intervals, to ensure adherence to ACGME policies.
- D. Each program will be overseen by a Program Director who reports to both the appropriate Department Chair and the DIO. This Director will assure adherence to ACGME policies as they apply to the specific program. **The Program Director cannot be the same person as the Department Chair.** Appropriate support staff will be provided by the sponsoring institution through the mechanism established through the Department of Medical Education.
- E. The Graduate Medical Education Committee (GMEC) will have the responsibility for monitoring and advising on all aspects of residency education.
 - 1. Membership shall be appointed by the Dean of the School of Medicine as outlined in the GMEC charter published in the School of Medicine faculty handbook. It must include peer nominated resident physicians.
 - 2. The GMEC charter will also specify the specific duties and responsibilities of the group, and its meeting frequency.
 - 3. The Dean shall appoint a subcommittee of the GMEC called the GMEC Taskforce that shall be composed of members of the GMEC, report to the GMEC, and meet on a more frequent basis all as outlined in the charter.
 - 4. Other subcommittees may be formed by the consent of the GMEC based on the needs of the sponsoring institution to ensure compliance with accreditation standards and must include a resident member.

The link to the GMEC Charter is on the Graduate Medical Education website:
<http://medicine.hsc.wvu.edu/media/17496/gmec-charter.pdf>

III. Principles Governing GME at WVU:

- A. At the Robert C. Byrd Health Sciences Center, it is important for everyone to recognize that all programs are dependent on each other in order to reach the goals of the residency programs.
- B. Recognizing that Departments have service commitments to other programs, any plan to change the annual commitment to another service or program must be approved by the GME Committee, or its subcommittee.
- C. All requests for rotations at institutions outside the Health Sciences Center must be approved by the GME Committee, or its subcommittee. A prerequisite for approval is the ability to demonstrate that specialty specific requirements cannot be met within the sponsoring institution.

- D. Because resident participation in the GME committee and its working groups is required to meet accreditation standards, program directors must take steps to ensure that residents willing to serve are given time for these duties.
- E. Requests for review in change in resident complement must meet the following requirements:
1. Completion of request in complement change form for formal review and approval by the GMEC.
 2. There must be documentation of approval by the pertinent Resident Review Committee (RRC) of the ACGME.
 3. There must be documentation that there is a need for additional physicians of that specialty in the region.
 4. The program must obtain financing of the additional resident(s) from a participating hospital, or from the Executive Leadership Group (ELG) which includes the Dean, Chief Medical Officer, and President of the primary teaching hospital.
- F. An RRC may grant exceptions for up to 10 % of the 80-hour limit, to individual programs based on a sound educational rationale. Programs requesting this must have permission of the institution's GMEC.

IV. Designated Institutional Official:

The Designated Institutional Official (DIO) is to establish and implement procedures to ensure that s/he, or a designee in the absence of the DIO, reviews and cosigns all program information forms and any correspondence or document submitted to the ACGME by the program directors that either addresses program citation or requests changes in the programs that would have a significant impact, including financial, on the program or institution. [ACGME Institutional Requirements](#) I.A.5.a

The DIO will be an ex-officio voting member of the GMEC.

V. 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.

Details are outlined in the [Criteria for Eligibility and Selection of Candidates Policy](#)

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

VI. Recruitment:

Department 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 applicants outside West Virginia.

VII. Resident Doctor Licensure Requirements:

All allopathic and osteopathic resident physicians are required to obtain and maintain a license to practice medicine in the State of West Virginia as outlined in the [Resident Doctor License Requirements Policy](#) of the School of Medicine, and subject to the requirements of the Board of Medicine. All allopathic residents must provide proof of a passing USMLE Step 3 prior to issuance of a PG 3 contract. All osteopathic residents must provide proof of a passing COMLEX Level 3 prior to issuance of a PG3 contract.

VIII. Evaluation of Programs, Trainees and Faculty:

Each program will develop procedures for evaluating performance and progress of its graduate trainees consistent with those outlined in the ACGME Common Program Requirements. Methods for this review shall include but not be limited to:

- A. Critical assessment of performance in specified patient care experiences and responsibilities to include assessment of the six ACGME core competencies using the specialty specific Milestones.
- B. Review of patient charts or other records of specific clinical duties of individual resident physicians.
- C. Direct personal supervision and assessment by the program director and faculty of the trainee's competency to perform clinical duties. Duties include:
 1. Ability to gather appropriate and pertinent information about patient.
 2. Ability to integrate it with current "state of the art" knowledge and develop a differential diagnosis.
 3. Develop and implement a plan of care.
 4. Discuss patient care issues with the patient and/or family.

5. Work with a multidisciplinary team.
6. Teach other health care professionals.
7. Perform duties in an ethical and professional manner.

Individual evaluations of each resident physician will be conducted at least semiannually and a written or electronic record will be maintained by the Program Director. The resident physician shall have access to this information. In addition, an annual written summary evaluation will be maintained in the Program Director's or Program Manager's office.

In addition, a written summative final evaluation for each resident who completes the program must be maintained in the permanent file. The evaluation must include a review of the resident's performance during the final period of training and should verify that the resident has demonstrated sufficient professional ability to practice competently, independently, and without direct supervision. A copy must be forwarded to the Central GME Office.

If a resident leaves a program before completion, a summary evaluation letter must be maintained in the resident physician's file.

FACULTY PERFORMANCE: Each program will develop procedures for evaluating performance of faculty. Faculty performance must be evaluated by the program no less frequently than once per year. The evaluations should include a review of their teaching abilities, commitment to the educational program, clinical knowledge, and scholarly activities. Annual written confidential evaluations by residents must be included in this process.

PROGRAM EVALUATION: The educational effectiveness of a program must be evaluated at least annually in a systematic manner.

- A. Representative program personnel, i.e., at least the program director, representative faculty, and at least one resident, must be organized to review program goals and objectives and the effectiveness of the program in achieving them. The group must have regular documented meetings at least semi-annually for this purpose. In the evaluation process, the group must take into consideration annual ACGME resident and faculty surveys, **written comments from the faculty**, the most recent report of the GMEC of the sponsoring institution, and the residents' confidential written evaluation. If deficiencies are found, the group should prepare an explicit plan of action, which should be approved by the faculty and documented.

- B. Outcome assessment
 - 1. The program should use resident performance and outcome assessment on in-training examinations and board certification exams in its evaluation of the educational effectiveness of the residency program.
 - 2. The program should have in place a process for using resident performance assessment results together with other program evaluation results to improve the residency program.
- C. Performance of program graduates on the certification examination should be used as one measure of evaluating program effectiveness.
- D. To preserve anonymity, programs with four or less residents must forward the resident evaluations of the program and teaching faculty directly to the DIO rather than the program director. Evaluations for subspecialty residents/fellows in independent fellowships with four fellows or less will go directly to the DIO. Evaluations for fellows/subspecialty residents in dependent fellowship programs with four or less fellows will go directly to the program director of the core program.

IX. Transferring Resident Policy:

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 notification from the current Program Director. This verification must include written verification of previous educational experiences and a competency-based performance evaluation of the resident. 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 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) Program Directors must provide timely verification of residency education and performance for residents who wish to transfer upon the written request of the resident.
 - c) It is advisable to obtain a written consent from the transferring resident physician which would allow the WVU Program Director to

disclose any and all information about the transferring resident physician's file to the receiving Program Director, should the receiving Program Director contact WVU for information about the resident physician's academic and professional performance.

- 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.

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 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.
- b) 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.
- c) Program Director is responsible for obtaining proof of a formal NRMP or other matching program waiver of commitment if that is required before legally offering the position.

X. Academic Discipline and Dismissal Policy:

Each Program shall develop a disciplinary system to ensure resident physicians are competent, professional and ethical within the standards of care. Programs shall have a written procedure for implementation of the system and institution of corrective or disciplinary actions. The procedures shall be revised periodically and be in accordance with WVU School of Medicine GME and ACGME policies.

Programs 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 resident physician program, the School of Medicine or other facilities where the resident physician 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
- failure of USMLE Step 3.

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 resident physician's appointment
- terminate, limit or suspend a resident physician's appointment or privileges
- non-renewal of a resident physician's appointment
- dismiss a resident physician from the Program; or
- any other action that the Program or sponsoring institution 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 Program or University or other facilities where the resident physician 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 program. Corrective action may include oral or written counseling or any other action deemed appropriate by the program 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 resident physician 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 resident physician 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 resident physician to comply with the terms of the plan may result in termination or non-renewal of the resident physician'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 to 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 resident 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.

Grievance, Due Process, and Appeals

XI. Academic Grievance Policy and Procedure

- A. 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.

- B. 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.

- C. 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.

- D Procedure

1. Level I 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. Level 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). The resident/fellow is not entitled to legal representation during the Level 1 meeting.

2. 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 appropriate Department Chair 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 Chair is also functioning as the Program Director, then the Level 2 resolution will be handled by the DIO. The resident's/fellow'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 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 Chair (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 Chair. Copies of this decision will be kept on file with the Program Director, in the Chairman's office and sent to the DIO. The resident/fellow is not entitled to legal representation during the Level 2 meeting.

3. Level 3 Resolution

If the resident/fellow disagrees with the Department Chair'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 Chair, and any other pertinent information, to the

office of Graduate Medical Education within 5 working days of receipt of the Department Chair'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 grievable party at the scheduled meeting, following the protocol outlined in Section XI.F.

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.

E. 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/fellows, 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.

F. 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/fellow 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 GME Office. The program will post the final decision in the resident's or fellow's academic file.

G. 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.

XII. Conditions for Reappointment: Renewal and Promotion:

These decisions will be rendered by the program director with consultation from the program Clinical Competency Committee (CCC).

- A. Promotion: Decisions regarding resident promotion are based on whether resident/fellow has met all departmental and institutional requirements. The USMLE and COMLEX will be used as a measure of basic knowledge proficiency. Passage of the USMLE or COMLEX step 3 is a requirement for advancement for the 3rd year of residency for all residents as indicated in Section VII and the Resident Doctor Licensure Requirement.
- B. 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, the program director shall provide the resident/fellow with a four (4)

month advance written notice of its determination of non-reappointment unless the termination is “for cause.” The GME Office must also be notified in writing. Intent not to renew is subject to academic grievance as outlined in XI.

- C. Intent Not to Promote to the Next Level of Training: In the event the WVU School of Medicine GME program elects not to advance or promote a resident to the next level of training, the Program Director shall notify the resident with at least four (4) months advance written notice of said intent unless the cause for non-promotion occurs during the final four months of the contract period. The GME Office must also be notified in writing. Intent not to promote is subject to academic grievance as outlined in section XI.

XIII. Special Review of Residency Programs:

Criteria for Initiating a GMEC Special Program Review

Special Program Reviews will be used by the GMEC as a tool to support those programs that demonstrate a need for intervention, through results of the Annual Program Review with the DIO, results of Review Committee accreditation review, or some other internal means. They may also be used for review of non-standard programs or programs in initial accreditation. Results of the Special Program Review will be reported to the GME Taskforce and the GMEC.

1. Criteria for initiating a GMEC Special Review may include, but are not limited to:
 - ACGME resident/fellow survey results
 - ACGME faculty survey results
 - Letters of complaint sent to ACGME
 - Many departing faculty, or departure of key required specialty faculty
 - Low board scores, low first time pass rate, or low board take rates
 - Duty Hour violations
 - Annual Program Review with DIO
 - Inadequate ADS reports
 - Annual Program Data
 - Self-Study site visits
 - Results of Review Committee accreditation or some other internal means
 - Other concerns initiated by the GMEC and/or GME Taskforce or DIO
 - Button Hits
2. The Special Review Committee membership is within the Sponsoring Institution but not from within the department of the program under review that is comprised of at least:
 - a. one faculty member

- b. one resident/fellow &
 - c. additional internal or external reviewers and administrators which may include the DIO, as determined by the GMEC
 - d. one program manager
 - e. one person from the Central GME office
3. Interviews will be conducted with:
- a. at least one peer-selected resident/fellow from each PG level. In addition, the GMEC expects that all available residents be present
 - b. core faculty from the program
 - c. the residency program manager
 - d. the department chair
 - e. the program director
 - f. other individuals as deemed appropriate by the GMEC Special Review committee depending on the circumstances of the Review.
4. Specific outcome measures:
The GMEC Special Review will outline a reporting structure, monitoring procedures and timeline, including written recommendations and procedures for follow-up to improve ACGME-accredited program performance in specified areas.

Because the GMEC Special Review is an interventional process, the focus is on improvement and anticipated measureable end-point progress. A progress report may be required.

Special Program Reviews will be conducted on the non-standard programs at least every five years to serve as their accreditation review.

XIV. Supervision and Accountability (updated 7/1/17)

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)]

Levels of Supervision [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:

Direct Supervision:

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)]

XV. Duty Hours, Learning and Working Environment

Compliance with the duty hour standards as outlined in the ACGME common

program requirements are expected for all programs.

The primary responsibility for the development of a Duty Hours Schedule plan and monitoring for each of the specific graduate medical education programs resides with the program director and faculty of the specific programs. The institution will also provide a mechanism of central oversight to ensure compliance with current standards as outlined in the ACGME common program requirements. Processes will be developed in accordance with the requirements of the respective Specialty Board and the Accreditation Council for Graduate Medical Education, and will focus on specific factors unique to each department, and to the programs of 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. Each program will develop an internal review mechanism to evaluate Duty Hours schedule plans to comply with the policies of the ACGME.

Each program must have a written policy that is program specific and designed to optimize the patient care and the working environment for graduate trainees and students. Factors that must be addressed include, but may not be limited to, the frequency of call, the number of hours for each on call period, the amount of time that a participant or student will be allowed to continuously be on duty or on call, the amount of time off, and disaster situations:

At-Home Call

Time spent in the hospital by residents on at-home call must count towards maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the weekly maximum, will not initiate a new “off-duty period”

The Learning and Working Environment:

Patient Care in the Learning and Working Environment:

Patient Safety: Residents/fellows must:

- (1) report errors, adverse events, unsafe conditions, and near misses in a protected manner that is free from reprisal; and
- (2) contribute to inter-professional root causes analysis or other similar risk reduction teams.

Quality Improvement: Resident/fellows:

- (1) use data to improve systems of care, reduce health care disparities, and improve patient outcomes; and
- (2) participate in inter-professional quality improvement initiatives

Transitions of care:

- (1) Programs will create and implement a transitions of care policy. They will facilitate professional development for faculty members and residents/fellows regarding effective transitions of care; and
- (2) Ensure that participating sites engage resident/fellows in standardized transition of care consistent with the setting and type of patient care.
- (3) The institution will oversee that programs are meeting this requirement

Supervision: (Also see Section XIV)

- (1) Programs will create and implement a Supervision Policy that is consistent with institutional and program-specific policies; and
- (2) Inform the residents/fellows that there is a mechanism by which residents/fellows can report inadequate supervision in a protected manner that is free from reprisal. ("The Button" on the GME webpage)

Duty Hours, fatigue management and mitigation:

- (1) Residents/fellows duty hours must be consistent with the Common and specialty/subspecialty-specific requirements across all programs, addressing areas of non-compliance in a timely manner
- (2) There must be a system of care and a learning and working environment that facilitate fatigue management and mitigation for faculty members and resident/fellows; and
- (3) There must be an educational program for core faculty members and residents/fellows in fatigue management and mitigation

Professionalism:

- (1) Residents'/fellows' and core faculty members' fulfillment of educational and professional responsibilities, including scholarly pursuits must be monitored
- (2) Accurate and honest reporting of duty hours information must occur by residents and fellows
- (3) Identification of resident mistreatment must be monitored by institution ("The Button" on the GME webpage). Programs are responsible for informing the residents/fellows of this mechanism.

XVI. Non-Competition:

Neither WVU School of Medicine nor any of its ACGME Accredited Programs will require a resident/ fellow to sign a non-competition guarantee or restrictive covenant as part of their employment contract to participate in a training program sponsored by the School of Medicine.

XVII. Lab Coats, Meals, Night Call

Two lab coats will be issued to the resident at the beginning of training. For residents with training longer than 3 years, two additional lab coats will be issued by West Virginia University Hospitals at the beginning of the PGY IV year. Laundry service for resident training at West Virginia University Hospitals is provided free of charge.

Residents/fellows receive a meal card that may be used to purchase food from the hospital cafeteria. Basic food options will also be available in the resident on call/lounge facilities. Adequate sleeping accommodations that provide residents a private secure environment will be provided for residents assigned to night call or the residents feeling fatigued.

XVIII. Guidelines for Residency Rotations to or from other Institutions:

The reasons for resident rotations at other institutions include:

- A. To strengthen West Virginia University School of Medicine and West Virginia University Hospital's Graduate Medical Education Programs;
- B. To offer elective experiences not available at the sponsoring institution such as those in the domestic community practice setting;
- C. To fulfill specialty specific program requirements that cannot currently be better met at the sponsoring institution.
- D. External rotations for the purpose of auditioning for a possible fellowship program will be limited to one month during the entire length of the core program. These experiences may include all types of experiences including but not limited to fellowships offered by the sponsoring institution, general inpatient ward rotations, critical care rotations, and outpatient rotations.
- E. Requests for international rotations will follow the international rotation policy.

Requirements:

- A. External rotations must first have the approval of the Program Director. Subsequently the Department Chair, the GMEC Taskforce and the DIO must approve rotation.
- B. Requests for review by the GMEC Taskforce and DIO must include the educational rationale, and a letter of support from the Program Director.

These must be received at least 5 working days prior to the meeting in which they are expected to be reviewed

- C. Established rotations must be included in the description of the program submitted for accreditation as well as in material forwarded to applicants for Graduate Medical Education.
- D. A formal Affiliation Agreement (AA) must exist for all established rotations at participating institutions that are required for all residents. The development of affiliation agreements and fiscal agreements will follow the general pattern of the institution generic AA and must be current within the last 5 years.
- E. A Program Letter Agreement (PLA) shall be completed for each resident for each rotation at another institution that are unique one time rotations that outlines educational objectives, site director and faculty who will supervise the residents, evaluation methods and duration of the assignment. The Global PLA form is available for use if several residents will attend another institution for the same rotation.
- F. For rotations that residents voluntarily choose to rotate at other institutions the resident will be responsible for all expenses related to these away rotations including but not limited to travel, housing, meals, state licensure and application fees.

Resident Rotations for visiting residents:

All visiting residents must have a valid and current PLA signed by the program directors from both institutions involved. The PLA must verify that the sponsoring institution of the visiting resident will continue to provide salary support, benefits and malpractice insurance while they are rotating with programs sponsored by the WVU School of Medicine.

Visiting residents must not compromise the educational experiences of our own residents. The Program Director must request in writing to the GME Taskforce for approval; the GME Taskforce must approve any visiting residents prior to their arrival. The GME Taskforce may deny visiting resident rotations for any reason including but not limited to interference with our institutional resident educational opportunities.

XIX. Malpractice Coverage:

The West Virginia State Board of Risk and Insurance Management provides professional liability (malpractice) coverage for resident physicians. The Board of Risk is a state agency that self-insures professional liability coverage for all state employees. This occurrence-based coverage provides limits of one million dollars per occurrence and legal defense. The coverage applies to all acts within the assigned duties and responsibilities of the residency training program; it does not cover a resident physician for outside activities such as external moonlighting. A resident is required to provide his/her own professional liability coverage for activities outside the residency training program.

A resident must report any questionable incidents concerning patient care to the program director and to risk management at the Health Sciences Center. A written report must be completed and sent to Risk Management (P.O. Box 9032) to be reviewed and forwarded to the Board of Risk as needed. Risk Management can be reached at 293-3584 (Health Sciences) and 598-4070 (WVUH)

Liability coverage for claims filed after completion of program: In the event a claim or suit is filed after a resident leaves WVU School of Medicine, it is still the resident's responsibility to cooperate with the Risk Management department. Occurrences will be covered for the dates of resident employment and activities related to the training program.

XX. Disability and Health Insurance:

- A. Disability Insurance: The opportunity to participate in group long-term disability coverage is available through Standard Insurance Policy number 135501 by contacting 1-800-348-3226 or the WVU Human Resources/Benefits Office (304-293-4103).
- B. Health Insurance: A resident is eligible to enroll in the state employees' health insurance or state managed health care options through Employee Benefits at WVU Human Resources, Health Sciences Center (304-293-4103).

XXI. Leave Policies:

Residents/fellows accrue annual leave (vacation) and sick leave in accordance with State policy. There may also be additional leave time available for military leave, jury duty, parental leave, family medical leave, etc. Usage of this time is governed by departmental policies and operational needs of the department. However, the requirements set by the Specialty Board for each Department may limit the total days of leave which a resident may use in any given year.

The program director will notify the resident in writing if extended leaves for any reason may result in an extension of the original training period required by the specialty boards or program specific requirements.

For more information regarding [Resident/Fellow](#) leave policies, contact Human Resources. Topics covered include Annual Leave, Sick Leave, Holidays, Leaves of Absence, Procedure for Requesting Leave, Grievance, Witness, and Jury Leave.

XXII. Policies of WVUH Practitioner Health Committee:

Appendix I POLICIES OF THE WVUH PRACTITIONER HEALTH COMMITTEE

Purpose

The West Virginia University Hospitals, Inc. (WVUH) Practitioner Health Committee serves as the primary resource in the management of impaired Practitioners. Impairment includes any physical, mental, behavioral or emotional illness that may interfere with the Practitioners ability to function appropriately and provide safe patient care. The purpose of impaired Practitioner assistance is to maximize support for Practitioners through appropriate interventions. This process relates specifically to mental, physical or behavioral impairment and does not include performance management or disciplinary actions.

Policy

In order to assure the safety of patients, co-workers and trainees WVUH will address all reports of impaired or possibly impaired performance of Practitioners. WVUH will also strive to maintain the confidentiality of any and all individuals who may report any observed impairment or possible impaired performance of any practitioner(s) affiliated with the hospital. Impairment may be due, but not limited to physical, and/or mental/behavioral problems, including drug and alcohol use, misuse and/or abuse. All assessments, evaluations and treatment recommendations received by the Practitioner Health Committee shall be confidentially maintained under the peer review privilege, except as limited by regulation, ethical obligation, Medical Staff Manuals, and/or threat to patient safety. Practitioners referred to in this policy include, but are not limited to, faculty credentialed by WVUH, fellows, residents, interns and all allied health professionals.

Procedure

A. EDUCATION

1. WVUH will provide education on Practitioner health and impairment to the Medical, Dental, Allied Health Staff, and WVU Residents.
2. Hospital administrative leadership will assure that policies and procedures related to impairment and recognition issues specific to impairment are widely disseminated to appropriate hospital staff on an annual basis. WVUH encourages self-referral of any Practitioner in seeking help for health or impairment problem to the Practitioner Health Committee. Practitioners may voluntarily seek assistance from the WVU Faculty and Staff Assistance Program (FSAP) at any time with or without referral from either the Practitioner Health Committee or other administrative personnel.

B. NEW PRACTITIONER

1. Any Practitioner who requests to practice at WVUH whose ability to practice medicine may be affected, is undergoing treatment for substance abuse, any other physical or mental health problems, or who otherwise is reasonably believed to suffer from a substance abuse problem or any other physical or mental health problem must be referred by the Vice President of Medical Affairs to the Practitioner Health Committee. It is the responsibility of the department chair to notify the Vice President of Medical Affairs and supply in writing the nature of the referral.
2. The Practitioner Health Committee will make their recommendations to the Vice President of Medical Affairs. If determined by the Vice President of Medical Affairs that the Practitioner should seek further evaluation from a specialized counselor for his/her specialized need, at that time an Agreement of Understanding, on behalf of WVUH, as well as a written consent and release, on behalf of WVUH, will be presented to the Practitioner and shall be signed if he/she continues to seek privileges at WVUH. Such information being released includes, urine and blood screening times, results, appointment times, and any referrals to other entities/providers.
3. If further evaluation is required, following receipt of the evaluation, the Practitioner Health Committee will provide a recommendation to the Vice President of Medical Affairs on each of the following:
 - Advisability of appointment to the Medical, Dental or Allied Health Staff at WVUH, as applicable
 - Need for any additional monitoring and treatment
 - Need for limitations or conditions on privileges.

4. After discussing the Practitioner Health Committees recommendations with the department chair, the Vice President of Medical Affairs will determine the final recommendation regarding the applicant's ability to practice, which will be presented, to the WVUH Board of Directors, through the Joint Conference Committee. The Vice President of Medical Affairs may grant temporary privileges or allow a Practitioner to begin to treat patients at WVUH; however, the WVUH Board of Directors through the Joint Conference Committee has the final decision as to whether a Practitioner may practice at WVUH and under what conditions.
5. The Vice President of Medical Affairs will communicate the final recommendations to the Residency Program Director, the Designated Institutional Official (for residents only) and the department chair.
6. When the appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an agreed upon external provider. The Vice President of Medical Affairs will ensure that the executed "Agreement of Understanding" specifies treatment recommendations and conditions of appointment and/or clinical privileges must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling and meeting with the Practitioner Health Committee.
7. All further decisions as to what actions, if any, need to be taken, remain with the Vice President of Medical Affairs.

C. PROCEDURES FOR CURRENT PRACTITIONERS

1. Observed Impaired Behavior

- a. It is the responsibility of all medical, dental, allied health staff, and residents to immediately report any observed behavior which establishes a reasonable belief that a Practitioner is impaired or exhibiting inappropriate behavior (physical, emotional or psychological) or evidence of substance abuse problems that could impact on professional/clinical performance in the Hospital (evidence other than or in addition to observation of personal behavior includes, but is not limited to, improperly disposed-of syringes and missing or improperly accounted for drugs) to the Vice President of Medical Affairs and/or the department chair. During off-shift hours, the individual reporting should notify the Administrator-On-Call (AOC).
- b. Hospital Staff should notify the Administrator-On-Call (AOC) or the Vice President of Medical Affairs (if during regular business hours) of any

inappropriate behavior or suspected substance abuse. In the event that the Administrator-On-Call is notified, he/she will notify the Vice President of Medical Affairs and the Vice President of Medical Affairs will notify the department chair.

- c. The department chair, the Vice President of Medical Affairs or the Administrator-On-Call (AOC) during off-shift hours will investigate and verify the credibility of the allegation in C.1.a or C.2.b to ascertain the credibility of the complaint, concern or allegation. The Practitioner will not be told who filed the initial report. If the alleged impairment is deemed credible by the Vice President of Medical Affairs, department chair or the Administrator-On-Call (AOC) during off-shift hours, immediate drug testing may be requested. During business hours, the Practitioner may be referred to Employee Health. After hours, the Practitioner will be referred to the Emergency Department. Refusal to cooperate with testing is grounds for dismissal from WVUH and removal of residents from providing any patient care within the Hospital. Employee Health is the designated department to administer the drug testing as well as provide the results to the Vice President of Medical Affairs and/or the Practitioner Health Committee. Employee Health is not required and will not keep any file for individuals including but not limited to any test results and/or appointment times. If the impairment poses an immediate risk to patient safety, the Practitioner must be immediately removed from patient care and patient contact and an immediate precautionary suspension will occur. (For further information regarding precautionary suspension refer to Article IV, Section 4.3 in the case of credentialed Practitioners, and Appendix O in the case of residents.) If the impairment does not pose an immediate risk to patient safety, the Practitioner may continue with his/her patient care duties. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

2. Self-Referral

- a. All Practitioners are required to self refer to his/her department chair or the Vice President of Medical Affairs in the event that he/she experiences any substance abuse/health problem that could impact on professional/clinical performance in the Hospital. When reported to the department chair, the chair shall report to the Vice President of Medical Affairs. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.
- b. A Practitioner who seeks assistance with WVU FSAP is required to inform the Vice President of Medical Affairs of this evaluation. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

3. Procedures of the Practitioner Health Committee

- a. Upon referral to the Practitioner Health Committee, the Practitioner is required to sign a consent and release, on behalf of WVUH, allowing information regarding their treatment to be released to the Vice President of Medical Affairs and/or the Practitioner Health Committee by both the WVU FSAP and any treatment provider. Such information being released is, but not limited to, urine and blood screening times, results, appointment times, and any referrals to other entities/providers. In the event that he/she refuses to sign the consent and release, on behalf of WVUH, he/she will be precautionary suspending from duty, until the mental health assessment and the signing of the consent and release, on behalf of WVUH, is resolved. Refer to Article IV, Section 4.3 Precautionary Suspension or Appendix O, as applicable. All such reported information shall be kept confidential except as limited by law, ethical violation, or when patient safety is threatened.
- b. Following a referral from the Vice President of Medical Affairs and the receipt of any investigations and evaluations or results of drug testing, the Practitioner Health Committee will recommend to the Vice President of Medical Affairs on each of the following:
 - Advisability of continued appointment to WVUH
 - Need for any additional monitoring and treatment, continued or privileged, as applicable
 - Need for limitations or conditions on privileges
- c. After discussing the Practitioner Health Committees recommendations with the department chair, the Vice President of Medical Affairs will determine the final recommendation regarding the practitioner's ability to

practice, which will be presented to the WVUH Board of Directors, through the Joint Conference Committee.

- d. The Vice President of Medical Affairs will communicate the final recommendations to the Designated Institutional Official (for residents only) and the department chair (residents and faculty).
- e. When the continued appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an agreed upon external provider. The Vice President of Medical Affairs will develop an "Agreement of Understanding" with the Practitioner, which specifies treatment recommendations and conditions of appointment and must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling and meeting with the Practitioner Health Committee.
- f. All further decisions as to what actions, if any, need to be taken remain with the Vice President of Medical Affairs.
- g. If at any time the Practitioner fails to comply with the indicated terms and conditions, the Practitioner Health Committee will immediately report this information to the Vice President of Medical Affairs, which will report to the department chair. The Vice President of Medical Affairs has the authority to do one or more of the following:

- Terminate immediately
- Demand compliance or be terminated
- Precautionary suspend until in compliance

D. CONFIDENTIALITY

- a. The Practitioner Health Committee shall handle all communications and discussions in a confidential manner, including the identity of anyone making a report, consistent with applicable legal requirements and patient safety considerations.

XXIII. Faculty and Staff Assistance Program (FSAP):

The FSAP is a confidential problem-solving resource for WVU employees and their family members. This program provides a safe place to sort through problems and determine the best resources available. FSAP services are free to WVU employees. FSAP is designed to help meet the challenges presented

by such problems as stress, family concerns, emotional difficulties, parenting issues, etc.

XXIV. Moonlighting Policy:

All programs must have their own detailed Moonlighting policy.

Moonlighting may not be required. Moonlighting has been discouraged in the past for several reasons. First, it clearly competes with the opportunity to achieve the full measure of the educational objectives of the residency. Not only does the added time burden take away for study; it reduces rest and the ability for a more balanced lifestyle. Nevertheless, many residents find the need for additional income to be compelling, and wish to use their time away from their training program to meet financial obligations.

First and foremost, the moonlighting workload must not interfere with the ability of the resident to achieve the goals and objectives of their GME program. The program director should monitor resident performance to assure the factors such as resident fatigue are not contributing to diminished learning or performance, or detracting from patient safety. The program director may also choose to monitor the number of hours and the nature of the workload of residents engaging in moonlighting experiences (whether internal or external moonlighting) Professional activities outside the scope of the resident/fellow program, which includes volunteer work or service in a clinical setting, or employment that is not required by the resident's program (moonlighting) shall not jeopardize any training program of the University, compromise the value of the resident/fellow education experience or interfere in any way with the responsibilities and assignment of the program.

All residents engaged in external moonlighting must be licensed for unsupervised medical practice in the state where the moonlighting occurs. It is the responsibility of the institution hiring the resident to moonlight to determine whether such licensure is in place, adequate liability coverage is provided, and whether the resident has the appropriate training and skills to carry out assigned duties. Residents engaged in external moonlighting must obtain their own registered DEA license. A resident may not use the WVUH DEA license when engaged in external moonlighting.

The program director should acknowledge in writing that s/he is aware that the resident is moonlighting, and this information should be part of the resident's folder with copies to the Central GME office. The program director may revoke the right and privilege to moonlight at any time for any reason.

Time spent by residents in Internal and External moonlighting does count toward the ACGME 80 hour/week maximum hourly limit.

PGY-1 residents are not permitted to moonlight.
J-1 physician trainees may not moonlight, either internally or externally
ECFMG regulations.

XXV. 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.

XXVI. Harassment Policy:

A. Policy Statement: West Virginia University is committed to providing faculty, staff, and students with a work and educational environment free from all forms of harassment including but not limited to sexual harassment. The University will not tolerate behavior that interferes with an individual's work performance or that creates an intimidating, hostile or offensive work or learning environment. Therefore, harassment, in any manner or form, of West Virginia University students and employees is a violation of University policy and expressly prohibited.

All University faculty, students, and staff are expected to: engage in conduct that meets professional standards, remain sensitive to the effect of their actions and words on others, take appropriate action to prevent harassment, avoid behavior that might be construed as sexual harassment, and acquaint themselves with this policy.

Those in supervisory positions have a special responsibility to discourage sexual harassment as well as to implement and to enforce this policy. Violators of this policy are subject to disciplinary action that may include sanctions as severe as discharge of an employee or expulsion of a student. In addition, sexual harassment that constitutes sexual battery or other criminal law violations will be referred to the appropriate authorities for prosecution.

B. Legal Basis: Sexual harassment is prohibited by:

1. 1980 Equal Employment Opportunity Commission interpretive guideline of Title VII of the Civil Rights Act of 1964,
2. The Office of Civil Rights policy statement interpreting Title IX of the Educational Amendments of 1972.

3. The West Virginia Human Rights Act, and
4. The Board of Governors Policy Bulletin No. 9: Policy Regarding Sexual Harassment.

C. This information can be found on the West Virginia University [Division of Diversity, Equity and Inclusion](#) website.

XXVII. Program and Institution Closure/Reduction Policy:

If the School of Medicine intends to reduce the size of a program or to close a residency program, the department chair or program director shall inform the resident as soon as possible of the reduction or closure. In the event of such reduction or closure, 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 another program in which they can continue their education.

Should the WVU School of Medicine decide to discontinue sponsorship for graduate medical education, residents will be notified of the intent in writing by the DIO as soon as possible after the decision is confirmed by the GMEC and the institutional leadership including the Dean of the School of Medicine.

XXVIII. Resident Forum:

For details please reference the Resident Forum Charter at this link: [Resident Forum Charter](#)

XXIX. Other Policies

These by-laws provide authority to the GMEC to establish other policies to govern the activities of graduate medical education sponsored by the School of Medicine to protect the well-being and educational experiences of residents in these programs and to maintain compliance with the ACGME institutional, common program and specialty specific requirements. Residents have the right to receive and review all policies and procedures of the sponsoring institution in written or electronic format.

XXX. Revisions to the By-Laws

These by-laws may be revised or amended by majority vote of those members present at a standing or special meeting of the GMEC.