

# Integrated Plastic Surgery

## Resident Manual

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**WEST VIRGINIA UNIVERSITY**  
**DIVISION OF PLASTIC, RECONSTRUCTIVE, AND HAND SURGERY**  
**MISSION STATEMENT**

As members of the West Virginia University School of Medicine Division of Plastic Surgery, it is our goal to provide the highest quality of care to the people of West Virginia, as well as the surrounding geographical area. To achieve this goal we direct our efforts toward three activities:

**CLINICAL SERVICES:**

1. Developing and maintaining excellence in specialized programs of plastic surgical care including adult and pediatric general reconstructive surgery, breast reconstruction, cleft and craniofacial care, hand care, lower extremity salvage, general wound care, and cosmetic surgery.
2. Developing outreach programs to enhance resident and learner education, patient access, and convenience.

**EDUCATION:**

1. Providing a comprehensive training (clinical and didactic) program for physicians and learners in plastic surgery that achieves the high standards as established by the ACGME for eventual board certification that supports the compassionate, appropriate and effective treatment of patients with problems relevant to plastic surgery and promotes the ethical behavior consistent with the ASPS Code of Ethics
2. Providing exposure to basic plastic surgical principles and procedures, incorporating the core values of clinical care and surgical care to non-plastic surgery trainees.
3. Providing didactic teaching in the realm of plastic surgery to students of medicine, dentistry and other ancillary providers.

**RESEARCH:**

1. Promoting involvement by members of the Division of Plastic, Reconstructive, and Hand Surgery in research and scholarly academic activity. Residents are expected to engage with faculty and take advantage of this opportunity.

## INTRODUCTION

Plastic, Reconstructive, and Hand Surgery is a division of the Department of Surgery at the West Virginia University School of Medicine. The Plastic Surgery Residency is its educational arm. This relationship is maintained at the West Virginia University Ruby Memorial Hospital wherein we practice. Faculty members of the Division are members of the School of Medicine. Other divisions of the Department of Surgery are General Surgery, Bariatric Surgery, Cardiothoracic Surgery, Pediatric Surgery, Trauma/Acute Surgery, and Surgical Oncology.

## EDUCATIONAL GOAL

The overall educational goal of the Plastic Surgery Residency is to provide an educational program with sufficient experience in the evaluation, diagnosis and management of the plastic surgery patient to result in the emergence of physicians with the ability for independent, competent, and moral practice of the specialty. The West Virginia University School of Medicine Plastic Surgery Residency provides an organized, progressive educational experience with increasing patient care responsibilities in settings with diverse patient populations and a teaching staff with professional ability, enthusiasm and a commitment to teaching. The overall educational goals can be met by adhering to the six (6) ACGME competencies below.

## CRITERIA FOR APPOINTMENT/ELIGIBILITY AND SELECTION OF CANDIDATES POLICY

The sources of candidates for entry into graduate medical education programs will be graduates of Liaison Committee for Medical Education (LCME), American Osteopathic Association (AOA)-accredited medical schools, and international medical graduates (IMG) with ECFMG certification and/or licensure. All programs participate in an organized matching program when one is available to select qualified applicants. WVU School of Medicine only accepts J-1 Visa Status for Resident Physician positions when a visa is required for employment in the United States. In addition, to be eligible for consideration a candidate must be a:

- A.** Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
- B.** Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
- C.** Graduate of a medical school outside the United States and Canada who meet at least one of the following qualifications:
  - a.** Have received a currently valid certification from the Educational Commission for Foreign Medical Graduates (ECFMG) or
  - b.** Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
- D.** Graduate of medical school outside the United States who has completed a Fifth Pathway program provided 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 U.S. college or university, 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 foreign 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 Graduated 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).

E. Candidates must meet all federal standards as may be required by Centers for Medicare & Medicaid Services (CMS) or other federal and state regulatory agencies. Applicants that are designated by CMS as “excluded providers” shall not be eligible to appointment as a resident.

Residents selected outside the normal matching process, whether that is through the match ‘scramble’ or during the ‘off-cycle’ must be reviewed and approved by the Designated Institutional Official (DIO).

Program directors should base their selection on the eligible candidate’s ability, aptitude, and preparedness as evidenced by their academic credentials including but not limited to class rank, course evaluations, and standardized licensure qualifying examination scores, communication skill both written and verbal, and letters of recommendation from faculty and the Dean of their school verifying their ability, aptitude, and preparedness as well as their motivation and integrity. There must not be any discrimination in the selection process with regard to race, age, religious affiliation, creed, sexual orientation, gender, gender identity, color, national origin, disability or veteran status.

### **ACGME COMPETENCIES**

The goal of the Plastic Surgery Residency at West Virginia University School of Medicine is to train residents to embrace the ACGME competencies during residency as stated below.

#### ***Patient Care***

Patient Care that is compassionate, appropriate and effective for the treatment of health problems and the promotion of health. Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice

#### ***Medical Knowledge***

Medical Knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents must demonstrate knowledge of the pertinent basic science subjects, such as anatomy, physiology, pathology, embryology, radiation biology, genetics, microbiology, pharmacology, as well as practice management, ethics, and medico- legal topics.

#### ***Practice-Based Learning and Improvement***

Practice-Based Learning and Improvement that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. Residents are expected to develop skills and habits to be able to meet specific goals.

#### ***Interpersonal and Communication Skills***

Interpersonal and communication Skills that result in effective information exchange and teaming with patients, their families, and other health professionals. Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents are expected to communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; communicate effectively with physicians, other health professionals,

and health related agencies; work effectively as a member or leader of a health care team or other professional group; act in a consultative role to other physicians and health professionals; and maintain comprehensive, timely, and legible medical records, if applicable.

### ***Professionalism***

Professionalism as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. Residents are expected to demonstrate compassion, integrity, and respect for others; responsiveness to patient needs that supersedes self interest; respect for patient privacy and autonomy; accountability to patients, society and the profession; and sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

### ***Systems-Based Practice***

Systems-Based Practice as manifested by actions that demonstrate an awareness of and responsiveness to larger context and system health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to work effectively in various health care delivery settings and systems relevant to their clinical specialty; coordinate patient care within the health care system relevant to their clinical specialty; incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; advocate for quality patient care and optimal patient care systems; work in inter-professional teams to enhance patient safety and improve patient care quality; and participate in identifying system errors and implementing potential systems solutions.

Each rotation and didactic experience will contribute to the acquisition of a given competency. It is the responsibility of the resident to obtain these competencies by vigorous attention to patient care in and out of the operating room, diligent study of the literature appropriate to plastic surgery, and attendance at didactic sessions. It is the responsibility of the faculty to provide clinical and didactic resources to the residents/fellows that will allow the residents/fellows to acquire these competencies and to evaluate their progress in doing so regularly and take corrective action when necessary.

## **SUPERVISION POLICY**

**Purpose:** To establish a policy to ensure all residents are provided appropriate supervision while gradually gaining autonomy and independence.

### **Responsibilities/Requirements**

1. Lines of supervision in the Department of Surgery follow a set of guidelines, which is used throughout all of the rotations.
2. PGY 1's are to be supervised directly or indirectly with direct supervision immediately available.
3. Junior (PGY 2-3) residents will supervise intern activities and also communicate with their superiors, either upper-level residents or faculty.
4. Senior (PGY 4-6) residents will also serve in a supervisory role and will communicate with faculty. Ultimately the decisions rest upon the faculty.

**Levels of supervision are defined as:**

**Direct Supervision:** Physically present with the resident and patient

**Indirect Supervision:** (Direct supervision **immediately** available) Supervising physician physically within the hospital and immediately available to provide Direct Supervision.

**Indirect Supervision:** (Direct supervision available) Supervising physician is not physically present within the hospital, but is immediately available by means of telephone and/or electronic modalities, and is available to provide Direct Supervision.

**Oversite:** Supervising physician is available to provide review of procedures with feedback provided after care is delivered.

The Department wants to make it clear that all residents should feel comfortable seeking help. Only through non-judgmental interactions can residents learn effectively. Management and patient care can seem overwhelming at times and it is the responsibility of the faculty surgeons to ensure an environment where residents feel they have the necessary support and can perform to their utmost abilities.

**FACULTY SUPERVISION / RESPONSIBILITY GUIDELINES**

Supervision of the residents shall be carried out by the teaching faculty under the direction of the Program Director. It is the Program Director's responsibility to see that such supervision is adequate and appropriate to maintain both the optimal education environment and excellent quality of patient care. Determining the level of responsibility for each resident will be the responsibility of the Program Director with input from the teaching faculty.

The following is a list of faculty guidelines:

1. As a faculty member, you bear the ultimate responsibility for patient care and for providing the documentation in the medical record of the care provided. These responsibilities should be exercised without diluting the educational process.
2. Patient interaction should be real, not theoretical. Bedside, office and operating room clinical skills should be stressed and modeled. At least some new patient presentations should occur at the bedside.
3. All patients admitted to the plastic surgery service during the week should be seen and formally staffed with the resident on the day of admission. Patients admitted after this time should be seen and evaluated with formal staffing with the resident the following day. If there is an acute change in the patient's condition during the daytime, the appropriate faculty member is to be notified immediately by the resident. If this occurs after hours, the resident will contact the individual faculty member or the Plastic Surgery faculty member on call at that time. For patients admitted on weekends or holidays, staffing should occur no later than 24 hours after admission. If you are absent, residents must be aware of your designee for patient care issues.
4. You are responsible for informing your residents of when they must contact faculty immediately relative to the following patient care issues: end of life status change, ICU admission, need for emergency operative intervention, etc.
5. You should plan your schedule so you will be available at all times during the day when patient care and teaching activities are proceeding. Residents must be aware of your designee when you are out of town or otherwise absent.
6. Feedback should be given to residents informally on a daily basis and formally at the end of the rotation via the evaluation process. Suggestions for improvement should be made early enough for corrective action to be attempted.
7. Regular chart reviews should be conducted. The focus should be on record completion and avoidance of unnecessary tests and procedures, and assessment of appropriate patient care and documentation.
8. Rotating medical students and residents from other services must be included in teaching and patient care activities. When requested, evaluations on these students and residents should be completed in a timely manner. Plastic surgery residents must be instructed and evaluated for operative techniques during operative procedures, as well as preoperative and postoperative care.

9. Insist that residents/fellows on your service consult the literature regularly about issues that arise in the context of patient care. Ask them to cite the literature and share their findings with you and other team members.
10. You are responsible for attending and participating in scheduled conferences and other didactic activities of the Division and Department. An attendance log will be kept for program certification purposes.

## **SUPERVISION**

**S**afety of the patient as well as safety of the resident are of paramount importance. The Department of Surgery will not compromise the safety of a patient in any way. All patient care will be supervised by the attending faculty to varying degrees to allow for increasing autonomy and growth of the resident. It is the Department's goal to create a nurturing environment where residents may feel safe and secure at all times while gaining independence.

**U**ltimate responsibility resides with the attending physician who supervises all resident activities. All clinical work is done under the supervision of an attending faculty. While the degree of supervision in any given examination/procedure will vary with the particulars of the event, as well as the level of training of the resident, the ultimate responsibility for the written report created is that of the attending surgeon.

**P**ersonal responsibility and accountability. Residents and faculty are expected to hold themselves up to the highest standards. Professionalism should be maintained at all times. It is understood that at times errors will be made, it is also understood that these errors should serve as learning points as to avoid them in the future.

**E**xpiration. It is inevitable that at some point in a resident's career they will have to deal with the death of a patient. In this event the resident will notify their senior resident and/or attending immediately. Resident will be given proper training in regards to end of life issues, death pronouncements, communicating death to families and necessary paper work. Attending faculty will be available at all times to provide support to residents following the death of a patient. **"Ready or Not"**. PGY-1 residents will participate in a supervisory evaluation at the completion of their PGY-1 year. Successful completion of the evaluation will be necessary for the resident to be given supervisory privileges for the upcoming year.

**Vital Signs.** All significant change in patient vital signs or mental status will be communicated to the resident's supervisor. Should a patient become unstable at any time, this will be communicated to the attending surgeon.

**Invasive procedures.** Residents will be supervised by a more senior resident or attending faculty until they are felt competent to perform that procedure independently. Hospital privileging criteria will also be followed.

**Status.** Any change in patient status needs to be communicated to the attending faculty. Any change in level of care requiring a change in unit acuity, will be immediately communicated to the attending. Any change in code status will also be relayed to the attending faculty.

**Introductions & Issues.** Faculty and residents will introduce themselves and inform their patients of their role in each patient's care. All family or patient issues or concerns will be brought first to the attention of the supervising resident. If resolution cannot be obtained, all issues will be discussed with the attending. Issues that arise between nursing, consulting services, ancillary care, etc. will be brought to the attention of the attending surgeon.

**On call.** A printed, emailed or online call schedule is sent out monthly to residents, faculty and the hospital paging office. In the event of unforeseen circumstances, such as illness, the resident will be informed by the program director, senior resident or program coordinator who the supervising surgeon will be. All faculty will be available during the day and when on call via telephone and/or beeper.

**Notification.** Faculty will be notified of all elective admissions or transfers within 2-4 hours of arrival. All discharges will be discussed with the attending surgeon. All changes in care plans will be communicated to the attending faculty.



If she/he is unavailable, then the program director or the chairman of the department should be contacted in order to make a final decision on the plan and/or treatment. When the residents are called for consults in the Emergency Department or the wards, the attending faculty will be notified immediately following the resident's evaluation.

## EDUCATIONAL CONFERENCES

Our conference schedule is designed to cover a comprehensive curriculum for plastic surgery topics.

As part of the Department of Surgery Academic Wednesday morning, all surgical residents are relieved of all non-emergent duties to participate in the academic morning. The Core Curriculum Conference and the Plastic Surgery Academic Hour are a dedicated periods wherein all plastic surgery faculty, all plastic surgery residents, and rotating non-plastic surgical residents meet once weekly on Wednesdays. Attendance is mandatory and recorded for plastic surgical staff and residents. Physician extenders, nursing, and ancillary staff are invited and encouraged to attend as well.

**1. Core Curriculum Conference** The goal of the core curriculum conference is to provide the trainee with focused instruction on a topic relevant to plastic surgery. Each Wednesday (6:00-7:00) consists of a multimodality format designed to instruct the plastic surgery resident on the core topics pertinent to general plastic surgery. The formatting will incorporate a Written Board question and answer session. Plastic Surgery Indications, Operations, and Outcomes, will be used in a two-year rotating conference schedule. Topics include the full spectrum of reconstructive and aesthetic surgery. The conference is organized and monitored by the program director with weekly faculty facilitators.

**2. The Plastic Surgery Academic Hour:** Plastic Surgery Academic Hour is held each week on Wednesdays (8:00-9:00) during the Department of Surgery Academic morning.

**a. Plastic Surgery Grand Rounds:** The goal of grand rounds is to present a topic germane to the practice of plastic surgery in an instructive manner so as to extend the current understanding of the topic to residents in training, physician extenders, nurses, and ancillary providers. The resident in training is encouraged to participate in discussion and should use the didactic hour topics as incentive for further selected reading as these topics are covered on both in-service and the written examination for certification in plastic surgery. A rotating schedule of topics will be managed by the program director to assure global and salient content. Plastic surgery staff and/or field leaders will prepare 45 minute PowerPoint presentations on selected topics. A 15 minute period of discussion will occur thereafter. The presenters will be evaluated on their presentation.

**b. Journal Club:** The goal of the journal club conference is to promote active review of peer reviewed published literature. The plastic surgery staff will create a repository of recently (within the last 6 months) published papers. A plastic surgery resident will select up to 3 articles to read, prepare a PowerPoint presentation, and present at conference. It is expected that they will facilitate discussion by critically reviewing the papers for experimental design, execution, bias, outcomes analysis, and conclusions. Not only the resident, but the participants are expected to gain a critical understanding of the literature, its content, and its applicability. Plastic Surgery residents will be evaluated on their presentations.

**c. Morbidity and Mortality Conference:** The goal of the morbidity and mortality conference is self- surveillance as practicing plastic surgeons, to review best practices, to self-reflect, individually and as a collective, and to evolving strategies for self and practice improvement. Morbidities and mortalities from the period four weeks prior to the conference will be accrued. Residents who participated in the listed cases will be responsible for preparing a PowerPoint presentation of the individual case. The presentation will include salient points of the case- preoperative, intraoperative, and postoperative. Associated photography is anticipated to enhance the discussion. A short literature review is expected to close the presentation. The responsible attending physician will be in attendance to participate in the presentation. Plastic Surgery residents will be evaluated on their presentation.

**d. Craniofacial Conference:** The goal of craniofacial conference, held the second Thursday monthly at noon, is to review new and follow up craniofacial cases in a multidisciplinary review, discussing presentation, diagnosis, and treatment arriving at a summative recommendation for each patient.

e. **Vascular Anomalies Conference:** The goal of vascular anomalies conference, held the third Thursday monthly at noon, is to review new and follow up cases in a multidisciplinary review, discussing presentation, diagnosis, and treatment arriving at a summative recommendation for each patient.

**EXCEPTIONS:** Residents are only excused from conference:

1. with approved time off recorded by the Program Director
2. with advance notification of absence (via email) to the Program Director AND his approval for said absence. (Ashley Hagood should be copied on the note of approval from the Program Director.)

**ATTENDANCE:**

An attendance rate of 80% or higher at the Plastic Surgery conferences listed is required. During the Wednesday academic morning, clinical responsibilities are waived to attend conferences. While on surgery in general rotations, you should attend any other conferences specific to that rotation held during the week.

**SKILLS LAB SESSIONS**

Assigned labs are mandatory. They are monitored by the Program Director and other members of the faculty who provide training and feedback.

The skills lab sessions are designed to be a “practice arena” for the surgical resident. These sessions allow the resident to practice, review, and sometimes test skill and techniques to gain competence confidence.

Skills labs include:

**PGY 1 and 2**

1. IV insertion.
2. Suturing techniques and knot tying.
3. Chest tube insertion.
4. Central line insertion.
5. Microsurgical Simulation

**PGY 3**

1. Cleft Repair Simulation
2. Microsurgical Simulation

**PGY 3-6**

The perfused cadaveric lab sessions are designed to be a “practice arena” for the surgical resident to elevate common tissues and flaps used in the practice of plastic surgery. These sessions allow the resident to practice, review, and sometimes test skill and techniques to gain competence and confidence in seven procedures.

Cadaveric labs include:

1. Exposure of the facial skeleton.
2. Elevation of deep inferior epigastric (DIEP) flap.
3. Elevation of fibular flap.
4. Elevation of anterolateral thigh (ALT) flap.
5. Elevation of radial forearm flap.
6. Elevation of pectoralis flap.
7. Component separation.

## PLASTIC SURGERY CASE LOG POLICY

The Plastic Surgery Operative Log (PSOL) is a computerized web-based log of all operating room procedures performed in the Plastic Surgery section. The Accreditation Council for Graduate Medical Education (ACGME) is the organization responsible for accrediting all residency training programs. The ACGME requires collection and submission of Operating Room Data. The accuracy of the data is very important to the continued accreditation of our program and to the assessment of eligibility of each resident for the qualifying examination of the American Board of Plastic Surgery (ABPS). Remember that procedures performed in the emergency room (e.g. closed reduction of fractures, etc.) count as cases and should be recorded. It is mandatory that cases be logged throughout the continuum of the resident's surgical training. It is *not* acceptable to log the minimal number of required cases and stop recording cases. Failure to maintain an accurate PSOL may result in ineligibility for the qualifying examination of the ABPS. Data collection is the responsibility of the individual resident. To enter your cases, you must go to the ACGME web site and sign-in with your ID and password. Cases should be entered **at least weekly**. Operative logs are monitored each month by the program director and Program Education Committee (PEC). If cases are not logged and kept current, the resident will be disciplined. Surgical case logs must be completed and available for the entire program upon graduation. No certifications will be issued until all logs are completed and the final surgical record is signed. Residents who have not entered their cases in a timely manner will be subject to disciplinary action. Letters may also be placed in the resident's file addressing the issue of non-compliance and may be discussed during evaluations with the Program Director. The entry of case logs in a timely manner is one of the factors contributing towards each resident's "Professionalism" Milestone.

## PLASTIC SURGERY CASE LOG DIRECTIONS

The Plastic Surgery Operative Log System (PSOL) is an internet based case log system utilizing CPT codes to track a resident's operative experience. The Residency Review Committee (RRC) has indexed these codes into categories for evaluation. This program was designed to allow residents to enter procedures on a regular basis at their convenience. Entry can be done from any PC connected to the World Wide Web at any time 24 hours a day.

1. Go to the [www.acgme.org](http://www.acgme.org) homepage. Review the Case Log System Resident User Guide Select. The Resident Case Log System Screen will have updated information on instructions to obtain a user ID. User's manuals and listing of all available CPT codes are also available.
2. Once you receive an email from the ACGME with a User ID, enter the User ID and Password and click on the "Login" button.
3. You may change your password at any time after the initial first time log in. If you would forget your password you may contact the ACGME by clicking forgot password or reset a new password.
4. Take a few moments to review the welcome page and the manual. Depending on the level of user access allowed, certain heading tabs may not be available.

If you need additional information or help, please contact Ashley Hagood at (304) 293-7480.

## CORE REQUIREMENTS FOR INTEGRATED PROGRAM (PGY-1 and PGY-2)

### **Alimentary Tract/Abdominal Surgery (20 cases)**

Laparoscopic/endoscopic surgical technique  
 Laparotomy  
 Abdominal wall closure  
 Herniorrhaphy  
 Bowel anastomosis or repair  
 Other

### **Breast and Oncologic Surgery (20 cases)**

Mastectomy  
 Lumpectomy  
 Axillary lymphadenectomy  
 Soft tissue extremity tumors  
 Trunk tumor resection  
 Head and neck tumor resection  
 Non-axillary lymphadenectomy  
 Other

### **Trauma/Critical Care/Anesthesia Procedures (20 cases)**

Central line placement Tube thoracotomy Tracheostomy Intubation  
 Fasciotomy  
 Management of the critically ill surgical patient Initial trauma resuscitation and stabilization  
 Burn resuscitation  
 Other

## OPERATIVE MINIMUMS FOR PLASTIC SURGERY

The Resident Review Committee of the America Board of Plastic Surgery has established operative minimums for the resident in plastic surgical training. These are effective July 1, 2014

### **Reconstructive Procedures**

**1000 cases**

<i><b>Head and Neck Congenital Defects</b></i>		<i>50 cases</i>
Primary cleft lip repair	7	
Primary cleft palate repair	7	
Secondary cleft lip or palate repair	7	
Other congenital head/neck defects	29	
<i><b>Head and Neck Neoplasms</b></i>		<i>70 cases</i>
Reconstruction with local flap	16	
Reconstruction with free flap	2	
Other including skin graft/resections	42	
<i><b>Head and Neck Trauma</b></i>		<i>50 cases</i>
Treat occlusal injury	8	
Treat upper mid face fracture	8	
Treat nasal fracture	4	
Treat complex soft tissue injury	15	

Other head/neck trauma	15	
<b><i>Reconstructive Breast</i></b>		100 cases
Breast macromastia	24	
Absent breast		
Expander/Direct implant	30	
Pedicled flap	4	
Free tissue transfer	4	
Others include fat grafting/secondary procedures	38	
<b><i>Trunk Procedures</i></b>		25 cases
Treat pressure sore/Debride/VAC	3	
Treat pressure sore with flap	5	
Treat wound of trunk with flap	15	
Other trunk	2	
<b><i>Total Hand/Upper Extremity</i></b>		122 cases
<u>Hand Wound Requiring Recon</u>		
Primary closure	5	
Skin graft	5	
Reconstruction with local flap	6	
Amputation	7	
<u>Tendon Repair</u>		
Repair tendon	16	
Release of adhesions	4	
Tendon transfer	2	
<u>Nerve Injury</u>		
Reconstruct nerve	10	
<u>Fracture/Dislocation</u>		
Operative repair	30	
Release of joint contracture	2	
<u>Treatment of Dupuytren's</u>	2	
<u>Nerve Decompression</u>	16	

<u>Revasc/Replant of Digit</u>	4	
<u>Arthroplasty</u>	3	
<u>Treat Congenital Deformity</u>	2	
<u>Treat Neoplasm of Hand</u>	8	
<b>Lower Extremity Procedures</b>		<i>25 cases</i>
Treatment with graft	12	
Treatment with local flap	9	
Treatment with free tissue transfer	3	
Other lower extremity procedure	1	
<b>Burns</b>		<i>24 cases</i>
Burn reconstruction	16	
Other burn procedures	8	
<b>Other Reconstructive Cases</b>		<i>534 cases</i>

## Aesthetic Procedures

**150 cases**

<b>Total Head and Neck</b>		<i>50 cases</i>
Facelift	10	
Brow Lift	2	
Blepharoplasty	20	
Rhinoplasty	10	
Other Head/Neck	8	
<b>Total Breast</b>		<i>30 cases</i>
Breast Augmentation	16	
Mastopexy	12	
Other Breast	2	
<b>Total Body Contouring</b>		<i>50 cases</i>
Brachioplasty	2	
Abdominoplasty	10	
Body Lift	2	

Thighplasty	2	
Suction Assisted Lipectomy	15	
Other Body	19	
<b>Total Other</b>		<i>20 cases</i>
<b>Free Tissue Transfer</b>		<i>20 cases</i>
<b>Tissue Expansion</b>		<i>30 cases</i>
<b>Liposuction</b>		<i>15 cases</i>
Head and neck	5	
Trunk	5	
Extremity	5	
<b>Injectables</b>		<i>21 cases</i>
Botox	7	
Soft Tissue Fillers	7	
Autologous Fat	7	
<b>Lasers</b>		<i>10 cases</i>
Aesthetic	5	
Reconstructive	5	

## RESEARCH POLICY

The Division of Plastic Surgery recognizes research as an essential, integral component to both training and practice. It promotes academic thought, stimulates self-assessment and evolves new treatment strategies. As such, it is mandatory that each resident evolve and complete at least 3 research projects over the course of six (6) years of plastic surgical training (2 projects for those in the independent program). Project completion is defined as presentation at a regional/national meeting or submission to a medical journal. It will be expected that one project be completed by the end of the PGY-3 year. The remaining two projects will be completed by the end of the PGY-6 year.

Residents have the opportunity to present research projects they have completed before faculty, colleagues and students. PGY 1 and 2 residents will be required to submit an abstract for the Surgery Residents Research forum at the Zimmermann Lectureship held in March of each year. Residents will compete at the annual Greenbrier Resident Paper Competition at the West Virginia State American College of Surgeons Meeting (typically held in May).

## QUALITY IMPROVEMENT POLICY

The Division of Plastic Surgery recognizes exercises in quality improvement as an essential, integral component to both training and practice. As such, it is mandatory that each resident participate in the quality improvement curriculum (a 10 session course) during which time they will evolve and complete a yearly QI project. Project completion is defined as presentation at the Annual Quality Improvement Fair.

### **ABSITE EXAM/ PLASTIC SURGERY IN-SERVICE EXAM**

Residents in integrated training years 1 and 2 are expected to participate in the annual ABSITE exam on the scheduled day.

The Plastic Surgery in-service exam is administered annually (usually in March). All residents in training years 1 – 6, are expected to participate in the exam.

Residents not scoring in the 30th percentile or higher on the ABSITE exam or in the 30th percentile or higher on the annual in-service exam may lose the privilege to attend off-campus meetings during the next academic year.

### **USMLE/LICENSE POLICY**

The WVU Department of Surgery will comply with the School of Medicine's Bylaws and Policies regarding the completion of the USMLE exams and application for a West Virginia State Medical License. In doing so the following department policy will be in effect.

Overview:

All PGY 1 residents will have completed Step 1 and Step 2 CS AND CK prior to starting their intern year.

1. All PGY 1 residents will have applied for Step 3 by June 30 of their intern year.
2. All PGY 2 residents will have successfully completed and passed the USMLE Step III exam by Dec 31<sup>st</sup> of the residents PGY II year. If the resident has not passed USMLE III, by December 31<sup>st</sup>, they must re- apply, complete and pass the exam by April of their PG 2 year. Failure to complete, will result in immediate Academic Probation.
3. All PGY 2 residents will have applied for their WV State medical license by April of their PGY 2 year. International Medical Graduates (IMG's) will start the process for their WV State medical license toward completion of his/her PGY 3 year to be eligible to enter his/her PGY 4 year of residency. Failure to apply for a WV State Medical License by April 1 of the PGY II (PGY III for IMGs) year results in immediate Academic Probation.
4. No PGY 3 or 4 contracts for any resident will be issued until proof of application for a WV State license is on file in the Program Coordinator's office.

### **Time Limit and Number of Attempts Allowed to Complete All Steps**

Although there is no limit on the total number of times you can retake a Step or Step Component you have not passed, the USMLE program recommends to medical licensing authorities that they:

1. Require the dates of passing the Step 1, Step 2, and Step 3 examinations to occur within a sevenyear period; and
2. Allow no more than six attempts to pass each Step or Step Component without demonstration of additional educational experience acceptable to the medical licensing authority.

For purposes of medical licensure in the United States, any time limit to complete the USMLE is established by the state medical boards. Most, but not all, use the recommended seven years as the time limit for completion of the full USMLE sequence. While medical schools may require students to pass one or more Steps for advancement and/or graduation, you should understand the implications for licensure. For states that establish a time limit for completion of all three Steps, the "clock" starts running on the date the first Step or Step Component is passed or, in some cases, on the date of the first attempt at any Step. For definitive information, you should contact directly the licensing authority in West Virginia. The addresses and phone numbers are listed below in order to give you state-specific requirements.



### **EXPECTATIONS OF A RESIDENT'S BEHAVIOR:**

1. Follow the ACGME work hour restrictions and secure your appropriate days off. It is your responsibility to be familiar with the ACGME work hour guidelines and how to log and track them.
2. Be at work on time every day you are scheduled to work.
3. Answer your pages promptly. Allow adequate time for others to answer their pages.
4. Stay groomed and showered every day.
5. Dress: shirt/tie equivalent, or scrubs and white coat. No sweatshirts, sweatpants, jeans, shorts, etc. WVU jackets are acceptable.
6. Round every day. See every patient on rounds. Pre-round as needed to present concise, complete, data filled, focused exchanges with staff. Examine every patient on rounds and remove every dressing.
7. Finish pre-rounds before Wednesday morning conferences or before going to the OR.
8. Monitor the global schedule to have an awareness of who may need help and what offers the best learning opportunities.
9. Work a full day, even if you do not specifically have OR cases or clinic.
10. On days when you may not have cases, attend a clinic or help with surgery in other rooms.
11. Down time is a good time to read, study operative techniques, or evolve and work on research projects before you are distracted by other obligations and duties at home.
12. "Covering" for someone means that you are responsible for **all** of that resident's duties/responsibilities: rounding, direct patient care, floor calls, ER calls, pre-op.

### **CALL RESPONSIBILITIES:**

1. Respond to pages quickly and courteously. It is your responsibility to remain in proximity to a phone when you are on call.
2. It is your responsibility to maintain availability to evaluate patients within approximately 30 minutes. You must choose your residence, maintain transportation, and arrange your personal life and child care accordingly.
3. Respond to any patient for whom you are consulted, regardless of your assigned rotation. Questions should be directed to the attending on-call to govern treatment expertise or hospital coverage.
4. When contacted by an outside facility pass along information that you've received to the ER or admitting unit.
5. Review the patient's complaint, lab/imaging data, and physical findings with the attending on call.
6. Every patient seen during the residency has an assigned attending. There are no patients assigned to a "service" or "resident". It is your responsibility to define who the attending is, document it in the chart, and keep them informed. No patient should be admitted without the knowledge of an attending, and no attending should be assigned when he/she is out of town.
7. Enter a history and physical (H&P) note on each patient when they are seen. This must be documented within 24 hours at the latest.
8. Ensure proper follow-up care for patients seen in the ER in the appropriate attending's clinic. You may have to usher them into or through the system. It is your responsibility to learn, or investigate, the method of follow-up for each patient within each hospital system. Do not permit a patient to get lost to follow up.
9. Never direct questions from known patients to a local ER or to our ER unless instructed so by the attending physician. They should be assessed for urgency and questions should be directed to the attending on call, or to the treating attending, as appropriate.
10. Patients evaluated in the ER should be assessed and treated definitively, with a clear plan communicated to the ER, the plastic surgery attending, and the resident assigned to the accepting service in hospital. Patients with problems that can be treated in the ER should not be sent to clinic to receive that same treatment. Communication should be HIPPA compliant.
11. If your plan includes going to the OR, be sure to investigate the results of labs, x-rays, the patient's NPO status, and the availability of the OR prior to calling the attending. Obtain consent if the patient will go to the OR that night or the next day.

12. Take photos of every patient you see and transmit those photos to the appropriate attending via an appropriate HIPPA compliant source.

## **CODE OF PROFESSIONALISM**

The West Virginia University School of Medicine embraces the following Code of Professionalism amongst all students, residents, faculty, and staff. This Code provides the foundation for proper lifelong professional behavior. It is the expectation that this behavior will be consistently maintained at its highest level both inside and outside of the professional training environment. This is one of the core ACGME competencies.

### **The nine primary areas of professionalism are defined as:**

#### ***Honesty and Integrity***

Honesty in action and in words, with self and with others Does not lie, cheat, or steal  
Adheres sincerely to school values (love, respect, humility, creativity, faith, courage, integrity, trust)  
Avoids misrepresenting one's self or knowledge  
Admits mistakes

#### ***Accountability***

Reports to duty/class punctually and well prepared  
Keeps appointments  
Is receptive of constructive evaluations (by self and others)  
Completes all tasks on time  
Follows up on communications

#### ***Responsibility***

Reliable, trustworthy, and caring to all  
Prompt, prepared, and organized  
Takes ownership of assigned implicit and explicit assignments Seriously and diligently works toward assigned tasks  
Wears appropriate protective clothing, gear as needed in patient care

#### ***Respectful and Nonjudgmental Behavior***

Consistently courteous and civil to all  
Tolerates diversity in culture, country of origin, gender, sexual orientation, religious preference, political views, age, ethnicity, and race  
Works positively to correct misunderstandings  
Listens before acting  
Considers others' feelings, background, and perspective  
Realizes the value and limitations of one's own beliefs, and perspectives  
Strives not to make assumptions

#### ***Compassion and Empathy***

Respects and is aware of others' feelings  
Attempts to understand others' feelings  
Demonstrates mindfulness and self-reflection

#### ***Maturity***

Exhibits personal growth  
Recognizes and corrects mistakes  
Shows appropriate restraint

Tries to improve oneself  
Has the capacity to put others ahead of self  
Manages relationships and conflicts well  
Maintains personal and professional balance and boundaries  
Willfully displays professional behavior  
Makes sound decisions  
Manages time well  
Able to see the big picture  
Seeks feedback and modifies behavior accordingly  
Maintains publicly appropriate dress and appearance

### ***Skillful Communication***

Effectively uses verbal, non-verbal, and written communication skills that are appropriate to the culture/setting  
Writes and speaks with clarity at a comprehensible level  
Seeks feedback that the information provided is understood  
Speaks clearly in a manner understood by all  
Provides clear and legible written communications  
Gives and receives constructive feedback  
Wears appropriate dress for the occasion  
Enhances conflict management skills

### ***Confidentiality and Privacy in all patient affairs***

Maintains information in an appropriate manner  
Acts in accordance with known guidelines, policies, and regulations  
Seeks and reveals patient information only when necessary and appropriate

### ***Self-directed learning and appraisal skills***

Demonstrates the commitment and ability to be a lifelong learner  
Accomplishes tasks without unnecessary assistance and works and values the team  
Completes academic and clinical work in a timely manner  
Is honest in self-evaluation of behavior, performance, skills, knowledge, strengths, weaknesses, limitations, and suggests opportunities for improvement  
Is open to change  
Completes in-depth and balanced, self-evaluations on a periodic basis.

## **TRAUMA COVERAGE POLICY**

The Jon Michael Moore Trauma Center (JMMTC) is an ACS verified Level 1 Trauma Center. In being so, there are several standards that are required to maintain that designation. The JMMTC operates on a tiered trauma response system. Trauma victims deemed to require major resuscitation are designated as Priority One (P1) traumas and require the in-house presence of an attending surgeon. Those that fall into the second tier of response are designated Priority Two (P2) patients. P2 patients require the presence of the PGY 4/5 chief resident on arrival.

Therefore the following policy regarding this matter has been established:

1. This policy applies to weekdays from 6:00 p.m. to 6:00 a.m. and weekends/holidays 6:00 a.m.-6:00 a.m.
2. There will be a chief resident (PGY 4 or 5) in house at all times.
3. There will be a published back-up chief call schedule.
4. All off hour cases will be performed by the appropriate level resident. When possible, the PGY-3 resident will also scrub on all senior level cases with the Chief resident.

5. When the in-house chief is required to go to the OR during off hours a discussion will be held with the operating attending prior to beginning the case. Should it be deemed that the case is of such a critical nature that the chief resident's absence would be a detriment to the patient; the back-up chief will be called in from home. If the back-up chief happens to be of the same service as the operating attending, that chief has first option to perform the case to maintain continuity of care. Otherwise, it will be at the in-house chief's prerogative to perform the case or pass it to the back-up chief. Otherwise, when the in-house chief goes to the OR and a P2 Trauma is paged, the PGY-2/3 resident will immediately report to the OR to relieve the chief resident. The chief will break scrub and report to the trauma. After an assessment is made and plan established, the chief will return to the OR and the PGY- 2/3 resident will take over directing the trauma resuscitation

The back-up chief will also be available to come in from home at the request of the in-house chief should it be felt that additional chief support is necessary.

Adapted from U. Conn Surgery Residency Manual- Resident Documentation Requirements 9/2008 Revised 5/2009

### **PHOTOGRAPHY POLICY**

Photography is a critical component of your training and the care of your patients and the communication thereof. It is imperative that you recognize the sensitivity of this information and that it be treated with the same level of security as a medical record.

Outlined below are steps that you must follow with regard to patient photos:

1. Cameras/photo taking devices **must be** kept secure at all times.
2. Do not use your camera/photo device storage medium as you photographic repository.
3. You must use an encrypted or secure University repository for the storage of your patient images.  
The departmental server is the primary location for your photographic use. All images should be downloaded and filed. Downloads should be done daily to minimize the exposure risk.

### **EMAIL GUIDELINES**

Email shall be considered an appropriate mechanism for official communication unless otherwise prohibited by law. Official communication to residents by email will be sent with the full expectation that residents and fellows will receive email and read these emails daily on work days. Residents must insure that there is sufficient space in their accounts to allow for email to be delivered. Residents have the responsibility to recognize that certain communications may be time-critical. Residents will not be held responsible for an interruption in their ability to access a message if system malfunctions or other system-related problems prevent timely delivery of, or access to, that message (e.g., power outages or email system viruses).

If a resident chooses to forward his/her mail to another email address (AOL, Hotmail, departmental server, etc.), the resident's campus email address remains the official destination for official university and school correspondence.

### **DUTY HOUR POLICY**

Beginning July 2004, the ACGME began enforcing the 80-hour duty week for resident physicians. In addition, as of 2011, the ACGME has set aside new regulation concerning intern work restrictions. The goal is to enhance the educational experience by allowing the resident adequate time for rest and activities outside the hospital environment. It is vitally important that we comply with the regulations not only to stay within the guidelines but also to provide a program focused on educational needs not service needs. Therefore, it is important to have a thorough understanding of the rules, so that we can stay in compliance.

### ***The Rules***

1. Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities.
2. Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Maximum Duty Period of Length
  - a. Duty periods for PGY1 residents must not exceed 16 hours in duration
  - b. Duty periods for PGY2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
  - c. The program encourages residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 2200 and 0800, is encouraged.
  - d. Effective transfer of patient care is essential for patient safety. As such, residents are permitted to remain on-site in order to accomplish these tasks; this period of time must be no longer than an additional four hours.
  - e. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
  - f. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to the single patient. Justification for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family. In these cases, the resident must appropriately hand over the care of all other patients to the team responsible and document the reasons for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
4. PGY1 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods. 5. Intermediate level residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty. (Integrated residency PGY 5 and 6).

### **TRACKING DUTY HOURS**

The **Duty Hours** menu item is assigned to users who are expected to track Duty Hours at some point during their educational experience. The use of this tool is customizable by program. It may be used by residency programs to monitor for Duty Hours violations, or by other programs for general time tracking. Trainees can use it to log the length of time spent on a given task, during a certain activity and at a particular site. Programs may also require that Trainees record a Supervisor for the log entry.

Select Duty Hours detail, then click on day(s) in the small calendar to record time entry. [Required]

User: Harvey Cushing

Task: Planned Duty Hours

Activity: ☒ scheduled activities only  
Ambulatory Care

Site: ☒ scheduled sites only  
Please select...

Choose a Supervisor: Picotte, Susan LaFlesche

Enter a comment about the shift (optional):

Start and End Time: 12:30pm to 8:30pm (8 hrs)

May 2011

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4

Legend:

- ☒ Planned Duty Hours
- ☒ Unplanned Duty Hours
- ☒ In-House Call
- ☒ Vacation and other Non-Duty Hours
- ☒ Entries copied automatically from the system shift schedules. Click [up](#) (unverified) links to verify these entries. Verification can only be done on items in the past.

You may toggle the **Task Types** displayed in the calendar below.

Use the form in the top portion of the screen to enter the details to be logged. Then, click on the dates that those details should be applied to using either the date-pick calendar or the calendar below. The calendar below will populate with the details logged.

To add multiple entries to a single day, modify the log details for the next entry in the form and click on the day again in either of the available calendars.

Supervision:

- Approved by Supervisor: ☒
- Needs to be approved by Supervisor: ☐

January March

February 2011

Duty Hours for Harvey Cushing

SUN	MON	TUE	WED	THU	FRI	SAT	TOTALS
30	31	1	2	3	4	5	
6	7	8	9	10	11		
✓ Vacation [Emergency Medicine] 10:00am-6:00pm	✓ In-House Call [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ In-House Call [Emergency Medicine] 10:00am-6:00pm		
12	13	14	15	16	17	18	
		✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 10:00am-6:00pm	✓ Planned Duty Hours [Emergency Medicine] 11:00am-9:00pm		38.00 hours Total: 38.00 hours
20	21						
	✓ In-House Call [Emergency Medicine] 10:00am-6:00pm						8.00 hours Total: 8.00 hours
22	23						
							76.50 hours 24.00 hours Total: 100.50 hours Vacation: 8.00 hours (Non-Duty Hours task types not included in total calculations.)

The **Totals** column may or may not display, depending on your program's configuration.

To edit an entry, click on the linked task. To delete an entry, click the icon. If notes were logged for an entry, you may click on the icon to open the note.

The current date will be highlighted. Your ability to log entries in the future may be restricted by your Program Administrator.

To view Statistics and Violation information, click the **View Stats Reports** link.

Step 1: What are the details of the hours worked? Use the select lists to describe the hours worked.

**Task:** Select the task that best describes the hours being logged. This list is defined by your Program Administrator. Please note that the Task selected will impact how violations calculate for the hours logged; see your Program of Duty Hours Administrator if you have question on the task(s) you should log.

**Activity:** Your program may require that you select an activity. If it is required, you will not be able to record an entry until an activity is selected.



If the **scheduled activities only** box appears and is checked, then the select box will be limited to those activities that appear on your schedule 60 days in the past and 30 days in the future. You may uncheck this box to re-populate the select box with all available activities.

Please note, when the **Activity** field precedes the **Site** field, then your **Activity** selection will filter the list of available sites. The reverse is also true - if the **Site** field precedes the **Activity** field, then your **Site** selection will filter the list of available activities.

**Site:** Optional field - not all programs track Sites. If the field is included, select the site for the hours being logged. If the **scheduled sites only** box appears and is checked, then the select box will be limited to those sites that appear on your schedule 60 days in the past and 30 days in the future.

Please note, when the **Site** field precedes the **Activity** field, then your **Site** selection will filter the list of available activities. The reverse is also true - if the **Activity** field precedes the **Site** field, then your **Activity** selection will filter the list of available sites.

**Choose a Supervisor:** Optional field - not all programs use Supervision. Select the individual who supervised you during the time logged.

**Enter a comment about the shift (optional):** You may include a comment with the log entry that will be available to supervisors and administrators.

**Start and End Time:** Indicate the length of time being logged. If you enter a shift length that exceeds the length permitted for your training rank and program, you may be prompted by one or more questions. When the shift length form displays, you must answer each question and enter a comment before you can save the entry.

**Step 2: What calendar day(s) do the details entered apply to? Use the date-pick calendar to select the days on which you want to log hours.**

**Select Dates calendar:** Once you have described the details of the log entry using the fields described above, use the **Select Dates** calendar to apply those details to applicable dates. As you select dates, the log details will populate in the **Selected Dates** list and on the calendar below.

### ***Calendar Options and Explanations***

**Legend:** Log entries are color-coded by Task Type; these colors are described in the legend. All checked types will display in the calendar. You may uncheck types to filter the calendar entries by task.

**Supervision:** There are 3 types of supervision available in E\*Value: None, Active, and Passive. None - If Supervision is not used, your entries will automatically be accepted and they will display the green check mark icon.

Active - If supervision is set to Active, then the selected supervisor will need to validate the entry before it is accepted. The entry will display a red exclamation icon until the hours are validated. Once it is validated, it will display the green check mark icon. Depending on your program setup, you may not be able to edit an entry that has already been validated.

Passive - If supervision is set to Passive, then the entry will default to accepted once it is logged. The supervisor will be notified that an entry was made. If the supervisor agrees with the entry, no action will be taken. If the supervisor disagrees with the entry, then the entry will be set to unapproved.

**Duty Hours calendar:** The calendar will populate with entries logged from the **Select Dates** calendar. You may also apply details from the select box above by clicking on a date in this calendar. To edit an entry on the calendar, click on the linked task.

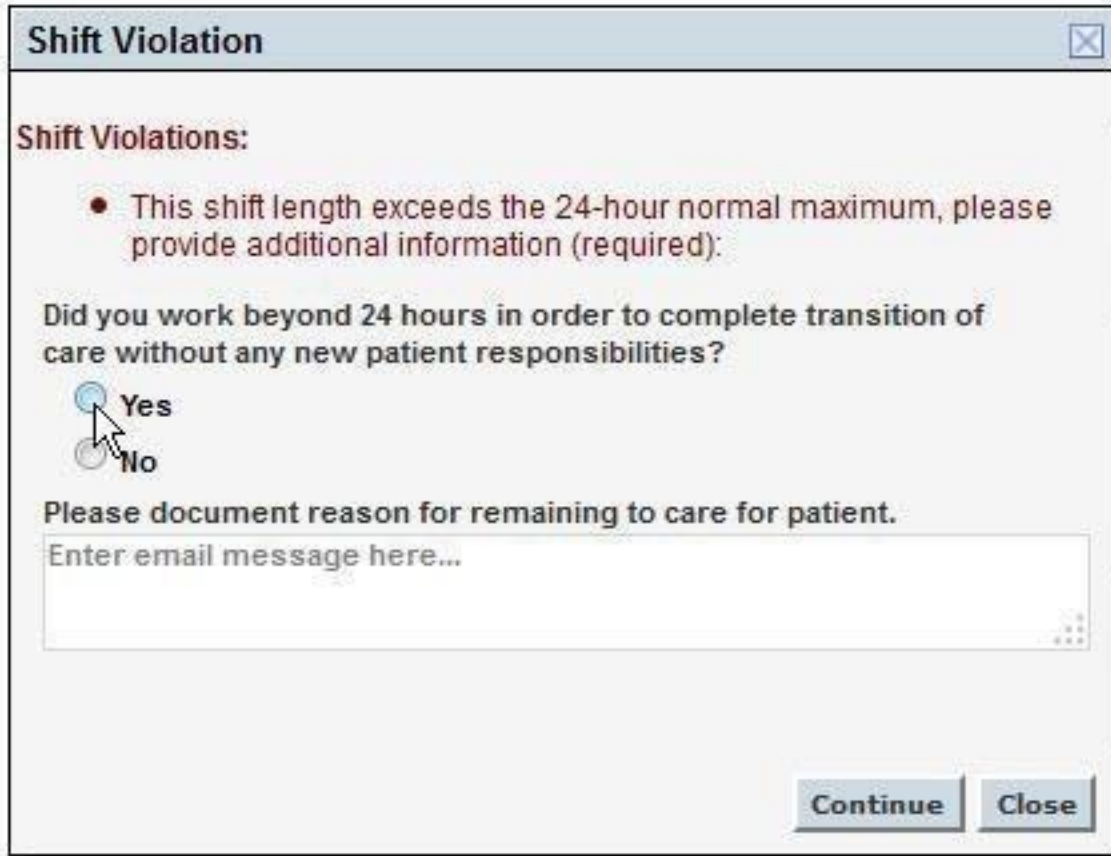
## Shift Violation Questions

You may be prompted to answer questions about shifts that could be potential Duty Hours violations.

### Shift Length Violations

When a shift is logged with a length that exceeds the permitted shift length for your training rank, but it is within the allotted time for transitioning patient care, a popup window may prompt you to indicate whether or not you were assigned new patient care responsibilities during this time:

Depending on your answer and your program's setup, you may be prompted to answer additional questions and enter a comment about the shift. Shifts logged that exceeded the permitted shift length due to transitioning patient care only will display on the Duty Hours calendar with a T:

A screenshot of a 'Shift Violation' dialog box. The title bar is light blue with the text 'Shift Violation' and a close button. The main area has a light gray background. It starts with the heading 'Shift Violations:' in bold. Below it is a red bullet point: 'This shift length exceeds the 24-hour normal maximum, please provide additional information (required):'. Then is the question 'Did you work beyond 24 hours in order to complete transition of care without any new patient responsibilities?'. There are two radio buttons: 'Yes' (selected) and 'No'. Below is the prompt 'Please document reason for remaining to care for patient.' followed by a text input field with the placeholder 'Enter email message here...'. At the bottom right are 'Continue' and 'Close' buttons.

**Shift Violation**

**Shift Violations:**

- This shift length exceeds the 24-hour normal maximum, please provide additional information (required):

Did you work beyond 24 hours in order to complete transition of care without any new patient responsibilities?

☒ Yes  
☐ No

Please document reason for remaining to care for patient.

Enter email message here...

**Continue** **Close**



Planned Duty Hours Emergency Medicine 15pm 🚫	6 Planned Duty Hours T Internal Medicine Clerkship 8:30am-...	7 Planned Duty Hours T Internal Medicine Clerkship ...-10:30am 🚫	
	13	14	15
	20	21	22

Shifts that exceed the **Permitted Shift Length** due to transitioning care only are noted with a T on the trainee's calendar.

### Shift Break Violations

If you log consecutive shifts separated by a length of time that is less than the required shift break for your training rank and program, then you may be prompted to answer a comment about the shortened shift break:

### Verifying Shifts Imported from Schedule

Programs have the option to import shifts from E\*Value's Shift Scheduling tool to their trainee's Duty Hours calendars. If your program chooses this option, those shifts will display on your Duty Hours calendar as "Unverified." After the actual shift occurs, you should modify the hours, if necessary, and verify that you worked that shift. Click the **uv** link to verify the shift:

If the actual shift exceeds the permitted Shift Length for your program and Rank, then you will be prompted to answer any Shift Length Violation questions that have been defined by your program.

### Editing an Entry

To edit an existing entry, click the task name on the calendar in the lower portion of the screen. The **Edit Duty Hours Entry** box will display. Please note, programs that track Supervisors for hours logged have the option to lock entries once they have been validated by a supervisor. If your program is configured this way, you may not be able to edit entries that appear with the green check mark icon. The following will display when you click on the entry:

Shift Violation

Shift Violations:

- This entry violates the Break Between Shifts requirements for your program. Please include comments with this entry.

Enter email message here...

Continue

Close

<div>7</div> <div>Planned Duty Hours v</div> <div>Emergency Medicine</div> <div>...-9:00am</div>	<div>8</div> <div>Planned Duty Hours uv</div> <div>Emergency Medicine</div> <div>8:00am-5:00pm</div>	<div>9</div>
<div>14</div>	<div>15</div> <div>Planned Duty Hours uv</div> <div>Emergency Medicine</div> <div>8:00am-</div> <div>verify entry</div>	<div>16</div> <div>Planned Duty Hours v</div> <div>Emergency Medicine</div> <div>12:00am-1:00pm</div>
<div>21</div>	<div>22</div> <div>Planned Duty Hours v</div> <div>Emergency Medicine</div> <div>8:00am-5:00pm</div>	<div>23</div>

## Reviewing Statistics and Violations

You can click the **View Stats Reports** link in the lower-left corner of the logging screen to preview your Duty Hours Statistics and Violations. The Duty Hours Trainee Reporting window will open: Your statistics for the selected date range will display. Any violations that occurred during the period will display by type, as shown in the example below:

✓ Hours Entry Verified by Supervisor

No Longer Updatable

User:

Noah Cambell (entry for Sunday, January 2, 2011)

Task:

Planned Duty Hours

Site:

Al Medical

Activity:

Emergency Medicine

Choose a Supervisor:

Cass, Kathy

Enter a comment about the shift (optional):

Start and End Time:

8:00am

to

8:00pm (12 hrs)

Close

[View Stats Reports](#)



## Duty Hours Trainee Reporting



Please specify the desired date range to run Duty Hours Statistic and Violation Reports. For additional history, please see Duty Hours under the Reports menu.

Start Date: June 1, 2011 End Date: June 30, 2011

Date Type: (by Calendar Month)

[View Duty Hours Statistics](#)

Select the date range to be reviewed. You can either run the report by Calendar Month or a date range specified by your Program Administrator.

Click the **View Duty Hours Statistics** button to continue.

# Duty Hours Trainee Reporting



Please specify the desired date range to run Duty Hours Statistic and Violation Reports. For additional history, please see Duty Hours under the Reports menu.

Start Date: March 1, 2011 End Date: March 31, 2011

Date Type: (by Calendar Month)

[View Duty Hours Statistics](#)

## Duty Hours Statistics between 03/01/2011 12:00 AM - 03/31/2011 12:00 AM

Total Hrs Worked	Avg Hrs Per Days Worked	Avg Hrs Per Week	Vacation Days	Days Not Logged	% Logged	% Validated
137.00	9.79	30.94	0.00	15.00	51.61%	0.00%

## Duty Hours Violations between 03/01/2011 12:00 AM - 03/31/2011 12:00 AM

Shift Length							
Rank	Shift Start	Shift End	Shift Hours	Max Hours	Activities	Comments	Document
PGY2	03/01/2011 08:03	03/02/2011 08:03	24.00	21.00	Emergency Medicine		
PGY2	03/08/2011 08:03	03/09/2011 08:03	24.00	21.00	Emergency Medicine		
PGY2	03/15/2011 08:03	03/16/2011 09:03	25.00	21.00	Emergency Medicine		
PGY2	03/22/2011 08:03	03/23/2011 09:03	25.00	21.00	Emergency Medicine		

## Email Notices and Reminders

Please note that your program may send email notices reminding you to log your hours. This is configured by program, but in most cases you will continue to receive these reminders until hours are logged.

## Duty Hours Violations:

Failure to log Duty Hours 2 weeks within a single month constitutes one violation. Two violations over 2 months will place the resident on Administrative leave.

Two occurrences of Administrative Leave over 6 months lead to Academic Probation. Any subsequent violation of Duty hour recording in that year results directly in Probation.

Each resident will log his or her hours into the E\*value, online system at [www.e-value.net](http://www.e-value.net). You will be given a login name and password. If you should forget your name or password please contact the Residency Manager, Ashley Hagood.

Weekly periods run from Monday through Sunday. The hours are to be logged in upon completion of their Sunday shift. The hours will be retrieved by the program on Monday and compiled. Off-service residents should also record their hours.

### **AT-HOME CALL**

Time spent in the hospital by residents on at-home call must count towards the 80 hour 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 80 hour weekly maximum, will not initiate a new “off duty period”.

### **TRANSITIONS OF CARE**

#### **I. Rationale**

To assure continuity of care and patient safety, ACGME requires a minimum number of patient care transitions, a structured and monitored handoff process, training for competency by residents in handoffs, 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.

#### **II. Policy**

A. Each training program should review call schedules at least annually to minimize transitions in patient care within the context of the other duty hour standards. Whenever possible, transitions in care should occur at a uniform daily time to minimize confusion. Should changes in the call schedule be necessary, documentation of the process involved in arriving at the final schedule should be included in the minutes of the annual program review.

The dedicated Department of Surgery sign-out time each weekday (M-F) is from 5:30-6:30 pm.

Call Schedules are made monthly and done so in a manner so that transitions of care are kept to as much of a minimum as possible.

Department of Surgery call schedules are available within the Connect call system. These include service specific as well as attending staff contact information.

B. Each residency training program that provides in-patient care is responsible for creating an electronic patient checklist utilizing an appropriate template and is expected to have a documented process in place to assure complete and accurate resident-to-resident patient transitions. At a minimum, key elements of this template should include:

Patient name

Age

Room number

ID number

Name and contact number of responsible resident and attending physician Pertinent diagnoses

Allergies

Pending laboratory results and X-rays

Overnight care issues with a "to do" list including follow up on laboratory and X-rays Code status

Other items may be added depending upon the specialty.

C. There must be a structured face-to-face, phone-to-phone, or secure intra-hospital electronic handoff that occurs with each patient care transition. At a minimum this should include a brief review of each patient by the transferring and accepting residents with time for interactive questions. All communication and transfers of information should be provided in a manner consistent with protecting patient confidentiality.



The Department of Surgery instituted a “Protected Time” between 5:30-6pm each day for the Handoff/Sign-out of patient care to the Night Team. The On Call” paging system reads: “Please hold Non-Urgent Pages between 5:30-6pm for Surgery Sign-out”.

All surgery residents will be excused from the floors and the operating room during the handoff/transition time period. The nurse managers of the floors have been notified to hold all non- urgent pages and calls until after this time.

Once a month a faculty member is assigned to moderate and document the sign-out process of the surgery teams.

D. Each training program is responsible for notifying the hospital telephone operators about its call schedule so that the entire health care team (staff physicians, residents, medical students, and nurses) know how to immediately reach the resident and attending physician responsible for an individual patient's care.

E. Each training program is responsible for assuring its trainees are competent in communicating with all caregivers involved in the transitions of patient care. This includes members of effective inter- professional teams that are appropriate to the delivery of care as defined by their specialty residency review committee. Methods of training to achieve competency may include annual review of the program-specific policy by the program director with the residents, departmental or GME conferences, or review of available on-line resources. Programs must include the transition of care process in its curriculum. Residents must demonstrate competency in performance of this task. Programs must develop and utilize a method of monitoring the transition of care process including evaluation of the residents, as well as the process, using E\*Value, and must update this method as necessary.

### III. GME Monitoring and Evaluation

A. To evaluate the effectiveness of transitions, monitoring will be performed using information obtained from electronic surveys in E\*value. Each resident must be evaluated, at minimum, once per year, to assess their ability to effectively and safely hand off their patients. For the first year resident, best practice would necessitate this evaluation to occur early in the academic year so problem areas may be addressed quickly.

B. Programs must have residents and faculty complete an evaluation, at least annually, on the effectiveness of the handoff system. This will be done via questions on the standard program evaluation for both residents and faculty. In addition, programs may choose to add specialty specific questions to gain more detailed information.

C. Monitoring and assessment of the Handoff process by the program must be documented in the Annual Program Review. In addition, during the annual meeting between the Program Director, the Department Chair, and the DIO, this documentation will be reviewed to confirm the Transition of Patient Care process is in place and being effectively taught, monitored, and evaluated by the program. Deficiencies in this area will result in an in-depth special program review of your program.

GMEC approved: September 9, 2011 GMEC modified: September 13, 2013

### **EVALUATION POLICY**

Residents are evaluated on a continuous basis and, as an academic institution, evaluations are extremely important. They provide much-needed and required feedback on the performance of the resident on each particular service. If a specific problem occurs, it will be addressed in a timely manner. Less severe problems are discussed in the evaluation meeting between the Program Director and the resident.

Formal evaluation of each resident will be performed using the following evaluation tools.

1. Faculty, physician extender, peer, patient, and nursing staff evaluation forms from each rotation (360 evaluation process)
2. ABSITE score
3. Plastic Surgery In-Service scores
4. The Plastic Surgery Milestone Evaluations (six ACGME Competencies)
5. Attendance and participation in conference
6. Resident operative experience tracking (Record Keeping of Cases)
7. Duty Hour log (Record Keeping of Hours)

## 8. Clinical Competency Committee Meetings (quarterly for each resident)

Formal evaluation of each rotation will be performed using the following evaluation tools.

1. Rotation evaluation
2. Faculty assessment

For residents, completion of evaluations in a timely manner is a key factor contributing to the “Professionalism” milestone.

An evaluation is completed for each resident at completion of each rotation. Any negative evaluations will be brought to the attention of the Program Director, who will bring it to the attention of the resident. Measures to correct the problem will be addressed.

Resident performance review is performed 2 times a year by the program director and 2 times a year by the Clinical Competency Committee (CCC). The resident has access to the evaluations at all times through the E\*value system. The resident will meet with the Program Director on a semi-annual basis to discuss his/her progress in the program. These meetings take place in January and June. All rotation evaluations will be reviewed with the resident and if there is an area of concern, the program director may have additional meetings if required. Each year all residents participate in the American Board of Surgery In-Service Training Examination (ABSITE) and the Plastic Surgery In-Service Exam given nationally by all Surgery departments to evaluate each individual’s progress. These examinations are designed to assess the residents’ fund of knowledge.

All evaluations are kept as part of the resident’s portfolio. Residents are urged to review their portfolios monthly and sign all evaluation forms. Residents may have access to their academic files at any time. The residents each have electronic files and can be obtained by entering the E\*value system. The Program Director is available for discussion and the residents are encouraged to seek guidance for any perceived difficulty or problem. The residents routinely and anonymously complete confidential evaluations of their various rotations, the program and the surgical faculty. The following are a list of evaluations used to assess the resident and used for the resident to assess the program.

### **Plastic Surgery Transition of Care Evaluation** Completed each rotation

An assessment of the ability of the resident to transfer patient care in a safe, effective, efficient manner. Performed by the program director at a minimum of once during each rotation during PGY 1 and 4, and if warranted otherwise. A component of the 360 Evaluation.

### **Plastic Surgery Physician Extender Evaluation** Completed each rotation

An assessment of the resident that includes medical knowledge, transfer of patient care, teaching, progress, professionalism, and care coordination. Performed at the end of each rotation by physician extenders that regularly engage the resident. A component of the 360 Evaluation.

### **Plastic Surgery Nursing Evaluation** Completed each rotation

An assessment of the resident that includes medical knowledge, transfer of patient care, teaching, professionalism, and care coordination. Performed at the end of each rotation by clinic nurses that regularly engage the resident. A component of the 360 Evaluation.

### **Plastic Surgery Peer to Peer Evaluation** Completed each rotation

An assessment of the resident that includes transfer of patient care, teaching, progress, professionalism, and care coordination. Performed at the end of each rotation by resident peers that regularly engage the resident. A component of the 360 Evaluation.

**Plastic Surgery Resident Evaluation of Rotation** Completed each rotation

An assessment of the overall rotation training experience to allow for timely feedback. Performed at the end of each rotation by the resident.

**Plastic Surgery Resident Evaluation of Faculty** Completed each rotation

An assessment of the faculty who engaged the resident during the rotation including teaching ability, commitment to educational program, clinical knowledge, professionalism, and scholarly activities. Performed at the end of each rotation by the resident.

**Plastic Surgery Resident Surgery In General Review** Completed July PGY3

An assessment of the first three years of the integrated plastic surgery training program. The intent is to evaluate the surgery in general experience for utility of individual rotations, specific and overall educational value, educational content, and attainment of designated educational goals and objectives. Performed by the resident at completion of PGY 3.

**Plastic Surgery Exit Interview** Completed July PGY6

An assessment of the resident's plastic surgical training experience. The intent is to evaluate the plastic surgery training experience for utility of individual rotations, specific and overall educational value, educational content, and attainment of designated educational goals and objectives. Performed by the resident at completion of PGY 6.

**Plastic Surgery Milestone Evaluations** Completed each rotation

An assessment of resident performance during each rotation that evaluates each of the six clinical competencies. The Plastic Surgery Milestone Project, a joint initiative of the Accreditation Council for Graduate Medical Education and The American Board of Plastic Surgery, Inc. is the framework for the evaluation. The milestones represent knowledge, skills, attitudes and other attributes for each of the six competencies organized in a framework from less to more advanced, and are targets for resident performance as the resident moves from entry through graduation. Performed at the end of each rotation by clinical physicians that regularly engage the resident.

**Patient Satisfaction Surveys** Completed each rotation

An assessment of the resident that includes medical knowledge, communication skills, professionalism, and care coordination. Performed at the end of each rotation by patients for whom the resident has cared. A component of the 360 Evaluation.

**Plastic Surgery Resident Self Evaluation** Completed quarterly

An assessment of the resident that involves a self-assessment of communication and operative skills. Performed quarterly by the resident. A component of the 360 Evaluation

**Audit of Patient Encounter** Completed quarterly PGY1 & 4

An assessment of the ability of the resident to complete and document an effective and efficient patient encounter including history interview, physical examination, medical decision making and plan, and record keeping. A chart audit is performed by the program director at a minimum of once quarterly during PGY 1 and 4, and if warranted otherwise.

**Observation of Patient Encounter** Completed quarterly PGY1 & 4

An assessment of the ability of the resident to complete an effective and efficient patient encounter including history interview, physical examination, professionalism, medical decision making, and record keeping. The program director directly observes a patient encounter at a minimum of once quarterly during PGY 1 and 4, and if warranted otherwise.

**Operative Skills Focused Assessment** Completed quarterly

An assessment of the performance of the resident during a specific operative procedure in which he participated.



Assessment includes appropriateness of surgical indication, tissue handling, use of assistants, use of instruments, observation of sterility, economy of motion, knot tying, understanding of flow, and team dynamics. Performed by the staff surgeon who directly worked with the resident. This assessment may be completed at any time during the six years of residency.

**Research Progress and Evaluation** Completed June and December

A one-on-one interview between the resident and program director twice yearly for the specific purpose of keeping research on task. Research and quality improvement projects are discussed including progress, challenges, mentor relationships, goals, and outcomes (posters, presentations, publications). Recommendations and short and long term goals are outlined.

**Plastic Surgical Skill Evaluation** Completed PGY 4, 5, and 6

An assessment of the ability of the resident to perform nine specific, frequently encountered plastic surgery procedures-three per year, each with graduated complexity. The program director and resident will coordinate so that the resident can be directly observed during the execution of each procedure. Assessment will include pre-operative preparation, justification of selected procedure, attention to safety, surgical marking/positioning, knowledge of surgical steps, handling of tissue, use of assistants, temperament, handling of complications, immediate postoperative result, dressing application, and CPT coding. Performed quarterly PGY 4, 5, 6.

**Evaluation of Presentation** Completed quarterly PGY4, 5, 6

An assessment of the ability of the resident to present a topic in a public forum including organization, communication skills, audiovisual materials, content, and audience engagement. Performed at the end of the presentation by audience participants.

**Quality Improvement Review** Completed quarterly PGY4, 5, 6

An assessment of the ability of the resident to present a topic in a public forum including organization, communication skills, audiovisual materials, content, and audience engagement. Performed at the end of the presentation by audience participants

**Program Semi-Annual Review** Completed December

A one-on-one interview between the resident and program director midway through the academic year. The year to date is discussed including medical licensure, state licensure, portfolio status, in-service scoring, duty hours, surgical log status, research and quality improvement project status, clinical competency committee review and recommendations, wellness, resident concerns, and program director concerns and recommendations. A recommendation of continuance/discontinuance will be made and endorsed by both the program director and resident.

**Program Annual Review** Completed June

A one on one interview between the resident and program director at the end of the academic year. The year is discussed including medical licensure, state licensure, portfolio status, in-service scoring, duty hours, surgical log status, research and quality improvement project status, clinical competency committee review and recommendations, wellness, resident concerns, and program director concerns and recommendations. A recommendation of continuance/discontinuance will be made and endorsed by both the program director and resident.

## **PROMOTION POLICY** Criteria for advancement

Residents are expected to complete all items listed in this section before advancing to the next level.

### ***PGY 1 advancing to PGY 2***

1. identify the purpose of clinic visit / hospital admission
2. obtain a thorough and purposeful patient history
3. perform an accurate and comprehensive physical exam
4. develop an appropriately ordered, reasonable differential diagnosis (3 or more) for presenting problem
5. develop a working diagnosis
6. recognize when a patient is sick (i.e. move patient to appropriate level of care, be able to troubleshoot)
7. order appropriate labs/tests for the presenting problem
8. prescribe medication appropriately
9. show ability to retrieve data well (key x-rays, studies, interventions, etc.)
10. demonstrate ability to obtain consults and explain to consultants the patient's course and issues
11. show ability to organize and prioritize in daily ward care
12. display abilities during in-house call, including communicating any issues about patients overnight, so that faculty are confident in resident's abilities
13. demonstrate proper informed consent for PGY 1 level procedures: central lines, chest tubes, arterial lines, breast biopsies, hernias
14. display legible and organized documentation with a completed problem list and plan for each patient
15. communicate effectively with team to keep them informed of daily patient management issues
16. demonstrate appropriate skills in mentally preparing for surgery (reading up on cases and thinking about the surgical technique prior to surgery)
17. recognize limitations and seek help appropriately
18. accept feedback well regarding operative technical skills
19. introduce self to patient and address patient with appropriate title
20. demonstrate cultural sensitivity (caring for patients regardless of gender, race, religion, or creed) in the work environment
21. learn from experience
22. document all procedures performed during PGY 1 year including: central lines, arterial lines, chest tubes, DPLs, intubations, FAST exams
23. attend > 80% of conferences, specifically M&M, Didactic Hour, and Journal Club
24. demonstrate a commitment to carrying out professional responsibilities including:
  - a. being on time to conferences/rounds/appointments
  - b. dressing professionally outside the OR
  - c. documenting duty hours weekly
  - d. completing dictation appropriately and timely
  - e. complying with departmental policies
  - f. completing evaluations within 14 days of receiving them
  - g. attending 1 clinic per week
25. demonstrate efficient and thorough patient sign-out
26. perform well in a team environment
27. teach medical students effectively (on the moment-to-moment things)
28. utilize medical databases (Up-to-Date, Pub Med, etc.) to gather best medical evidence
29. complete intern lab skills curriculum
30. complete remediation by May 1 when scoring below 40% on the ABSITE

### ***PGY 2 advancing to PGY 3***

1. identify and work up a clinical problem appropriately
2. communicate a working diagnosis to the patient
3. discuss surgical and non-surgical treatment alternatives appropriately with patient
4. discuss appropriate follow-up and /or discharge planning with patient
5. show ability to organize and prioritize in emergent situations
6. show ability to organize and prioritize in daily ward care
7. accurately interpret radiologic exams (i.e. CT scans or plain films)
8. order appropriate labs/tests for the presenting problem
9. utilize medical databases (Up-to-Date, Pub Med, etc.) to gather best medical evidence
10. display abilities during in-house call, including communicating any issues about patients overnight, so that faculty are confident in resident's abilities
11. demonstrate proper informed consent and document all PGY 2 level procedures including: open hernia repair, lap chole, amputation, appendectomy, bowel resection & anastomosis, and fascial closure
12. display legible and organized documentation with a completed problem list and plan for each patient
13. communicate effectively with team to keep them informed of daily patient management issues
14. demonstrate appropriate skills in mentally preparing for surgery (reading up on cases and thinking about the surgical technique prior to surgery)
15. recognize limitations and seek help appropriately
16. accept feedback well regarding operative technical skills
17. demonstrate efficient and thorough patient sign-out
18. teach medical students effectively (on the moment-to-moment things)
19. begin to evaluate the literature for presentations
20. introduce self to patient and address patient with appropriate title
21. demonstrate cultural sensitivity (caring for patients regardless of gender, race, religion, or creed) in the work environment
22. learn from experience
23. attend > 80% of conferences, specifically M&M, Didactic Hour, and Journal Club 24. demonstrate a commitment to carrying out professional responsibilities including:
  - a. being on time to conferences/rounds/appointments
  - b. dressing professionally outside the OR
  - c. documenting duty hours weekly
  - d. completing dictation appropriately and timely
  - e. complying with departmental policies
  - f. completing evaluations within 14 days of receiving them
  - g. attending 1 clinic per week
26. pass USMLE Step III examination
27. maintain current BLS, ACLS, and ATLS certification
28. complete remediation by May 1 when scoring below 40% on the ABSITE

### ***PGY 3 advancing to PGY 4***

1. identify and work up a clinical problem appropriately
2. communicate a working diagnosis to the patient
3. discuss surgical and non-surgical treatment alternatives appropriately with patient
4. discuss appropriate follow-up and /or discharge planning with patient
5. show ability to organize and prioritize in emergent situations
6. show ability to organize and prioritize in daily ward care
7. accurately interpret radiologic exams (i.e. CT scans or plain films)
8. order appropriate labs/tests for the presenting problem

9. independently manage patients in the ICU
10. utilize medical databases (Up-to-Date, Pub Med, etc.) to gather best medical evidence
11. display abilities during in-house call, including communicating any issues about patients overnight, so that faculty are confident in resident's abilities
12. demonstrate proper informed consent and document all procedures through PGY 3 level including: open hernia repair, lap chole, amputation, appendectomy, bowel resection & anastomosis, and fascial closure
13. display legible and organized documentation with a completed problem list and plan for each patient
14. communicate effectively with team to keep them informed of daily patient management issues
15. demonstrate appropriate skills in mentally preparing for surgery (reading up on cases and thinking about the surgical technique prior to surgery)
16. recognize limitations and seek help appropriately
17. accept feedback well regarding operative technical skills
18. demonstrate efficient and thorough patient sign-out
19. teach medical students effectively and mentor PGY 1 and 2 residents (on the moment-to-moment things)
20. evaluate the literature for presentations
21. introduce self to patient and address patient with appropriate title
22. demonstrate cultural sensitivity (caring for patients regardless of gender, race, religion, or creed) in the work environment
23. learn from experience
24. attend > 80% of conferences, specifically M&M, Didactic Hour, and Journal Club 25. demonstrate a commitment to carrying out professional responsibilities including: a. being on time to conferences/rounds/appointments
  - h. dressing professionally outside the OR
  - i. documenting duty hours weekly
  - j. completing dictation appropriately and timely
  - k. complying with departmental policies
  - l. completing evaluations within 14 days of receiving them
  - m. attending 1 clinic per week
27. maintain current BLS, ACLS, and ATLS certification
28. complete remediation by May 1 when scoring below 40% on the ABSITE

#### ***PGY 4 advancing to PGY 5***

1. obtain a thorough and purposeful patient history
2. perform an accurate and comprehensive physical exam
3. use medications and diagnostic studies appropriately
4. record complete and accurate information
5. communicate effectively with residents, faculty, and nursing to ensure optimal patient care
6. obtain consultations from appropriate services for elective care of patients
7. demonstrate reliability and responsibility for patient care
8. refer patients to appropriate practitioners and agencies
9. use available information technology to obtain and manage information
10. effectively communicate with patients and families a treatment plan including appropriate informed consent for operation
11. effectively counsel and educate patients and families to the risks and benefits of surgery as well as expectation and alternatives to surgery
12. describe treatment plans clearly to other physicians and record it in textual and other forms
13. facilitate the learning of students, residents and other health care providers
14. lead a surgical team to perform excellent patient care
15. obtain the technical skills needed to perform specified procedures encountered in each rotation

16. obtain the medical knowledge to solve patient care problems encountered in each rotation
17. judge when to seek available assistance from attending
18. access appropriate assistance within the health care system for coordination and management of ongoing care
19. prepare for cases by reading on surgical technique/anatomy, reviewing patient chart, and looking at patient films prior to start time
20. maintain professional, responsive, and mutually respectful working relationships with peers, subordinates, and all levels of patient care staff
21. attend weekly clinic of the various faculty members
22. complete medical records promptly
23. document duty hours on a weekly basis
24. document all procedures in the ACGME case logs website
25. participate in weekly conferences (for full duration)
26. deliver a comprehensive one hour didactic conference on a selected topic
27. complete evaluation forms for faculty and rotation in a timely manner
28. perform microsurgical vascular anastomosis and neural repair on a cadaver
29. complete goals and objectives (technical and cognitive) for each of the rotations within the first year  
behave in a manner consistent with the values of WVU
30. submit at least one medical paper (case report, chapter, etc.) for publication.
31. complete summation interview including logging of all cases
32. successfully achieve competency in Medical Knowledge, Patient Care, Professionalism, Interpersonal Communication Skills, Practice-based Learning and Improvement, and Systems-based Practice

#### ***PGY5 advancing to PGY6***

1. advocate for patients within the health care system
2. practice cost-effective health care and resource allocation without compromising quality of care
3. describe patient care actions in CPT language in an accurate and ethical fashion
4. appraise and assimilate evidence from scientific studies related to his/her patients' health problems
5. accurately assess the performance of junior residents, rotating residents from other services, and medical students
6. provide prompt consultations upon request
7. complete goals and objectives (technical and cognitive) for each of the rotations
8. complete summation interview including logging of all cases
9. achieve a score of  $\geq 30$ th percentile on the plastic surgery in-service examination

#### ***PGY6 to graduation***

1. assess aesthetic patients for their suitability for operation and choosing an appropriate operative or non-operative approach
2. describe patient care actions in CPT language in an accurate and ethical fashion
3. evaluate the accuracy, validity, and usefulness of a publication or presentation on plastic surgery 4.  
achieve a score of  $\geq 30$ th percentile on the plastic surgery in-service examination

## **COMPLETION OF RESIDENCY**

Residents will not receive certification of completion and eligibility for the qualifying examination for the American Board of Plastic Surgery until:

1. All dictations are complete
2. Plastic Surgery Operative Log is up-to-date and complete
3. Exit Interview with Program Director is complete
4. Duty Hours are up-to-date

## **MOONLIGHTING POLICY**

**Moonlighting is NOT permitted for plastic surgery residents.** The Division of Plastic Surgery feels activities outside the educational program must not interfere with the resident's performance nor must they compete with the opportunity to achieve the full measure of the educational objectives of the residency. The faculty feels that a surgical residency is a demanding and rigorous experience. It is felt that moonlighting also interferes with the resident's opportunities for study, relaxation, rest and a balanced life style.

## **VENDOR INTERACTION POLICY**

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.

It is the policy of the West Virginia University School of Medicine GMEC that interactions with industry and its vendors should be conducted so as to avoid or minimize conflicts of interest. When conflicts of interest do arise they must be addressed appropriately.

Consistent with the guidelines established by the American Medical Association Statement on Gifts to Physicians, acceptance of gifts from industry vendors is discouraged. Any gifts accepted by residents should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate only if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. Residents may not accept gifts or compensation for listening to a sales talk by an industry representative. Residents may not accept gifts or compensation for prescribing or changing a patient's prescription. Residents must consciously separate clinical care decisions from any perceived or actual benefits expected from any company. It is unacceptable for patient care decisions to be influenced by the possibility of personal financial gain.

Industry vendors are not permitted in any patient care areas except to provide in-service training on devices and other equipment and then only by appointment. Industry vendors are permitted in non-patient care areas by appointment only.

Appointments may be made on a per visit basis or as a standing appointment for a specified period of time, with the approval of the program director or department chair, or designated hospital or clinic personnel issuing the invitation. Vendor support of educational conferences involving resident physicians may be used provided that the funds are provided to the institution not directly to the resident. The program director should determine if the funded conference or program has educational merit. The institution must not be subject to any implicit or explicit expectation of providing something in return for the support. Financial support by industry should be fully disclosed by the meeting sponsor. The meeting or lecture content must be determined by the speaker and not the industrial sponsor. The lecturer

is expected to provide a fair and balanced assessment of therapeutic options and to promote objective scientific and educational activities and discourse.

All residents should receive training by the teaching faculty regarding potential conflicts of interest in interactions with industry vendors.

### **PARKING POLICY**

Here are some helpful hints and information that address many of the more common questions we receive regarding parking.

1. Do not use patient/visitor parking lots. This is one of the most egregious parking offenses an employee can commit, with the exception of parking illegally in a handicapped space. This practice does not reflect the patient first values of our organization.
2. Do not park illegally anywhere on WVUH property. There are always permit parking spaces available in resident lots B-1 and E. If you cannot find a space, approach one of the Security Officers and they will direct you to a space.
3. If you have more than one vehicle and you forget to transfer your permit, please obtain a staff temporary permit, good for one day. You will need to obtain the permit from the Security office.
4. If you lose your parking permit, please see the Security Office for replacement. There is a fee to replace a lost permit.
5. If you have been towed, you will need to contact the WVUH Security Office or a security officer. Parking Policy

### **RESIDENT MEETING TRAVEL POLICY**

It is encouraged that residents generate research endeavors, execute them, and report them in accepted forums for peer review. To that end, travel to local, regional, and national meetings to present work on which the resident is the primary author or has made a significant contribution is also encouraged. The following outlines the policy to be followed with respect to this travel.

1. If more than one resident would be out to the same meeting, resident attendance should follow an ordered fashion from PGY-6 down to PGY-3 (ie; the more senior resident goes).
2. It is the resident's responsibility to submit to the Program Director via the Program Manager, his/her intent to present their work at least two months prior to the time away or at the time of abstract submission, whichever comes first. Submission and acceptance does NOT mean attendance will necessarily follow.
3. It is the resident's responsibility to arrange for all patient care responsibilities, call concerns, etc to be covered without interruption in care at least 30 days in advance of the time away. This must be submitted in writing to the Program Director via the Program Manager for approval.
4. In general, there is to be no resident travel in the first two years, PGY-1 and PGY-2. Exceptions may exist for instance if the matriculating resident is first author on the work AND the work was submitted prior to matriculation into the program and/or for large national forums for which podium presentations have been excepted (NOTE: Posters do NOT warrant attendance, but may be submitted and accepted). These instances will be considered on a case-by-case basis for approval for travel.
5. **Residents will be away two days.** The day prior for travel and the day of presentation with a single overnight stay between. As they will be representing the institution during their presentation, they are to claim the number of hours they participate in the meeting the day of their presentation as duty hours per ACGME mandate.
6. In general, the Division does, within reason, financially support travel, registration, and accommodations for those who present their work at meetings. This should not be interpreted as a given and is subject to Program Director approval and Departmental approval.

## **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, the following approval process must be followed:

1. Written request for an international rotation must be addressed to the Program Director specifying at a minimum when the rotation will occur, how long the rotation will last, where the rotation will be located, and who the supervising physician will be. If the Program Director approves, go to Step 2. If denied, STOP.
2. The Program Director will review the request with the program's education committee, if approved, go to step 3. If denied, STOP.
3. The Program Director will send the resident request and supporting documentation as described in #1 and #2 to the GME Office
4. The GME Office will schedule a review of the request at the regularly scheduled meeting of the GMEC Taskforce. If approved, go to step 5. If denied, STOP.
5. The GME office will notify the Program Director, the Resident, and the Dean that the rotation has been approved.
6. The Dean will have the final approval authority to approve or deny the rotation request, once the recommendation of the GMEC is received
7. Appeals of an unfavorable decision may be pursued through the GME Bylaws academic grievance process as outlined in Section XI

Once approval has been obtained at the level of the Dean, the resident is responsible for all educational related costs associated with this experience including but not limited to: travel, housing, food, passports, etc.

The resident will need to have their travel coordinated through the Global Engagement Office to review any State Department travel restrictions and required immunizations.

The resident is to complete the form on the WVU Export Control website: <http://exportcontrol.wvu.edu/> and get confirmation from that office.

International rotations for credit will not be permitted beyond one calendar month during the entire training period required for successful completion of the program curriculum with the following exception: Programs with International tracks will be permitted two months of international rotations. These rotations must be approved by the GME Taskforce and follow this policy.

## **FATIGUE AND STRESS POLICY**

Symptoms of fatigue and stress are normal and expected to occur periodically in the resident population, as it would in other professional settings. Not unexpectedly, residents may experience some effects of inadequate sleep and stress. The West Virginia University Department of Surgery has adopted the following to address resident fatigue and stress:

1. Residents and Faculty are required to complete a Sleep & Fatigue CBL Course in SOLE annually.
2. Recognition of resident excess fatigue and stress is important. Signs and symptoms of resident fatigue and stress may include but are not limited to the following:
  1. Inattentiveness to details
  2. Forgetfulness
  3. Emotional instability
  4. Irritability
  5. Increased conflicts with others
  6. Lack of proper hygiene



7. Difficulty with novel tasks
8. Multitasking
9. Impaired awareness

The symptoms of resident excess fatigue and stress may present in patient care settings or in non-patient care settings such as lectures and conferences. In patient care settings, patient safety, as well as the personal safety and well-being of the resident mandates an immediate and proper response sequence. In non-patient care settings, responses may vary depending on the severity and demeanor of the resident's appearance and perceived condition.

The following is intended as a general guideline for those recognizing or observing excessive resident fatigue and stress in either setting:

### **Patient Care Settings**

In the interest of patient and resident safety, identifying that a resident is exhibiting evidence of excess fatigue and stress requires the attending or senior resident to consider immediate release of the resident from any further patient care. The attending clinician or senior resident should privately discuss his/her concern with the resident, attempt to identify the reason for excess fatigue and stress, and estimate the amount of rest that will be required to alleviate the situation. In all situations, the attending clinician must attempt to notify the chief/senior resident on-call, residency manager, residency director, or department chair, respectively of the decision to release the resident from further patient care responsibilities.

If excess **fatigue** is the issue, the attending clinician must advise the resident to rest for a period for relief of fatigue before operating a motorized vehicle. This may mean that the resident should first sleep in the on-call room. The resident may go to the Emergency Room front desk and ask that they call for security, a cab or someone else to provide transportation home.

If **stress** is the issue, the attending, after privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity notification of program administrative personnel shall include the chief/senior resident on call, residency manager, residency director or department chair, respectively. A resident who has been released from further patient care because of excess fatigue and stress cannot appeal the decision to the attending.

A resident who has been released from patient care cannot resume patient care duties without permission from the program director.

The residency director may request that the resident be seen by the **Faculty and Staff Assistance Program (FSAP)**, (304) 293-5590, prior to return to duty.

### **Allied Health Care Personnel**

Allied health care professionals in patient service areas will be instructed to report observations of apparent resident excess fatigue and/or stress to the observer's immediate supervisor who will then be responsible for reporting the observation to the respective program director.

### **Residents**

Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, and the program director without fear of reprisal. Residents recognizing resident fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, and/or the residency director.

Following removal of a resident from duty, in association with the chief resident, the residency director must determine the need for an immediate adjustment in duty assignments for remaining residents in the program.

Subsequently, the residency director will review the residents' call schedules, work hour time cards, extent of patient care responsibilities, any known personal problems and stresses contributing to this for the resident.

For off-service rotations, the residency director will notify the program director of the rotation in question to discuss methods to reduce resident fatigue.

In matters of resident stress, the residency director will meet with the resident personally as soon as can be arranged. If counseling by the residency director is judged to be insufficient, the residency director will refer the resident to the FSAP (Faculty and Staff Assistance Program) for evaluation.

If the problem is recurrent or not resolved in a timely manner, the residency director will have the authority to release the resident indefinitely from patient care duties pending evaluation by FSAP.

## **VACATION POLICY**

The American Board of Plastic Surgery now requires all vacation, meeting and interview days be recorded on the application for the qualifying exam. A minimum of 48 weeks of full time surgical experience is required per residency year.

1. All Residents (PGY 1-6) will receive 3 weeks of vacation per year.
2. Residents will submit a request for their proposed vacation dates to the program director for the year, prior to July 31. Alternate dates should be included.
3. Any resident not submitting requested dates by July 31, will be assigned their vacation dates by the program director.
4. All attempts will be made to accommodate each resident's first choice.
5. *NO* vacations will be permitted in July, December, June, or during SICU rotations. (Rare exceptions may be granted at the program director's discretion)
6. All vacations must be taken in one-week intervals, and may NOT span weekends off. (i.e. you may not be out for 9 consecutive days, only 7). Please remember, when you are away, others are covering for you. Exceedingly rare exceptions may be made on a case-by-case basis in consultation with the program director.
7. Only one week of vacation will be allowed per month per resident.
8. Only one week of vacation will be allowed per rotation per resident.
9. A week constitutes 7 consecutive days.
10. Each service will share an equal burden of vacation absences by residents.
11. Only one resident per PGY year may be gone at the same time (This applies to years PGY-1 and PGY-2, obviously). Exceptions will be made on a case-by-case basis.
12. No vacations will be granted during the week prior to the In-service training exam.
13. No vacations will be granted during resident interviews in January.
14. Exceptions will be made on a case-by-case basis for unscheduled absences, e.g. deaths, births, or other family emergencies.
14. Vacations are not approved until all signatures (faculty service chief (General Surgery, years PGY-1 and PGY-2) and the Program Director) are obtained on the vacation request form and it is returned to the Program Director's office.
15. *DO NOT* make flight arrangements, reservations etc. until you are officially granted your vacation.
16. Senior residents (PGY-5 and PGY-6) are granted a *TOTAL* of five interview days. Any days necessary above these five, will be taken as vacation days. (These days are only granted for job and/or Fellowship interviews.) If a resident leaves at noon, ½ day will be charged to that resident.
18. Meeting/travel requests must also be approved by the Department Chair.

19. Requests for changes in vacation dates must be submitted in *writing* to the program director and will be approved or denied on a case-by case basis.

### **VACATION POLICY OFF-SERVICE ROTATORS**

The Department of Surgery recognizes that a significant number of residents rotating on our services will be requesting vacation during their time on our services. Our goal is to maintain a healthy learning environment while maximizing the educational experience of your residents. To help eliminate confusion and conflicts the Department of Surgery has put together the following guidelines for off-service residents requesting vacation while on a general surgery /sub-specialty service.

1. Vacation requests must be submitted 4 months in advance. Those requests falling in the first 4 months of the year (July-Oct) must be submitted by July 31.
2. Vacations are not approved until all three signatures (service chief resident, faculty service chief and Surgery program director) are obtained on the vacation request form and it is returned to the program director or coordinator's office.
3. *DO NOT* make flight arrangements, reservations etc. until you are officially granted your vacation.
4. All attempts will be made to accommodate each resident's first choice. The administrative chief resident and the program directors, if needed, will mediate disputes.
5. *NO* vacations will be permitted in July, December, or June. (Rare exceptions may be granted at the program director's discretion)
6. *NO* vacations will be granted during the week prior to the General Surgery In-service training exam (the last week in January).
7. *NO* vacations will be permitted on the Trauma/SICU Services surrounding holidays. These include: Fourth of July, Christmas, and New Year. (Rare exceptions may be granted at the program director's and head of Trauma's discretion.) Residents will be assigned days off during either Christmas or New Years.
8. All vacations must be taken in one-week intervals. Exceptions will be made on a case-by-case basis in consultation with the administrative chief resident and the program director.
9. Only one week of vacation will be allowed per month per resident.
10. Only one week of vacation will be allowed per rotation per resident.
11. Only two total weeks per individual resident will be permitted while on the surgical services.
12. A week constitutes 7 consecutive days.
13. Only one resident per rotation may be on vacation at a particular time.
14. Exceptions will be made on a case-by-case basis for unscheduled absences, e.g. deaths, births, or other family emergencies.
15. All requests must be made on the Surgery department's vacation request form. This form can be obtained from the program administrator (Linda Shaffer 293-1254).
16. Meeting/travel requests must be submitted one month prior to the rotation. These will be considered on an individual basis. Only the days of the meeting and one travel day will be granted. Additional days will be considered vacation.
17. If a resident is away from the service to attend a meeting, they will not be permitted to take a separate vacation that same month.
18. Requests for exceptions to the above guidelines must be submitted in *writing* to the program director and will be approved or denied on a case-by case basis.

## **SICK LEAVE**

**Accumulation of Leave** – Additional Information regarding leave can be found at [www.hr.wvu.edu](http://www.hr.wvu.edu)

Accumulation of sick leave is unlimited. Full-time regular classified staff and 12 month regular faculty accrue 1.50 days of sick leave per month during active employment. 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 of your service
3. Contact or leave a voice mail message for Residency Program Manager, Ashley Hagood 293-7480.

Sick time may be taken for:

1. Scheduled Doctor/Dentist appointment for employee
2. Non-scheduled appointment for employee’s child (i.e. called by caretaker or daycare that child is sick and needs medical attention).
3. Funeral leave (3 days) for immediate family. If additional leave is required (i.e. extensive travel), it must be **approved by the Program Director.**
4. Maternity/Paternity Leave

If you have any questions on whether sick time can be used or not, please contact the Residency Program Manager.

**Excessive/unexplained absences may affect your competency evaluation or even your promotion to the next level of training.**

## **MATERNITY AND PATERNITY LEAVE (FAMILY MEDICAL LEAVE)**

Sick Leave/Short Term Disability is to be used for Maternity/Paternity Leave. If you have exhausted all of your sick time to cover your time off, you will be required to use any unused vacation time.

Additional information regarding all leaves can be found [www.hr.wvu.edu](http://www.hr.wvu.edu)

In addition to WVU, leave policies, the Accreditation Council for Graduate Medical Education (ACGME) and The American Board of Plastic Surgery (ABPS) 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 ABPS (American Board of Plastic Surgery) has the following requirements in regard to medical or maternity leave:

1. A leave of absence during training will NOT be included toward completion of the minimum forty-eight (48) week/year requirement. This includes military leave and Paternity/Maternity leave. Plastic Surgery Program Director must contact the Board in writing detailing any leave of absence plans for residents during training.
2. The Board considers a residency in plastic surgery to be a full-time endeavor and looks with disfavor upon any other arrangement. The minimum acceptable residency year, for both prerequisite and requisite training, must include at least 48 weeks of full-time training experience per year.
3. Should absence exceed four (4) weeks per annum for any reason, the circumstances and the proposed correction (i.e. make-up time) of this irregular training arrangement must be approved by the program director.
4. The forty-eight (48) weeks can be averaged over the training years in the program. Any additional months required in the program must be approved by the RRC-PS. Documentation of this approval must be provided to the Board by the program director.
5. **No credit, but no penalty, is given for military, maternity/paternity or other leaves during training.**

## **PRACTITIONERS' HEALTH COMMITTEE**

The Practitioners' Health Committee serves as a resource in the 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 Practitioners' Health Committee has formulated the following guidelines.

### **SUBSTANCE USE**

Any resident or faculty member who requests an appointment to practice at WVUH who has a reasonable suspicion of substance abuse or has a history of substance abuse and/or treatment of substance abuse must be initially referred to the Practitioners' Health Committee. The Practitioners' Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person specializing in substance abuse. After receiving an evaluation, and consulting with the Department Chairperson, the Practitioners' Health Committee will make a recommendation concerning:

1. Advisability of an appointment to WVUH Need for restriction of privileges
2. Need for monitoring
3. Need for consent agreement concerning rehabilitation, counseling or other conditions of appointment

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 based upon the recommendation of the Departmental Chairperson, the Vice-President of Medical Staff Affairs and the Practitioners' Health Committee. These recommendations will be communicated to the GME office and the Program Director/Chair (for residents), the Vice-President of Medical Staff Affairs and the Practitioners' 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. Where the circumstances dictate a need for monitoring, the resident/faculty must sign an agreement that he/she will meet with a member of the Practitioners' Health Committee and agree to random blood and urine drug screens and other conditions that the Committee determines are appropriate in their sole discretion as requested by the Practitioners' Health Committee, the Vice-President of Medical Staff Affairs, and other supervisors.

All conditions of privileges and all test results will be communicated in writing to the GME office, Program Director/Chair (for residents) and the Vice-President of Medical Staff Affairs.

### ***Practicing Residents/Faculty***

It is the responsibility of all faculties, residents, or any other person, 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 Practitioners' Health Committee in the event that he/she experiences any substance abuse/health problem which 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 Program Director/Chair or Vice-President of Medical Staff Affairs receives a report suggesting impairment of a physician (faculty or resident) or observes behavior suggesting impairment, then the following actions are required:

1. The Program Director/Chair or Vice-President of Medical Staff Affairs will do the best of his/her ability to ensure that the allegation of impairment is credible.
2. The Program Director/Chair or Vice-President of Medical Staff Affairs must notify the Dean, the Vice-President of Medical Staff Affairs (the Chairperson), and the Practitioners' Health Committee (within twenty-four (24) hours or within the next business day) in writing of any reported incidents or observed behavior suggesting impairment.
3. The Program Director/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 medical staff for faculty and removal of residents from providing any patient care within the hospital.
4. The Program Director/Chair or Supervisor must immediately remove the physician from patient care or patient contact.
5. The Program Director/Chair or Supervisor must immediately make a mandatory referral to the Employee Assistance Program (EAP), based on the possibility of impaired performance.
6. The Program Director/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 medical staff for faculty and removal of residents from providing any patient care within the hospital.
7. The Program Director/Chair or Supervisor must immediately remove the physician from patient care or patient contact.

The EAP office will require that the physician sign a release, authorizing exchange of medical information between EAP, the Chairperson, WVUH, and the Practitioners' Health Committee. EAP will provide a report of their evaluation and treatment recommendations in a timely manner to the Dean, Practitioners' Health Committee, Chairperson, and the Vice-President of Medical Staff Affairs of WVUH. The Practitioners' 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 Practitioners' Health Committee will participate in the monitoring of physicians until the 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 there is a physical, emotional or psychological impairment that may interfere with the physicians' ability to function appropriately and provide safe patient care must be initially referred to the Practitioners' Health Committee. The Practitioners' Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person specializing 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 screens.

### **HARASSMENT**

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.

## **DISCIPLINE POLICY**

Administrative responsibilities including accurate and timely documentation are vital to the practice of medicine. Not only in regards to patient care but also in the maintenance of the Surgery Residency Program. Throughout the surgery residency there are numerous administrative tasks in addition to documentation that must be completed. Failure to do so violates the essence of Professionalism, one of the six core competencies.

These tasks include:

1. Weekly recording of duty hours
2. Monthly updates of Operative Logs
3. Yearly CBL's
4. Reporting for semi-annual evaluation with the program director
5. Completion of USMLE Step III
6. Employee Health requirements
7. Fulfilling research requirements
8. Completing dictations within the allotted time frame.

### **Consequences:**

A series of administrative steps have been approved by the Program Education Committee to correct noncompliance. Residents will be reminded 10 days before the end of the month in an email containing a list of tasks to be completed by the end of the month. On the first of the month, if the required administrative tasks are not completed, the resident will be notified by the Residency Administration that his/her meal card has been turned off. The meal card will remain off the number of days it took to complete the deficiencies. If the deficiencies persist by the 15TH of the month the resident will be placed on administrative leave (see below) until the delinquencies are corrected.

### ***Administrative Leave:***

When a resident is on administrative leave, residents will relinquish all operative assignments during the day but will fulfill all other floor care, clinic assignments and all other non-OR responsibilities. The time freed up from the operative theater will be used to complete the delinquencies. These residents will take call (night time and weekends) as assigned. In addition, if a resident has been placed on administrative leave for a third time in a single year, each day on administrative leave will consume one day of vacation time allotted. If a resident has no vacation remaining or exceeds the number of days remaining, days will be subtracted from the following year's allotment. Upon completion of the missing documentation, the resident will contact the Residency Program Administrator. Upon verification by the Residency Program Administrator that all documentation requirements have been completed, the resident may return to full clinical status. If vacation days were required, this will be communicated to the Program Director and a note placed



into the resident's file. Residents accruing three Administrative leaves in any one PGY year or five during their residency, will proceed to the next step.

***Academic Probation:***

Academic probation is a residency specific disciplinary action, which is not reportable or appealable. It does not become part of the permanent record. Academic probation will last for a period of three months during which the resident must comply with all Surgery, WVU School of Medicine, ACGME, and RRC policies. If the resident violates any policy, s/he may be placed on Probation (see below).

Academic probation also applies to those who have failed to complete documentation while on administrative leave, those who have accrued more than three administrative leaves in a single year, more than five cumulatively in five years or have used all vacation time remaining in residency. With respect to documentation, deficiencies must be completed and no further deficiencies develop. Should these two conditions be met, the resident will return to normal status. Should deficiencies persist or new ones develop, the resident will be placed on probation.

***Probation:***

Probation shall be instituted for three months. "Have you ever been on Probation?" is a question asked by many states during the licensing process, hospital credentialing and insurance companies and thus should be avoided to save time and angst in the future. During probation, the remedial plan consists of correction of delinquencies and 100% compliance with all documentation and administrative requirements. If the resident does not comply, see Final Actions.

***Final Actions:***

The Program Director may proceed directly to termination from the program or consider allowing the resident to finish the year but not to be promoted to the next year. In the case of graduating residents, the PD may decide that the resident has failed to satisfactorily complete the residency requirements and therefore would be unable to validate residency training, an essential requirement for being accepted for the Qualifying examination of the American Board of Surgery.

***Duty Hours:***

Failure to log Duty Hours 2 weeks within a single month constitutes one violation. Two violations over 2 months will place the resident on Administrative leave.

Three occurrences of Administrative Leave over 12 months leads to Academic Probation. Any subsequent violation of Duty Hour recording in that year results directly in Probation.

***Case Logs:***

Failure to update case logs by the last day of each month, will result in immediate Administrative Leave. Placement on Administrative Leave 3 times in one PGY year or five occurrences during the program, will result in Academic Probation.

***USMLE/WV State Medical Licensure***

Failure to complete the USMLE Step III exam by Dec 31 of the residents PGY II year results in immediate Academic Probation.

Failure to apply for a WV State Medical License by April 1 of the PGY II year results in immediate Academic Probation.

***CBL'S:***

Failure to complete required CBL's by the assigned deadline, will result in Administrative leave.

## **ACADEMIC DISCIPLINE AND DISMISSAL POLICY**

The Department of Surgery's Plastic Surgery Program will follow the WVU School of Medicine GME and ACGME policy on academic discipline and dismissal. This policy is derived from the SOM/GME by-laws which can be found at <http://medicine.hsc.wvu.edu/gme>.

The Department of Surgery may take corrective or disciplinary action including dismissal for cause, including but not limited to the following circumstances:

1. Unsatisfactory academic or clinical performance
2. Failure to comply with the policies, rules, and regulations of the SOM/GME by-laws Resident Program, University or other facilities where the resident is trained
3. Revocation or suspension of license
4. Violation of federal and/or state laws, regulations, or ordinances
5. Acts of moral turpitude
6. Insubordination
7. Conduct that is detrimental to patient care
8. Unprofessional conduct.

Corrective or disciplinary actions may include but not limited to:

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

### ***Level I Intervention***

Oral and/or Written counseling or other Adverse Action:

Minor academic deficiencies that may be corrected at Level I include: unsatisfactory academic or clinical performance or failure to comply with the policies, rules, and regulations of the SOM/GME by-laws Resident Program or University or other facilities where the resident 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 actions for such minor academic deficiencies and/or offenses are not subject to appeal.

### ***Level II Intervention:***

Probation/Remediation Plan or other Adverse Action:

Serious academic or professional deficiencies may lead to placement of a resident 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 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 to comply with the terms of the plan may result in termination or non-renewal of the resident's appointment.

### ***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:

1. Demonstrated incompetence or dishonesty in the performance of professional duties, including but not limited to research misconduct.
2. 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.
3. Insubordination by refusal to abide by legitimate reasonable directions of administrators or of the WVU Board of Governors.
4. 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.
5. Substantial and manifest neglect of duty.
6. Failure to return at the end of a leave of absence.
7. 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 of GME Bylaws.

## **ACADEMIC GRIEVANCE POLICY**

**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 Surgery abides by this Policy, which was derived from the WVU/GME website by-laws at <http://medicine.hsc.wvu.edu/gme>.

### **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

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

### **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. If the aggrieved resident is a Transitional Year resident, then the DIO will appoint a Department Chairman to handle the Level 2 grievance. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence that 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. The resident/fellow is not entitled to legal representation during the Level 2 meeting.

### **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 grievable 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 resident/fellow is not entitled to legal representation during the Level 3 meeting.

### **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.

### ***Procedure***

**Attendance:** All committee members should be present throughout the hearing.

The aggrieved resident/fellow must personally appear at the Grievance Committee meeting.

**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.

**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.

**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.

**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.

### ***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."

## **PROGRAM CLOSURE/REDUCTION POLICY**

In the event that the Plastic Surgery Residency program is closed, reduced or discontinued, the department will inform the residents in writing as soon as possible. If a resident is unable to complete his/her training in the program, the department will make a good faith effort to assist the resident in enrolling in an ACGME accredited program in the same specialty at the appropriate PGY level.

## **GUIDELINES FOR A RESIDENT/FELLOW CRISIS OR SUDDEN DEATH**

In the event of a resident/fellow crisis (e.g., suicide, suicide attempt, major injury or illness, victim of a crime, etc.), these guidelines will serve as a basis for communicating the crisis to appropriate constituencies, responding to the crisis, and identifying ways to prevent future crises.

### **GME Crisis Team and Communication**

A GME Crisis Team includes the Vice Dean for Education and Academic Affairs, the Designated Institutional Official (DIO) and all members of the GME Taskforce. When notified of a resident/fellow crisis, the Vice Dean and/or DIO will schedule an emergency meeting of the GME Crisis Team. The Executive Dean, and/or DIO, or designee, will communicate the crisis to the Vice President/Executive Dean of the School of Medicine, CEO of WVU Medicine, the Chief Medical Officer, the Vice President of Clinical Programs at WVU Hospitals, the UHA Board, the WVU Medicine Board, or other officials (e.g. University President and/or Provost) as needed depending on the crisis.

When appropriate, the crisis response team will notify and/or contact:

- Resident(s)/Fellow(s)
- The residency/fellowship program of interest including the chair and program director (see Appendix 1 for sample communications)
- Family members
- General counsel for health sciences
- Risk Manager/Privacy Officer
- Director, Communications & Marketing, School of Medicine Administration
- Hospital chaplain
- WVU Police
- The home institution if the resident/fellow was a visiting resident/fellow.
- Faculty and Staff (see Appendix 1 for sample communications)

### **Crisis Response**

***The Vice Dean and/or DIO will serve as the leader for the emergency crisis response meeting. The Vice Dean and/or DIO will designate specific tasks and duties. The immediate duties and responsibilities may include the following:***

***When appropriate, the GME crisis response team will reach out to the resident/fellow and/or family to:***

1. Offer assistance.
2. Collaborate with the Vice President of Clinical Programs at WVU Hospitals to provide referrals to counseling services available in family's locale.
3. Solicit information from family about funeral arrangements, family's wishes regarding privacy and confidentiality, family's wishes related to attendance by school community at funeral and any other requests from family. Assist in hotel arrangements near campus.
4. Ask for the name and phone number of an appropriate family representative for the School to maintain communication with the family.
5. Contact general counsel if a resident/fellow was a victim of a crime.

***When appropriate, the GME Crisis Team will:***

1. Send counseling staff immediately to location.
2. Meet immediately with any individuals identified as having a close relationship to the resident/fellow in crisis, or known to be "at-risk."
3. Communicate crisis to residents/fellows, faculty, and staff and arrange times and locations for counseling sessions/crisis stations for residents/fellows, faculty, and staff (see Appendix 1 for example communications).
4. Identify outside resources to assist family of deceased and/or to visit the hospital for follow-up assistance.
5. Alert faculty and staff to signs and symptoms of "at-risk" individuals that should be reported to the Vice Dean and/or DIO (See Appendix 2).

***When appropriate, the GME Crisis Team will collaborate with appropriate leadership and the Director, Communications & Marketing, School of Medicine Administration to:***

1. Send a letter of condolence to family.
2. Disseminate information about funeral and/or memorial service to faculty, staff and residents/fellows. Include driving directions to funeral services.
3. Consider whether school memorial service, moment of silence, school flag half-mast or other gestures are indicated.
4. Consider whether school schedule or calendar should be modified.
5. Entertain requests for tangible memorials, such as plaques, scholarship funds, etc., keeping in mind that all future deaths will need to be addressed consistent with these decisions.

***When appropriate, the GME Crisis Team will:***

1. Arrange for personal items to be returned to family. Empty desk, locker and mailbox and maintain inventory of items returned to family.
2. Remove resident's/fellow's name from rosters and directories.
3. Consider providing sympathy cards at a central location for hospital community to write notes and sign.
4. Consider leaving resident's/fellow's photo in any class composite photographs.



***When appropriate, the GME Crisis Team will contact the Department to:***

1. Close academic record.
2. Inactivate all addresses and e-mail lists.

***When appropriate, the GME Crisis Team will contact University Hospital insurance to:***

1. Assist resident/fellow and family to determine coverage and potential benefits.

***When appropriate, the GME Crisis Team will contact staff to:***

1. Remove from mailing and e-mail distribution lists.

***When appropriate, the GME Crisis Team will:***

1. Determine if the resident/fellow has pending rotations that may require modifications.
2. Determine if the resident/fellow applied to any residency or fellowship programs and communicate accordingly.

## **Appendix 1**

### **Sample Communications to Residents/Fellows, Faculty, and Staff**

We are deeply saddened to inform you that Jane Doe, a member of the Class of XXXX, passed away, on Saturday, December 1, 2018.

Services are scheduled as follows:

Grief counselors will be available on Monday, December 4, 2018 at 12:00 in XXXX.

Some residents/fellows may be more vulnerable to the impact of a sudden loss than others, especially in cases of presumed suicide. These residents/fellows should be contacted separately to ensure that their needs are met.

Due to the tragic news of John Smith's untimely passing, we will be holding special grief counseling sessions on the following dates and times:

Wednesday, January 2, 2018 @12:00 PM in XXXX

Thursday, January 3, 2018 @1:00 PM in XXXXXX

These sessions are open to all residents/fellows who wish to attend. Bereavement counselors and mental health providers will be available to speak with you. In addition, the Wellness Director will be holding a number of slots open on those days for individual counseling. Please call XXXXXXXXXX if you wish to schedule an appointment.

As you all know, Jane Doe, Class of 2020, died suddenly on the night of January 7, 2020. As the WVU community mourns the tragic loss of our resident/fellow, some of us may seek more information, asking how did this happen and why? We have limited ability to answer these questions, in part because we do not know precise answers, and in part out of respect for the privacy of the deceased and his family.

Here is a capsule of the facts we do know, which you may share with any resident/fellow who ask for information:

1. Richard Doe was killed in an automobile accident on Wednesday, January 7th at approximately 10:15 p.m.
  2. The location XXXXX.
  3. The Dominion Post has reported this event in one article as a suicide.
  4. To our knowledge, no suicide note has been found.
  5. The County Prosecutor's Office has not allowed the University to view any evidence gathered.
  6. The Police and authorities are conducting an investigation to determine the cause and manner of death.
- Neither suicide nor accidental death has been confirmed. A final report is not expected for some weeks or months.

Sudden death of a young person, a member of our University family, causes shock, anger, denial and numerous other reactions. There is no "right" way to feel, and, whatever the cause of death, each of us will have unique responses to this tragedy. We can all help each other as friends and colleagues, and professional assistance is readily available. The Faculty and Staff Assistance Program (FSAP) has provided counselors to quickly assist residents/fellows, faculty and staff since the day the death became known.

Anyone who wishes to consult a counselor should do so by calling XXXXXXXXX. I ask that anyone who identifies a member of the WVU family who appears to need assistance notify me, so that help can be provided.

Warmest regards,  
Dean

The following is reproduced in part, with permission from Underwood, Maureen M., LCSW and Dunne-Maxim, Karen MS, RN, Managing Sudden Traumatic Loss in the Schools, New Jersey Adolescent Suicide Prevention Project.

If the death has been declared a suicide:

This morning we heard the extremely sad news that John Doe took his life last night. I know we are all saddened by his death and send our condolences to his family and friends. Counselors will be available today for residents/fellows, faculty and staff who wish to talk to a counselor. Information about the funeral will be provided when it is available.

Suspicious death not declared suicide:

This morning we heard the extremely sad news that John Doe died last night from a gunshot wound. This is the only information we have officially received on the circumstances surrounding the event. I

know we are all saddened by John Doe’s death, and send our condolences to his family and friends. Counselors will be located today in Room \_\_\_\_\_ at \_\_a.m., \_\_p.m., and \_\_p.m. for residents/fellows, faculty and staff who wish to talk to a counselor. Information about the funeral will be provided when it is available.

**CONFLICT OF INTEREST DISCLAIMER**

I am aware that this educational resource been provided to the West Virginia University Department of Surgery, by support from an outside source/industry. I also understand that I have no obligation to use, buy or promote any products from this company. I have no personal, financial or professional responsibility to this company by accepting this gift.

GIFT: \_\_\_\_\_

INDUSTRY/COMPANY: \_\_\_\_\_

DATE: \_\_\_\_\_

NAME(print): \_\_\_\_\_

NAME(signature): \_\_\_\_\_

EDUCATIONAL RATIONAL:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PROGRAM DIRECTOR: \_\_\_\_\_

DATE: \_\_\_\_\_

## RESIDENT CONTRACT REVIEW

### NOTIFICATION OF TERMS AND CONDITIONS OF APPOINTMENT MEDICAL AND DENTAL RESIDENTS

Name: «Name»

Annual Salary: «PGSALARY».00

Administrative Supplement: «SUPPLEMENT».00

College *College of Medicine*

Title *Medical Resident*

Start *start\_date*»

Stop «*end\_date*»

**Appointment:** This appointment is made by virtue of the authority vested by law in the West Virginia University Board of Governors and is subject to and in accordance with the provisions of the rules, regulations and policies of the governing board.

#### 1. Conditions of Employment:

Consistent with the provisions of the rules, regulations, and policies of the governing board and of West Virginia University, this appointment and/or compensation is/are subject to the fulfillment of the responsibilities of the position during the term of the appointment, the availability of the state funding, and the following:

#### 2. License to Practice Medicine/Dentistry:

If the medical resident holds a Medical Doctor (M.D.) degree and has already completed twelve months of residency training and is otherwise eligible for licensing, this appointment is subject to resident obtaining and maintaining an unrestricted license to practice medicine from the State of West Virginia and/or from any other State's licensing authority where resident has been assigned by the Dean of the School of Medicine. If the medical resident holds a Doctor of Osteopathy (D.O.) degree, this appointment is subject to resident obtaining and maintaining an unrestricted license to practice medicine from the State of West Virginia Board of Osteopathy and/or from any other State's licensing authority where resident has been assigned by the Dean of the School of Medicine. In the case of dental residents, this appointment is subject to resident obtaining and maintaining an unrestricted license to practice dentistry from the State of West Virginia and/or from any other State's licensing authority where resident has been assigned by the Dean of the School of Dentistry.

#### 3. Resident Responsibilities:

This appointment is subject to resident obtaining and maintaining a resident appointment at the affiliated hospital(s) to which resident is assigned by the Dean of the West Virginia University School of Medicine or Dentistry. The resident shall be subject to all policies, rules, and regulations of said affiliated hospitals(s).

#### 4. Health Maintenance Organizations, Managed Care Entities and Other Purchasers of Health Care:

Resident's signature below in acceptance of this appointment shall constitute the authorization by resident for the School of Medicine or Dentistry or affiliated hospitals of the School of Medicine or Dentistry,

to release confidential information concerning resident's education, skills, quality of care, utilization, and patient care experience to health, maintenance organizations, managed care entities and other purchasers of health care that contract for the provision of professional medical/dental services by residents. The resident participating in managed care activities shall be subject to all policies, rules, regulations and agreements of said organizations or entities.

#### **5. Benefits:**

Information on benefits including conditions for reappointment, conditions under which living quarters, meals, laundry are provided, professional liability insurance, liability insurance coverage for claims filed after completion of program, and health and disability insurance can be found in the Resident Manual and the GME/ WVU Bylaws, in print and on the GME website, at [www.hsc.wvu.edu/som/gme](http://www.hsc.wvu.edu/som/gme).



P.O. Box 9238, HSCN, Morgantown, WV 26506-9238

**VACATION AND MEETING REQUEST FORM**

RESIDENT: \_\_\_\_\_

**(Circle One): VACATION / MEETING**

DATES OF TRAVEL: \_\_\_\_\_

**(Only if attending meeting) LOCATION:** \_\_\_\_\_

**(Please Print) TITLE OF ABSTRACT/PAPER OR POSTER (Please have completed and attached Authorization to Travel Form):**

\_\_\_\_\_

**(If presenting abstract/paper or poster) SPONSORING FACULTY MEMBER(S):**

\_\_\_\_\_

**CHIEF FACULTY MEMBER SIGNATURE OF SERVICE FROM WHICH YOU WILL BE ABSENT:**

\_\_\_\_\_

**CHIEF RESIDENT OF SERVICE SIGNATURE:** \_\_\_\_\_

**ADMINISTRATIVE CHIEF SIGNATURE:** \_\_\_\_\_

**PROGRAM DIRECTOR'S SIGNATURE:** \_\_\_\_\_

Please return completed form to: Ashley Hagood, Program Manager  
West Virginia University  
P.O. Box 9238  
Morgantown, WV 26506-9238

## 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:

TRANSPORTATION

(Brief Description:)

AIR

AUTO MILEAGE

OTHER

REGISTRATION FEE

HOTEL

MEALS

OTHER (Specify)

OTHER (Specify)

PRESENTATION MATERIALS

TOTAL ESTIMATE

APPROVAL GRANTED: \_\_\_\_\_

Dept of Surgery Administration

JC9502