GRADUATE MEDICAL EDUCATION (GME) BYLAWS FOR TRAINING PROGRAMS

West Virginia University (WVU) School of Medicine
Robert C. Byrd (RCB) Health Sciences Center

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Introduction

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

IMPORTANT NOTE - In this document, the term "Resident", "Resident Physician", and/or "trainee" incorporates the following roles: Intern, Resident, Subspecialty Resident, and Fellow at any Post Graduate (PG) level of training in any of our programs. Allopathic physicians are defined as graduates of Liaison Committee for Medical Education (LCME) accredited medical schools or residents who have Exchange Commission for Foreign Medical Graduates (ECFMG) certificates. Osteopathic physicians are defined as graduates of accredited osteopathic medical schools.

Objectives:

A. The **primary concern** of both the WVU SOM and West Virginia University Hospitals (WVUH) will be to maintain and improve the health of the people of West Virginia and the Nation through education, service, and research.

B. **Mission** – Improving the health and wellbeing of everyone we serve.

   Vision – A hopeful and healthy West Virginia.

C. **Special attention** will be given to developing and maintaining programs that address the physician manpower needs of West Virginia and the surrounding region.

Administration:

A. The GME programs at the Robert C. Byrd (RCB) Health Sciences Center (HSC) will be led by an Associate/Assistant Dean of the WVU SOM functioning as the Designated Institutional Official (DIO) with the support of the Chair of the GMEC who shall be a member of the faculty appointed by the Dean, a Director of GME, and appropriate central GME, and program staff.

B. The DIO will coordinate the implementation of Accreditation Council for Graduate Medical Education (ACGME) policies as they apply to institutional policies.

C. The DIO will monitor individual programs at regular intervals to ensure adherence to ACGME policies or the policies of other specialty accreditation bodies, as appropriate.

D. Each program will be overseen by a Program Director who reports to both the appropriate Department Chair and the DIO. This Program Director will assure adherence to ACGME policies as they apply to the specific program or the policies of the appropriate specialty accreditation body. In general, **the Program Director cannot be the same person as the Department Chair (however, this may occur under special circumstances requiring both Graduate Medical Education Committee (GMEC) Taskforce and GMEC**

approval). Appropriate support staff will be provided by the sponsoring institution, via the mechanism established through the Department of Medical Education.

E. The GMEC will have the responsibility for monitoring and advising on all aspects of residency and fellowship education.

   1. Membership shall be appointed by the Dean of the WVU SOM, as outlined in the GMEC charter published in the WVU SOM faculty handbook. It must include peer nominated resident/fellow physicians.

   2. The GMEC charter will also specify the specific duties and responsibilities of the group, and its meeting frequency.

   3. The Dean shall appoint a subcommittee of the GMEC called the GMEC Taskforce that shall be composed of members of the GMEC, report to the GMEC, and meet on a more frequent basis as outlined in the charter.

   4. Other subcommittees may be formed by the consent of the GMEC based on the needs of the sponsoring institution to ensure compliance with accreditation standards and must include a resident/fellow member.

The link to the GMEC Charter is on the Graduate Medical Education website:
https://medicine.hsc.wvu.edu/media/370934/charter-of-the-gmec.pdf (CTRL + click)

Principles Governing GME at WVU:

A. At the RCB HSC, it is important for everyone to recognize that all GME training programs are dependent upon each other, and on the sponsoring institution, to reach the goals of the residency/fellowship programs.

B. Recognizing that Departments have service commitments, not only to their own residencies and fellowships, but also to other Department's specialty and subspecialty programs, any plan to change the annual commitment to another service or program must be approved by the GMEC, or its subcommittee.

C. All requests for rotations at institutions outside the RCB HSC must be approved by the GMEC, or its subcommittee. A prerequisite for approval is the ability to demonstrate that specialty specific requirements cannot be met within the sponsoring institution.

D. Because resident/fellow participation in the GMEC and its working groups is required to meet accreditation standards, Program Directors must take steps to ensure that residents/fellows who have been peer selected and are willing to serve on the GMEC are given time for these duties.

E. Requests for review of change in resident/fellow complement must meet the following requirements:

   1. The program must complete a proforma and obtain financing and approval for the additional resident(s)/fellow(s) from the Graduate Medical Education Evaluation and Operations Committee

(GMEEOC) as outlined in their charter: https://medicine.hsc.wvu.edu/media/367674/gmeeoc-charter.pdf (CTRL + click).

2. There must be documentation of approval by the pertinent Residency Review Committee (RRC) of the ACGME. Non-standard program complements will be approved by the GMEC.

3. There must be documentation that there is a need for additional physicians of that specialty or sub-specialty.

F. An RRC may grant exceptions for up to 10% of the 80-hour limit, to individual programs based on a sound educational rationale. Program requesting this must have permission from the institution's GMEC prior to submission to the ACGME.

Designated Institutional Official:

A. The DIO is to establish and implement procedures to ensure that s/he, or a designee in the absence of the DIO, reviews and approves/cosigns all programs' ADS Annual Updates, and all Program Letters of Agreement (PLAs). In addition, any correspondence or documentation submitted to the ACGME by the Program Directors must also be either approved via ADS, or co-signed by the DIO. *[ACGME Institutional Requirements I.A.5.b)]*

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

Criteria for Selection of Candidates:

A. The primary source of candidates for entry into (GME) programs will be graduates of LCME accredited medical schools. Candidates will be evaluated on the basis of their academic credentials, preparedness, aptitude, communication skills, letters of reference and recommendation, national qualifying examination results, and electronic or in-person interview. It is required that all programs participate in an organized matching program when a matching program is available for that specialty.

B. Details are outlined in the Criteria for Eligibility and Selection of Candidates Policy: https://medicine.hsc.wvu.edu/media/370722/criteria-for-appointment_10_12_2022.pdf (CTRL + click)

C. WVU only accepts J-1 Visa status for Resident/Fellow Physician positions when a visa is required for employment. Exceptions to this would require approval from the DIO and the GMEC Taskforce.

Recruitment:

A. To enhance recruitment, programs will sponsor activities such as student interest groups, continuing education conferences, and receptions for students at the medical schools in West Virginia.

B. Programs will maintain WVU supported web pages that will provide basic information and recruitment information for all applicants.

C. Programs will work with WVU School of Medicine Marketing Office to create a recruitment video to be added to their WVU supported web pages.

Resident Doctor Licensure Requirements:

A. All allopathic and osteopathic resident/fellow physicians are required to obtain and maintain a West Virginia permit or a West Virginia license to practice medicine, as outlined in the GME Resident Doctor License Requirements Policy, (CTRL + click)and subject to the requirements of the West Virginia Board of Medicine, the West Virginia Osteopathic Board of Medicine, and the applicable laws of the state of West Virginia.

B. All allopathic residents/fellows must provide proof of a passing USMLE Step 3 score prior to issuance of a contract at the PGY3 level or higher. All osteopathic residents/fellows must provide proof of a passing COMLEX Level 3 score (or USMLE Step 3 score) prior to issuance of a contract at the PGY3 level or higher.

Evaluation of Programs, Trainees, and Faculty:

A. Each program shall develop policies detailing how performance and progress will be evaluated for the program, its residents/fellows, and its faculty. These policies shall be consistent with the rules outlined in the ACGME Common Program Requirements. (CTRL + click)

B. Methods for these evaluations shall include, but not be limited to:

The Program:

i. A Program Evaluation Committee (PEC) will be appointed by the Program Director composed of at least two program faculty members, (at least one of whom is a core faculty member), the Program Manager, and at least one resident/fellow. Other members may be added to the PEC at the Program Director's discretion.

ii. In order to inform the PEC on educational experiences/rotations/blocks that are part of the program's curriculum, each trainee shall be assigned rotation-specific evaluations at or near the end of each experience/rotation/block. These evaluations will review the goals and objectives, the educational value, the overall availability and quality of the supervision, the quality of their wellness while on the rotation, etc. **Any experience/rotation/block which lasts longer than three months shall be evaluated at the three-month mark, and again at the end of the rotation.**

iii. Another evaluation that informs the PEC is the GME Program Evaluation that is assigned by the Program Manager, each spring, through the institutional electronic platform, (i.e., E-Value). This

evaluation is assigned to all program residents/fellows and to all program faculty. Reports on these evaluations shall be pulled in aggregate form only, and in such a manner than no data or comments can be traced back to any individual resident/fellow.

iv. The PEC will provide program oversight, acting as an advisor to the Program Director.

v. The PEC will craft, review, and assess progress on the program's self-determined goals.

vi. The PEC will systematically review the current educational environment, identifying strengths, challenges, opportunities, and threats as they relate to the program and its residents/fellows.

vii. The PEC will meet at least annually to review the program's curriculum goals and objectives, policies and procedures, aggregated resident/fellow and faculty evaluations, aggregated rotation evaluations, and other items as designated in the ACGME's Common Program Requirements.

viii. The PEC will complete, once per academic year, the assessments designated in the GME Annual Program Evaluation (APE) Form, which is available on the GME Study Observe Learn Engage (SOLE) site. A fully executed copy of this form shall be uploaded to the institutional electronic platform, (i.e., E-Value), by August 31st of the academic year following the year evaluated in the APE.

ix. Other assessments, as designated in the ACGME's Common Program Requirements, will be assigned to the PEC by the Program Director, as needed, and/or required.

The Residents:

i. A Clinical Competency Committee (CCC) shall be appointed by the Program Director including, at a minimum, three members of program faculty, at least one of whom is a core faculty member. Additional faculty members and/or health professionals with extensive interactions with the program's residents/fellows may be included at the Program Director's discretion. **No residents/fellows shall serve on the CCC.**

   a. Each program shall create a CCC policy detailing the scope and responsibilities of the CCC based on the rules laid out in the ACGME's Common Program Requirements.

   b. The CCC shall meet, at a minimum every six months, to review the aggregated evaluations for each resident/fellow in the program. Programs may have ad-hoc CCC meetings, as indicated, to address specific resident/fellow issues in a timely fashion.

ii. Throughout rotations, teaching faculty shall provide non-retaliatory direct personal supervision and observation of residents/fellows, accompanied by regular verbal feedback in order to reinforce well-performed duties and tasks, as well as to correct deficiencies.

iii. Residents/Fellows shall be evaluated on their performance of specified patient care experiences and responsibilities including assessment of the six ACGME core competencies using the specialty, or subspecialty, specific Milestones.

iv. Residents/Fellows shall be assessed via electronic review of patient charts and other records as they relate to the specific clinical duties of each resident/fellow physician.

v. Residents/Fellows shall be assessed using **regular** electronic evaluations assigned and completed via the institutional electronic platform, (i.e., E-Value). These evaluations shall be assigned to the appropriate program faculty, and to the peers with whom the resident/fellow interacted during the experience/rotation/block. The term "regular" in this case, refers to the written summative evaluation which shall be consistently assigned at, or near, the end of each experience/rotation/block. *As always, assigned evaluations must be completed in a timely manner – generally within two weeks of assignment.* **NOTE: For experiences/rotations/blocks which exceed three months duration, evaluation of the resident shall be documented AT LEAST every three months.**

vi. Observed evaluated activities include, but are not limited to:

a. Ability to gather appropriate and pertinent information about a patient, (a.k.a. History and Physical, [H&P])

b. Ability to integrate a patient's information with current "state of the art" knowledge and develop a valid differential diagnosis.

c. Ability to develop and implement a plan of care.

d. Ability to discuss patient care issues with the patient and/or family.

e. Ability to work as part of a multi-disciplinary team.

f. Ability to teach other health care professionals, including medical students and more junior residents/fellows.

g. Ability to perform duties in an ethical and professional manner.

vii. In addition to the aforementioned evaluations, residents/fellows shall also be evaluated on clinical performance by patients, self, and other members of the healthcare team, (i.e., nurses, technicians, etc.). These 360^{O} evaluations may be less frequent than those previously mentioned, but they must be assigned and completed at minimum annually. **NOTE***: A best practice would be to assign them quarterly, or at least every six months, to reflect progress within the academic year.*

viii. Residents/Fellows are generally required to provide clinical teaching to medical students and to more junior residents/fellows. Additionally, residents/fellows will present during M&M, Journal Club, and even didactics for certain programs. Teaching/speaker evaluations should be assigned to students, residents, fellows, and faculty who attend these more formal teaching sessions in order to provide constructive formative feedback on technique, content, and quality.

ix. **Longitudinal experiences, (i.e., continuity clinic), must be evaluated AT A MINIMUM of every three months, and upon completion of the longitudinal experience.**

x. The Program Director, or their designee, shall meet individually with each resident/fellow in their program, at a minimum of every six months, *(at least two times per academic year).*

a. The purpose of this one-on-one meeting is to discuss the resident's/fellow's progress over the past six months, and to collaboratively prepare their educational plan for the next six-month period.

b. The information discussed during this meeting shall include, but not be limited to:

- All formative and summative evaluations completed about the resident/fellow by program faculty, peers, self, patients, and other members of the healthcare team.
- Recommendations from the most recent CCC where the resident's/fellow's progress in the Milestones was discussed.
- The resident's/fellow's cumulative case logs and/or procedural logs, if applicable.

c. This semi-annual meeting shall be documented in writing by the Program Director, or their designee, and shall be maintained in the trainee's permanent electronic record by the Program Director and/or the Program Manager.

d. This documentation shall be made accessible to the resident/fellow at their request.

e. An annual electronic summary evaluation shall be maintained in the Program Director's or Program Manager's office which indicates each trainee's readiness, *(or lack of readiness),* to be promoted to the next training year in the program.

xi. The Program Director, or their designee, will complete an electronic written summative final evaluation for each trainee who successfully completes the program. **GME provides a standardized final summative form which is available on SOLE. This form contains the language required by the ACGME, and can be used by all programs.**

a. The final summative evaluation shall be maintained in the resident's/fellow's electronic permanent record.

b. The evaluation shall consider the recommendations of the CCC.

c. The evaluation shall include a review of the resident's/fellow's performance during their final period of training and shall verify that the resident/fellow has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice.

d. A copy of the evaluation shall be given to the resident/fellow upon completion of the program.

e. A copy of the evaluation shall be saved and maintained electronically in the institutional electronic platform, (i.e., E-Value).

The Faculty:

i. Each program will develop procedures for evaluating the performance of faculty, as it relates to the educational program.

ii. Faculty evaluation shall be completed by all residents/fellows in the educational program, at minimum annually. **NOTE:** A best practice would be to have trainees evaluate faculty more frequently, *(e.g., following each experience/rotation/block, on a quarterly basis, or at least semi-annually)*, to provide a more robust body of feedback to the teaching faculty.

iii. These evaluations shall include a review of each teaching faculty's clinical teaching abilities, participation in faculty development to enhance educator skills, degree of engagement with the educational program, clinical performance, professionalism, supervisory skills, and scholarly activities.

iv. These evaluations shall be in the form of electronic written, anonymous, and confidential assessments assigned in the institutional electronic platform, (i.e., E-Value).

v. Teaching faculty are required to receive feedback on their educator evaluations at least annually. This information shall be shared with the teaching faculty in individualized aggregate form only; and in such a manner that it cannot be traced back to any individual resident/fellow. NOTE: Results from faculty evaluations should be incorporated into any faculty development plans.

An Additional Safeguard:

i. To preserve anonymity, the teaching faculty and program evaluations for residency/fellowship programs with three or fewer residents/fellows will be pulled by the DIO rather than the Program Director. If there are three trainees, the DIO will de-identify the results and forward them to the Program Director. In cases where a program has only one or two trainees, evaluation results will be held by the DIO until several years' worth of data have amassed. **POLICY EXCEPTION***: In the event an evaluation reveals an egregious issue, the DIO shall immediately address said issue.*

ii. The teaching faculty and program evaluations for fellows in dependent fellowship programs with three or fewer trainees will be pulled by the Program Director of the Core Program. If there are three fellows, the Program Director of the Core Program will de-identify the results and forward them to the fellowship Program Director. In cases where a fellowship has only one or two fellows, evaluation results will be held by the Program Director of the Core Program until several years' worth of data have amassed. **POLICY EXCEPTION**: *In the event an evaluation reveals an egregious issue, the Program Director of the Core Program shall immediately address said issue.*

Edits to Section VIII Approved by GMEC Taskforce: 12/1/2021

Edits to Section VIII Approved by GMEC: 12/10/2021

Transferring Resident Policy:

A. To maintain professional relationships, policies, and program stability for residents/fellows and Program Directors, the following procedure must be followed when a resident/fellow wishes to transfer between training programs.

1. There are three types of transfers possible:

i. Transferring from one training program in WVU School of Medicine to another training program in WVU School of Medicine…

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

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

c. When the Program Director of the receiving program receives the written notification for the resident/fellow to pursue the transfer, then the Program Director of the receiving program may freely speak with the resident/fellow regarding a specific position opening within the program.

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

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

a. When a resident/fellow wishes to pursue a transfer to a training program outside of WVU School of Medicine, the resident/fellow must discuss the possibility of leaving the current training program with their current Program Director. In some cases, this discussion might reveal problems or concerns of the resident/fellow that can be solved by the Program Director that may obviate the resident's/fellow's desire to transfer. The Program Director may also advise on career planning and/or assist with the transfer. If the resident/fellow decides to seriously pursue the transfer, the resident/fellow must obtain written notification from their current Program Director to pursue the transfer.

b. Program Directors must provide timely verification of residency/fellowship education and performance for residents/fellows who wish to transfer upon the written request of that resident/fellow.

c. It is advisable to obtain a written consent from the transferring resident/fellow physician which would allow the WVU Program Director to disclose any and all information about the transferring resident/fellow physician's file to the receiving Program Director, should the receiving Program Director contact WVU for information about the resident/fellow physician's academic and professional performance.

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

a. Transferring from a training program outside of WVU School of Medicine – If not taken through a formal matching process, and prior to an offer being made to accept an outside resident/fellow transfer is finalized, a review of the credentials must be conducted and approved by the DIO to assure standards are being met and a vacancy in approved complement for the program exists. When a resident/fellow from a training program outside of the WVU School of Medicine wishes to pursue a transfer to a training program in the WVU School of Medicine, the resident/fellow must provide the WVU School of Medicine Program Director with a written release from their current Program Director in order to pursue the transfer. WVU School of Medicine Program Directors shall contact the current Program Director to discuss the academic status of the resident/fellow prior to seriously considering the applicant and prior to inviting the resident/fellow for an interview.

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

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

B. **NOTE**: It is inappropriate for a Program Director to initiate recruitment with a resident/fellow currently in a training program, at WVU or elsewhere, and discuss specific positions or arrangements with the resident/fellow without first receiving written notification from the current Program Director. This verification must include written verification of previous educational experiences and a competency-based, and milestone-based performance evaluation of the resident/fellow. It is inappropriate for a resident/fellow to seriously pursue a transfer to a training program, within WVU or elsewhere, without first discussing his/her plans with their current Program Director.

Academic Discipline and Dismissal Policy:

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

B. Programs may take corrective or disciplinary action including dismissal for cause including, but not limited to:

1. Unsatisfactory academic or clinical performance
2. Failure to comply with the policies, rules, and regulations of the resident/fellow physician program, the WVU School of Medicine, or other facilities where the resident/fellow physician 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
9. Failure to pass USMLE Step 3 or COMLEX 3

C. Corrective or disciplinary actions may include, but not be 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/fellow physician's appointment

4. Terminate, limit, or suspend a resident/fellow physician's appointment or privileges

5. Non-renewal of a resident/fellow physician's appointment

6. Dismiss a resident/fellow physician from the program

7. Any other action that the Program or Sponsoring Institution deems is appropriate under the circumstances

Level I Intervention:

1. Oral and/or Written remediation, counseling or other adverse action:

    i. Minor academic deficiencies that may be corrected at Level 1 include…

        a. Unsatisfactory academic or clinical performance

        b. Failure to comply with the policies, rule, and regulations of the Program, or University, or other facilities where the resident/fellow physician is trained

    ii. Corrective action for minor academic deficiencies or disciplinary offenses which do not warrant probation with remediation, as defined in the Level II Intervention, shall be determined and administered by each program.

    iii. Corrective action may include oral or written counseling, or any other action deemed appropriate by the program under the circumstances.

    iv. Corrective action for such minor academic deficiencies and/or offenses are not subject to appeal. The resident/fellow is not entitled to legal representation during a Level 1 Intervention meeting.

Level II Intervention:

1. Probation Plan or other Adverse Action:

    i. Serious academic or professional deficiencies may lead to placement of a resident/fellow physician on probation. An academic or professionalism deficiency that is not successfully addressed while on probation may lead to non-reappointment, or other disciplinary action.

    ii. The Program Director shall notify the resident/fellow physician in writing that they have been placed on probation and the length of the probation.

    iii. 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. The resident/fellow is not entitled to legal representation during the Level II Intervention meeting.

iv. Failure of the resident/fellow physician to comply with the terms of the plan may result in termination or non-renewal of the resident/fellow physician's appointment, or non-promotion to the next PG level of training.

Level III Intervention:

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

   i. Demonstrated incompetence or dishonesty in the performance of professional duties, including but not limited to research misconduct.

   ii. 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.

   iii. Insubordination by refusal to abide by legitimate reasonable directions of administrators or of the WVU Board of Governors.

   iv. Physical or mental disability for which no reasonable accommodation can be made, and which makes the resident/fellow unable, within a reasonable degree of medical certainty and by reasonable determined medical opinion, to perform assigned duties.

   v. Substantial and manifest neglect of duty.

   vi. Failure to return at the end of a leave of absence.

   vii. Failure to comply with all policies of WVU Hospitals, Inc.

2. A resident/fellow 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.

Academic Grievance Policy and Procedure – Grievance, Due Process, and Appeals:

A. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes, and complaints which may arise between residents and/or fellows and their Program Director or other supervising faculty member.

Policy:

1. 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:

i. Termination of a resident/fellow during an annual contract period

ii. Alleged discrimination

iii. Sexual harassment

iv. Salary or benefit issues

2. These grievances are covered under the employment grievance procedures for employees of West Virginia University as outlines in section XXV of these Bylaws.

Definitions:

1. Grievance – Any unresolved disagreement, dispute or complaint a resident or fellow has with the academic policies or procedures of the Residency/Fellowship Training Program or any unresolved dispute or complaint with his or her Program Director or other supervising faculty member.

2. These include but are not limited to issues of:

i. Suspension

ii. Probation

iii. Retention at current level of training

iv. Refusal to issue a certificate of completion of training

Procedure:

Level I Resolution

i. A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within (10) working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence which supports the grievance.

ii. Within (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.

iii. Level I of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in writing of the final decision. This should occur within (5) working days after the meeting between the resident/fellow and Program Director.

iv. A copy of the Program Director's final decision will be sent to the Department Chair and to the DIO. The resident/fellow is not entitled to legal representation during the Level 1 meeting.

Level II Resolution

i. 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 II resolution, which will begin with the aggrieved resident/fellow notifying the appropriate Department Chair of the grievance in writing.

ii. Such notification must occur within (10) working days of receipt of the Program Director's final decision. The resident's/fellow's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence which supports the grievance.

iii. If the Department Chair is also temporarily functioning as the Program Director, then the Level II resolution will be handled by the DIO.

iv. Within (10) working days of receipt of the grievance, the resident/fellow and the Department Chair will set a mutually convenient time to discuss the complaint and attempt to reach a solution.

v. Level II of this grievance procedure will be deemed complete when the Department Chair (or DIO) informs the aggrieved resident/fellow in writing of the final decision.

vi. This should occur within (5) working days of the meeting with the resident/fellow and the Department Chair.

vii. Copies of this decision will be kept on file with the Program Director, in the Department Chair's office, and sent to the DIO. The resident/fellow is not entitled to legal representation during the Level II meeting.

Level III Resolution

i. If the resident/fellow disagrees with the Department Chair's final decision, they may pursue a Level III resolution of the grievance. The aggrieved resident/fellow must initiate this process by presenting their grievance, in writing, along with copies of the final written decisions from the Program Director and Department Chair, and any other pertinent information, to the office of GME within (5) working days of receipt of the Department Chair's final written decision. Failure to submit the grievance in the (5) working day time frame will result in the resident/fellow waiving their right to proceed further with this procedure. In this situation, the decision at Level II will be final.

ii. 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 their Program Director, at the scheduled meeting following the protocol outline in Section XI.5

iii. 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 GME, and with the Program Director, and Department Chair. The decision of the Grievance Committee will be final.

The Grievance Committee

i. Upon the request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents/fellows, and three Program Directors. No members of this committee will be from the aggrieved resident's/fellow's own program.

ii. 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.

Grievance Committee Procedure

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

ii. 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/fellow may present any relevant information or testimony from any colleague or faculty member. The resident/fellow is **NOT** entitled to legal representation during the grievance committee hearing. The Program Director and Department Chair may be requested by the Committee to also be present for oral testimony. The Chair is authorized to exclude or remove any person who is determined to be disruptive.

iii. RECESSES AND ADJOURNMENT: The 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.

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

v. MEETING RECORD: A GME staff member may be present for the purpose of recording the meeting minutes. Minutes and the final written decision of the Grievance Committee will be placed on file in the GME Office. The program will post the final decision in the resident's/fellow's academic file.

Confidentiality

i. 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 – Renewal and Promotion:

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

1. Promotion: Decisions regarding resident/fellow promotion are based on whether resident/fellow has met all department, institutional, and/or ACGME milestone requirements. The USMLE Step 3 and COMLEX step 3 will be used as a measure of basic knowledge proficiency. Passage of the USMLE and/or COMLEX step 3 is a requirement for advancement for the 3rd year and beyond of residency for all residents as indicated in Section VII and the Resident Doctor Licensure Requirement.

2. Intent Not to Renew Contract: In the event that WVU School of Medicine elects not to reappoint a resident/fellow to the program and the agreement is not renewed, the Program Director shall provide the resident/fellow with a four (4) month advance written notice of its determination of non-reappointment unless the termination is "for cause". The GME Office must also be notified in writing. Intent not to renew is subject to academic grievance as outlined in Section XI.

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

Special Program Review (SPR) of Residency Programs:

Criteria for Initiating a GMEC Special Program Review (SPR):

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

2. Criteria for initiating a GMEC Special Program Review may include, but are not limited to:

i. ACGME resident/fellow survey results

ii. ACGME faculty survey results

iii. Any letter of complaint/concern regarding a specific training program (including, but not limited to, complaints to the ACGME, hospital or health science leadership, departmental leadership, etc.)

iv. Many departing faculty, or departure of key required specialty faculty

v. Low board scores, low first-time pass rate, or low board take rates

vi. Clinical and educational work hour violations

vii. Annual Program Review with DIO

viii. Inadequate ADS reports

ix. Annual Program Data

x. Self-Study site visits

xi. Results of Review Committee accreditation or some other internal means

xii. Other concerns initiated by the GMEC and/or GMEC Taskforce or DIO

xiii. Button Reports

3. The Special Program Review Committee membership is within the Sponsoring Institution, but not from within the department of the program under review, and will be comprised of at least:

   i. One faculty member

   ii. One resident/fellow

   iii. Additional internal or external reviewers and administrators which may include the DIO, as determined by the GMEC

   iv. One Program Manager

   v. One person from the central GME Office

4. Interviews will be conducted with:

   i. At least one peer-selected resident/fellow from each PGY level. In addition, the GMEC expects that all available residents be present

ii. Core faculty from the program

iii. The Residency Program Manager

iv. The Department Chair

v. The Program Director

vi. Other individuals as deemed appropriate by the GMEC Special Review Committee depending on the circumstances of the review.

5. Specific outcome measures – The GMEC Special Program Review will outline:

i. A reporting structure

ii. Monitoring procedures and timeline

iii. Written recommendations and procedures for follow-up to improve ACGME-accredited program performance in specified areas

A. Because the GMEC Special Program Review is an interventional and formative process, the focus is on improvement and anticipated, measurable, end-point progress. A progress report may be required. Results of the SPR will be presented both at the GMEC Taskforce and GMEC.

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

Supervision and Accountability:

A. Programs must provide a professional, respectful, and supportive environment that is free from mistreatment, abuse, and coercion of residents, fellows, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory, supportive, and respectful manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of residents/fellows and faculty regarding episodes of inappropriate and unprofessional behavior, especially when exhibited toward a trainee who is requesting supervision and guidance in the patient care setting.

B. The safe and appropriate care of each patient underlies all guidelines for supervision in medical education. Although the attending physician is ultimately responsible for the care of the patient, every physician involved in a patient's care shares in the responsibility and accountability for their individual actions. Each resident/fellow and faculty member must inform each patient of their respective role in that patient's care. *[ACGME CPR, VI.A.2.a).(2)]* Effective programs, in partnership with their Sponsoring Institution, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. The degree of supervision for a resident/fellow is expected to evolve progressively as the resident/fellow gains more experience. The level of supervision for each resident/fellow must be commensurate with that resident's/fellow's level

of independence in practice, and will be influenced by the complexity, acuity, and urgency of the patient's condition. *[ACGME CPR, VI.A.2.b).(1)]*

C. Depending upon each trainee's level of independence in practice, supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow, recognizing a trainee's progress toward independence. However, certain activities require the physical presence of the supervising faculty member, and each program must clearly define these activities. *[ACGME CPR, VI.A.2.d)]*

D. Levels of Supervision

1. To promote responsible and safe resident/fellow supervision, each program must define the appropriate levels of supervision for their specialty's common types of patient interactions. *[ACGME CPR, VI.A.2.f)]* The privilege of progressive authority, responsibility, conditional independence, and eventually a supervisory role in patient care must be assigned by the program director and by faculty members whose supervision assignments have been of sufficient duration to assess the knowledge and skills of each trainee. *[ACGME CPR, VI.A.2.e)]* While providing for graded authority and responsibility, the program must use the following classifications of supervision *[ACGME CPR VI.A.2.c)]:*

   i. Direct Supervision - The supervising physician is physically present with the resident/fellow during the key portions of the patient interaction, *OR, if the supervising physician and/or patient is not physically present with the resident/fellow, the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology,* (although some RRCs may choose not to permit this). All PGY1 residents must initially be supervised directly. *[ACGME CPR, VI.A.2.c).(1)]* Additional information on Direct Supervision may be found here. (CTRL-click)

   ii. Indirect Supervision - The supervising physician is not providing physical or concurrent visual or audio supervision, but is immediately available to the resident/fellow for guidance and is available to provide appropriate direct supervision should that be required. *[ACGME CPR, VI.A.2.c).(2)]*

   iii. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. *[ACGME CPR, VI.A.2.c).(3)]*

E. Procedures - For procedural/case supervision, each department will develop specific guidelines describing the mechanism for resident/fellow supervision in accordance with ACGME and Joint Commission requirements. These must include the following key principles:

1. Clinical responsibilities must be conducted in carefully supervised and graduated manner, tempered by progressive levels of independence to enhance clinical judgment and skills.

2. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.

3. Resident/fellow supervision must support each program's written educational curriculum.

4. Resident/fellow supervision should foster humanistic values by demonstrating a concern for each resident's/fellow's well-being and professional development.

6. Residents/Fellows are supervised by faculty physicians in accordance with these established guidelines.

7. Faculty call schedules are structured to assure that support and supervision are readily available to residents/fellows on duty, 24 hours a day, 7 days a week, 365 days per year.

8. The quality of resident/fellow supervision and adherence to the above guidelines are monitored through annual review of the residents'/fellows' evaluations of their supervising faculty and rotations, and via the GME Supervision Survey.

9. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval. Monthly progress reports will continue to be submitted until the situation or issue is resolved.

F. For a list of resident/fellow and attending physician patient care activities and supervision responsibilities, please CTRL-click on the following link:

Appendix L: Resident and Attending Physician Patient Care Activities and Supervision Responsibilities for Non-Operating Room Procedures (CTRL+click)

Well-Being in the Clinical and Educational Learning and Working Environment:

A. Well-being in faculty and trainees is a product of a positive, supportive program and departmental culture. Transparent two-way communication is essential.

B. The environmental, emotional, and situational demands on residents, fellows, and supervising faculty are profound, and appear to be increasing over time. Protecting the psychological, emotional, and physical well-being of residents, fellows, and faculty requires extensive collaboration and effort between GME, WVU SOM, and WVU Hospitals. It is our collaborative responsibility to create a supportive and positive learning and working environment which champions and normalizes provider physical and mental health and self-care in order to promote the best possible patient care and outcomes. *[ACGME CPR VI.C.1.e)]* In other words, in order to guarantee that we take excellent, safe, and effective care of our patients, it is our joint institutional responsibility to take care of our care givers. We need to help them in finding joy in medicine.

C. Each training program, in partnership with central GME, WVU SOM, and WVU Hospitals must focus effort and attention on effective workable call schedules, decreasing work compression *(being required to do the same amount of work in less time)* and increasing workplace safety and support. We must normalize the provision of time off for residents/fellows and faculty to attend medical, mental health,

and dental care appointments during their working hours without retaliatory attitudes and practices. *[ACGME CPR VI.C.1.c).(1)]* We must normalize back-up coverage systems which allow residents, fellows, and faculty the flexibility to take a day off when they are sick, need to care for a sick child, or have a family emergency. And we must ensure that these necessary absences occur without allowing a subculture of bullying, resentment, and retaliation. Harassing, hazing, berating, or questioning the dedication of a physician who has taken necessary time off is fundamentally unacceptable. *[ACGME CPR VI.C.2.]*

D. The ACGME's Clinical and Educational Work Hours Standards, as outlined in the ACGME Common Program Requirements (ACGME CPR), must be regularly overseen and monitored by the training program leadership and audited by the sponsoring institution's leadership. Violations of ACGME's Clinical and Educational Work Hours Standards are almost always a product of unrealistic clinical call schedules. In a timely manner, violations must be examined non-punitively for root cause by program leadership who are then responsible for reworking call schedules and modifying rotation goals and objectives. Any averaging, (i.e. 1-day off in seven, averaged over 4 weeks), that takes place must occur within each rotation.

1. Maximum Hours of Clinical and Educational Work per Week must be limited to no more than 80 hours, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. Regardless of specialty, a resident/fellow must *never* be scheduled for 80 hours of work in one week. *[ACGME CPR VI.F.1.]*

2. Mandatory Time Free of Clinical Work and Education includes *[ACGME CPR VI.F.2.]:*

    i. Adequate breaks between scheduled clinical work and education periods

        a. Residents and Fellows *must* have *at least* (14) hours free of clinical work and scheduled education following a 24-hour shift of in-house call. *[ACGME CPR VI.F.2.b)]*

        b. Residents and Fellows should have (8) or more hours free of clinical work and scheduled education between shifts. *[ACGME CPR VI.F.2.a)]*

    ii. At minimum, a resident/fellow must be scheduled for one 24-hour day off every seven days when averaged over a four-week period. *[ACGME CPR VI.F.2.c)]* For programs that require a one day off every seven, not averaged, these rules must be followed for that specific program, per their respective ACGME common program requirements. For a day off to qualify as a day off, it must be one block of 24 continuous hours *completely* free of administrative, clinical, and scheduled educational activities. Therefore, those training programs using (13) 28-day blocks for their rotations in one academic year must provide (4) days off within each block. Those training programs using calendar months for their rotations must provide (5) days off, within each month, except for February in a non-Leap year, because it is 28 days long, and therefore qualifies for (4) days off, instead of (5). More information is available here.

    iii. **A SPECIAL NOTE**: Vacation Days, Leave Days, and/or Sick Days are NOT "required days off". When a resident/fellow takes vacation or other leave, the ACGME requires that those days be omitted from the numerator and the denominator for calculating clinical and educational work hours, call frequency, or days off. Again, more information is available here.

3. Maximum Clinical Work and Education Period Length must not exceed 24 hours of continuous scheduled clinical assignment *[ACGME CPR VI.F.3.a)]*

    i. The resident/fellow may work up to four additional hours for activities related to patient safety, such as providing effective transitions of care, and/or resident education. A resident/fellow must *never* be assigned additional patient care responsibilities during this four-hour period. This period of up to 4 additional hours shall not be expected or incorporated as part of a call schedule. **The period of up to 4 additional hours is to help the resident/fellow, NOT the program.** *[ACGME CPR VI.F.3.a).(1)]*

4. Clinical and Educational Work Hour Exceptions shall *never* be expected, required, or scheduled. However, in rare circumstances, after handing off all other responsibilities, it is permissible for a resident/fellow, *who chooses to do so on their own initiative*, to remain or to return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to give humanistic attention to the needs of a patient or patient's family; or to attend unique educational events. The hours spent in these exceptional situations must be counted toward the 80-hour weekly limit and **should be logged as unplanned hours.** *[ACGME CPR VI.F.4.]*

5. Moonlighting *[ACGME CPR VI.F.5.a)]* permission for residents and fellows must be granted by the Program Director prior to any moonlighting occurring. Moonlighting may not interfere with a resident's or fellow's ability to achieve the goals and objectives of the educational program, and may not compromise either patient safety, or the resident's/fellow's fitness for work. Therefore, all moonlighting shall be monitored by program leadership, and permission to moonlight may be withdrawn at the Program Director's discretion.

    Additionally, all time spent by residents/fellows in internal and/or external moonlighting must be logged as "unplanned" clinical work hours and counted toward the 80-hour maximum weekly limit. Individual programs and entire institutions are within their rights to prohibit moonlighting for all trainees. PGY-1s are prohibited from moonlighting by the ACGME. J-1 visa-holding physician trainees are prohibited from moonlighting by the ECFMG.

6. In-House Night Float *[ACGME CPR VI.F.6.]* is required to occur within the context of the 80-hour and one-day-off-in-seven standards. ACGME RRCs may further restrict scheduled periods of in-house night float.

7. Maximum In-house On-Call Frequency *[ACGME CPR VI.F.7.]* must be scheduled no more frequently than every third night, and except for Internal Medicine, may be averaged over a four-week period. This means that in a 28-day rotation block, a resident or fellow may only complete a *maximum* of (9) scheduled overnight in-house call shifts, and in a calendar month rotation, a *maximum* of (10) scheduled overnight in-house call shifts.

E. At-Home Call *[ACGME CPR VI.F.8.]* is not subject to the every-third-night limitation, but At-Home Call is limited for residents and fellows in that it shall not be scheduled on a resident's/fellow's required days off, and all patient care activities, (i.e. phone calls, EMR entries and references, and/or return to the clinical site), count toward the 80-hour maximum weekly limit, and must be logged as "unplanned" clinical work hours. PGY-1s should not be assigned At-Home Call until/unless cleared by the CCC and the Program Director for indirect supervision. ACGME RRCs may have additional requirements regarding

this. The sponsoring institution provides central oversight *[ACGME Institutional Requirements III.B.5.a)]* to ensure programs follow clinical and educational work hours standards, and address violations in the spirit in which they are intended to be addressed. Each program will develop an internal review mechanism to evaluate Clinical and Educational Work Hours in compliance with the policies of the ACGME.

F. Each program must have a program specific written "Wellbeing in the Learning and Working Environment" policy Factors that must be addressed include, but are not limited to: the frequency of call, the number of hours for each o- call period, the amount of time that a participant or student will be allowed to continuously be on duty or on call, the amount of time off, the process for requesting a sick day, how to recognize fatigue in yourself and your colleagues, and what to do when fatigued, and inclement weather/disaster situations.

E. Fatigue Mitigation Education is a requirement of training programs for all of their residents/fellows, and faculty. This education must include, but is not limited to: recognition of the signs of fatigue and sleep deprivation; alertness management; and fatigue mitigation processes.

Experiencing fatigue in a supervised environment during training prepares residents and fellows for managing fatigue in practice. Programs are expected to adopt fatigue mitigation processes and ensure that department and program culture encourage the use of fatigue mitigation strategies. No retaliation or shaming, either overt or implied, shall be displayed or tolerated. *[ACGME CPR VI.D]*

Suggested strategies include but are not limited to: strategic napping; judicious use of caffeine; availability of other caregivers; time management to maximize sleep off-duty; learning to recognize the signs of fatigue and self-monitoring performance or asking others to monitor performance; remaining active to promote alertness; maintaining a healthy diet; using relaxation techniques to fall asleep; maintaining a consistent sleep routine; exercising regularly; increasing sleep time before and after call; and ensuring sufficient sleep recovery periods.

Clinical Responsibilities, Teamwork, and Transitions of Care in the Working and Learning Environment

Patient Safety:

1. Patient Safety activities in the Learning and Working Environment must emphasize the following items, but this list is not exhaustive:

    a. Reporting of errors, adverse events, unsafe conditions, and near misses in a protected, pro-active, and educational manner that is free from reprisal via the Patient Safety Event reporting tool used by Ruby Memorial Hospital, or by the participating site where the event occurred.

    b. Contributing to interprofessional root cause analysis (RCA) or other similar risk reduction teams when appropriate, and/or requested.

c. Programs will ensure experiential training and involvement for residents and fellows, along with their faculty, in the process of disclosing patient safety events to patients, and patients' families.

d. Creating, encouraging, and sustaining a fair and just culture for reporting patient safety events for the purposes of systems improvement.

Quality Improvement in the Learning and Working Environment:

1. Programs will use institution-specific data to improve systems of care, reduce health care disparities, and improve patient outcomes; and

2. Programs will participate in inter-professional quality improvement initiatives.

Transitions of Care in the Learning and Working Environment:

1. Programs will create and implement a detailed program-specific transitions of care policy. They will facilitate professional development for faculty members and residents/fellows regarding common clinical site-based processes for effective transitions of care.

2. Programs will ensure that participating sites engage their residents/fellows in standardized transitions of care consistent with the setting and type of patient care

3. Will establish simulated or real-time interprofessional training using communication which optimizes safe and effective transitions of care at the clinical site.

4. The institution will oversee programs are meeting this requirement.

XVII. Professionalism in the Learning and Working Environment:

1. Training Programs, in partnership with WVU SOM and WVU Hospitals, must educate residents, fellows, and faculty members concerning the professional and ethical responsibilities of physicians. This includes but is not limited to, their obligation to be appropriately rested and fit to provide the care required by their patients.

2. Residents, fellows, and faculty members are also professionally and ethically obligated to be observant, to intervene, and/or to escalate their concern about a fellow health care team member's fitness for work, depending on the situation, and in accordance with institutional policies. This includes impairment, including from illness, fatigue, and substance use, both in themselves, and in all members of the health care team. *[ACGME CPR VI.B.1]* Click here to view the GME Fit for Duty Policy.

3. Accurate and honest reporting of clinical and educational work hours by each resident and fellow, regardless of the type of training program they are in, is essential. There shall be zero

tolerance for any expectation, by any member of the health care team, explicit or implied, that a resident will remain at work, to "help the team", or otherwise, without an accurate and honest recording of ALL the clinical and educational hours worked.

4. Identification of resident mistreatment must be monitored by WVU SOM. In addition, WVU SOM must have a process for educating residents, fellows, and faculty regarding unprofessional behavior, and a confidential process for reporting, investigating, and addressing such concerns. *[ACGME CPR VI.B.6.]* We use two tools located on the GME webpage to help us with this: the Mistreatment Form, and the Professionalism Form, (formerly represented as "The Button"). Programs are responsible for informing their residents, fellows, and faculty about these two tools, where to find them, and how and why to use them.

    a. The Mistreatment Form allows any member of the health care team to report episodes of mistreatment or lack of supervision that have happened to them, or that they have witnessed. Once submitted, the report is sent directly to the DIO, the Chair of the GMEC, and the Director of GME for further action.

    b. The Professionalism Form allows any member of the health care team to report Lapses in Professionalism, as well as episodes of Exemplary Professionalism that have happened to them, or that they have witnessed.

    c. Once submitted, the report is sent directly to the DIO, the Chair of the GMEC, the Director of GME, and a GME staff member for further action.

Non-Competition:

A. Neither WVU SOM nor any of its ACGME accredited programs will require a resident or fellow to sign a non-competition guarantee or restrictive covenant as part of their employment contract to participate in a training program sponsored by the WVU SOM. *[ACGME CPR II.A.4.a).(9).(a)]*

Lab Coats, Scrubs, and Meal Cards:

A. Two lab coats and two sets of jade green scrubs are provided for each incoming resident/fellow by Medical Staff Affairs. These will be issued to the resident/fellow at the beginning of training. For residents/fellows with training longer than three (3) years, two additional lab coats will be issued by West Virginia University Hospitals at the beginning of their 4th year of training.

B. Residents/fellows receive a meal card designated to be used to purchase food from the hospital cafeteria while on call. In addition, basic food options are also provided in the resident on-call/lounge facilities at Ruby Memorial Hospital. Adequate sleeping accommodations that provide residents a private secure environment is provided for residents who are on call overnight, or who find themselves to be too fatigued to continue patient care, or to return home. *[ACGME CPR VI.D.2.]*

Guidelines for Residency Rotations To, or From, Other Institutions:

The reasons for resident rotations at other institutions include:

1. To complement the training opportunities at West Virginia University School of Medicine and West Virginia University Hospital's Graduate Medical Education Programs.

2. To offer elective experiences not available at the sponsoring institution such as those in the domestic community practice setting.

3. To fulfill specialty-specific program requirements that cannot currently be better met at the sponsoring institution.

4. External rotations for the purpose of auditioning for a possible fellowship program will be limited to one month during the entire length of the core program. These experiences may include a variety of experiences including but not limited to: fellowship offered by the sponsoring institution, general inpatient ward rotations, critical care rotations, and outpatient rotations.

5. Requests for international rotations will follow the GME International Rotation Policy.

Requirements:

1. External rotations must first have the approval of the Program Director. Subsequently the Department Chair, the GMEC Taskforce, and the DIO must approve the rotation.

2. Requests for review by the GMEC Taskforce and DIO require programs to complete the Off-Site Rotation Packet which is available on GME's SOLE site, and which includes the educational rationale for the rotation, and a letter of support from the Program Director. These must be received at least 5 working days prior to the GME Taskforce meeting in which they are expected to be reviewed.

3. Required external rotations must be included in the program's ADS update submitted annually to the ACGME, as well as in material forwarded to applicants for Graduate Medical Education.

4. A formal Affiliation Agreement (AA) must exist for all established continual required resident rotations or for rotations lasting longer than 90 days at participating institutions. The development of affiliation agreements and fiscal agreements will follow the general pattern of the institution generic AA.

5. A Program Letter of Agreement (PLA) shall be completed for each resident for each rotation at another institution. The PLAs for these unique one-time rotations will detail the educational objectives, site director, supervising faculty, evaluation methods, and duration of the assignment. There is also a global PLA form template available to use for either a required external rotation that will be done by all trainees in the program, or a standing elective external rotation which will potentially be completed by multiple trainees per year.

6. For an external rotation request which is initiated by the resident as a one-time special case – in addition to all of the other paperwork, the resident must provide a letter stating what their unique educational objectives are, and ensuring that they will be fully responsible for all expenses related to the away rotation including but not limited to: travel, housing, meals, state licensure, and application fees.

Resident Rotations for Visiting Residents:

1. All visiting residents must have a valid and current PLA signed by the Program Directors from both institutions involved. In addition, if required, an Affiliation Agreement must state that the sponsoring institution of the visiting resident will continue to provide salary support, benefits, and malpractice insurance while they are rotating with programs sponsored by the WVU School of Medicine.

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

3. All visiting residents must have a valid West Virginia Board of Medicine or Board of Osteopathic Medicine visiting medical training permit and follow WVUH employee health, and HIPAA requirements.

Malpractice Coverage:

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

B. A resident must report any questionable incidents concerning patient care to the Program Director and to Risk Management at the Health Sciences Center (HSC), and Risk Management at Ruby Memorial Hospital, WVUH. A written report must be completed and sent to both Risk Management (P.O. Box 9032) – HSC, and Risk Management (P.O. Box 8227) – WVUH, to be reviewed and forwarded to the Board of Risk as needed. Risk Management can be reached at 304-293-3584 (Health Sciences) and 304-598-1938 (WVUH).

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

Disability and Health Insurance:

A. Disability Insurance: The opportunity to participate in group long-term disability coverage is available through Standard Insurance Policy number 135501 by contacting 1-800-348-3226 or the WVU Human Resources/Benefits Office (304-293-4103).

B. Health Insurance: A resident is eligible to enroll in the state employees' health insurance or state managed health care options through Support Services at WVU Talent and Culture, Health Sciences Center (304-293-4103).

Leave Policies:

A. Residents/fellows accrue annual leave (vacation) and sick leave in accordance with State policy. There may also be additional leave time granted for military leave, jury duty, parental leave, family medical leave, etc. Usage of this time is governed by departmental policies, ACGME requirements, and the operational needs of individual departments. However, the requirements set by the ABMS Specialty and Sub-Specialty Boards may limit the total days of leave which a resident/fellow may use in any given year and still remain on their original training schedule.

B. The Program Director will notify the resident/fellow in writing if an extended leave may result in an extension of the original training period required by the ACGME and the ABMS specialty and sub-specialty boards..

C. For more information regarding Resident/Fellow leave policies, contact Support Services. Topics covered include Annual Leave, Sick Leave, Holidays, Leaves of Absence, Procedure for Requesting Leave, Grievance, Witness, and Jury Leave. In addition, please see the GME Institutional Leave Policy which may be accessed by (CTRL + click) this link, and scrolling down to *Leave Policy*: https://medicine.hsc.wvu.edu/gme/gme-policies/

Policies of WVUH Practitioner Health Committee (Appendix I):

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

B. Policy: In order to assure the safety of patients, co-workers, and trainees WVUH will address all reports of impaired or possibly impaired performance of practitioners. WVUH will also strive to maintain the confidentiality of all individuals who may report any observed impairment or possible impaired

performance of any practitioner(s) affiliated with the hospital. Impairment may be due, but not limited to physical, and/or mental/behavioral problems, including drug and alcohol use, misuse, and/or abuse. All assessments, evaluations and treatment recommendations received by the Practitioner Health Committee shall be confidentially maintained under the peer review privilege, except as limited by regulation, ethical obligation, Medical Staff Manuals, and/or threat to patient safety. Practitioners referred to in this policy include, but are not limited to, faculty credentialed by WVUH, fellows, residents, interns, and all allied health professionals.

Procedure:

EDUCATION

i. WVUH will provide education on Practitioner Health and Impairment to the Medical, Dental, Allied Health Staff, and WVU SOM Residents and Fellows.

ii. Hospital administrative leadership will assure that policies and procedures related to impairment and recognition issues specific to impairment are available on CONNECT. To access the Policies of the WVUH Practitioner Health Committee, please click here. You will need to enter your master id and password to access the policy.

iii. WVUH encourages self-referral of any practitioner in seeking help for health or impairment problem to the Practitioner Health Committee. Practitioners may voluntarily seek assistance from the WVU Faculty and Staff Assistance Program (FSAP) at any time with or without referral from either the Practitioner Health Committee or other administrative personnel.

NEW PRACTITIONER

i. Any practitioner who requests to practice at WVU Hospitals whose ability to practice medicine may be affected, is undergoing treatment for substance abuse, any other physical or mental health problems, or who otherwise is reasonably believed to suffer from a substance abuse problem, or any other physical or mental health problem must be referred by the Vice President of Medical Affairs to the Practitioner Health Committee. It is the responsibility of the Department Chair to notify the Vice President of Medical Affairs and supply in writing the nature of the referral.

ii. The Practitioner Health Committee will make their recommendations to the Vice President of Medical Affairs. If determined by the Vice President of Medical Affairs that the Practitioner should seek further evaluation from a specialized counselor for his/her specialized need, at that time an Agreement of Understanding, on behalf of WVUH, as well as a written consent and release, on behalf of WVUH, will be presented to the Practitioner and shall be signed if he/she continues to seek privileges at WVUH. Such information being released includes, urine and blood screening times, results, appointment times, and any referrals to other entities/providers.

iii. If further evaluation is required, following receipt of the evaluation, the Practitioner Health Committee will provide a recommendation to the Vice President of Medical Affairs on each of the following:

a. Advisability of appointment to the Medical, Dental, or Allied Health Staff at WVUH, as applicable.

b. Need for any additional monitoring and treatment.

c. Need for limitations or conditions on privileges.

iv. After discussing the Practitioner Health Committee's recommendations with the Department Chair, the Vice President of Medical Affairs will determine the final recommendation regarding the applicant's ability to practice, which will be presented to the WVUH Board of Directors, through the Joint Conference Committee. The Vice President of Medical Affairs may grant temporary privileges or allow a Practitioner to begin to treat patients at WVUH; however, the WVUH Board of Directors through the Joint Conference Committee has the final decision as to whether a Practitioner may practice at WVUH and under what conditions.

v. The Vice President of Medical Affairs will communicate the final recommendations to the Residency/Fellowship Program Director, the Designated Institutional Official (for residents/fellows only), and the Department Chair.

vi. When the appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an agreed upon external provider. The Vice President of Medical Affairs will ensure that the executed "Agreement of Understanding" specifies treatment recommendations and conditions of appointment and/or clinical privileges must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling, and meeting with the Practitioner Health Committee.

vii. All further decisions as to what actions, if any, need to be taken, remain with the Vice president of Medical Affairs.

PROCEDURES FOR CURRENT PRACTITIONERS

Observed Impaired Behavior:

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

b. Hospital Staff should notify the AOC or the Vice President of Medical Affairs, (if during regular business hours), of any inappropriate behavior or suspected substance abuse. If the

AOC is notified, he/she will notify the Vice President of Medical Affairs, and the Vice President of Medical Affairs will notify the Department Chair.

c. The Department Chair, the Vice President of Medical Affairs or the AOC during off-shift hours will investigate and verify the credibility of the allegation in 3.i.a or 3.i.b to ascertain the credibility of the complaint, concern, or allegation. The Practitioner will not be told who filed the initial report. If the alleged impairment is deemed credible by the Vice President of Medical Affairs, Department Chair, or the AOC during off-shift hours, the Practitioner may be referred to Employee Health. After hours, the Practitioner will be referred to the Emergency Department. Refusal to cooperate with testing is grounds for dismissal from WVUH and removal of residents/fellows from providing any patient care within the Hospital. Employee Health is the designated department to administer the drug testing as well as provide the results to the Vice President of Medical Affairs and/or the Practitioner Health Committee. Employee Health is not required and will not keep any file for individuals including but not limited to any test results and/or appointment times. If the impairment poses an immediate risk to patient safety, the Practitioner must be immediately removed from patient care and patient contact and an immediate precautionary suspension will occur. (For further information regarding precautionary suspension refer to Article IV, Section 4.3 in the case of credentialed Practitioners, and Appendix O in the case of residents.) If the impairment does not pose an immediate risk to patient safety, the Practitioner may continue with his/her patient care duties. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

Self-Referral:

a. All Practitioners are required to self-refer to his/her Department Chair or the Vice President of Medical Affairs if he/she experiences any substance abuse/health problem that could impact on professional/clinical performance in the Hospital. When reported to the Department Chair, the Chair shall report to the Vice President of Medical Affairs. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

b. A Practitioner who seeks assistance with WVU FSAP is required to inform the Vice President of Medical Affairs of this evaluation. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

PROCEDURES OF THE PRACTITIONER HEALTH COMMITTEE

i. Upon referral to the Practitioner Health Committee, the Practitioner is required to sign a consent and release, on behalf of WVUH, allowing information regarding their treatment to be released to the Vice President of Medical Affairs and/or the Practitioner Health Committee by both the WVU FSAP and any treatment provider. Such information being released is, but not limited to, urine and blood screening times, results, appointment times, and any referrals to other entities/providers. If he/she refuses to sign the consent and release, on behalf of WVUH, he/she will be precautionarily suspended from duty, until the mental health assessment and the signing of the consent and release, on behalf of WVUH, is resolved. Refer to Article IV, Section 4.3 Precautionary Suspension or Appendix O, as applicable. All such reported information shall

be kept confidential except as limited by law, ethical violation, or when patient safety if threatened.

ii. Following a referral from the Vice President of Medical Affairs and the receipt of any investigations and evaluations or results of drug testing, the Practitioner Health Committee will recommend to the Vice President of Medical Affairs on each of the following:

   a. Advisability of continued appointment to WVUH.

   b. Need for any additional monitoring and treatment, continued or privileged, as applicable.

   c. Need for limitations or conditions on privileges.

iii. After discussing the Practitioner Health Committee's recommendations with the Department Chair, the Vice President of Medical Affairs will determine the final recommendation regarding the applicant's ability to practice, which will be presented to the WVUH Board of Directors, through the Joint Conference Committee.

iv. The Vice President of Medical Affairs will communicate the final recommendations to the Designated Institutional Official (for residents/fellows only), and the Department Chair, (residents/fellows and faculty).

v. When the appointment is contingent upon rehabilitation, counseling or other conditions of appointment or practice, the Practitioner will be referred to WVU FSAP or an agreed upon external provider. The Vice President of Medical Affairs will develop an "Agreement of Understanding" with the Practitioner, which specified treatment recommendations and conditions of appointment and must be signed in writing, at the minimum, by the Vice President of Medical Affairs and the Practitioner. Such conditions may include, but are not limited to, random drug screens, continued counseling, and meeting with the Practitioner Health Committee.

vi. All further decisions as to what actions, if any, need to be taken remain with the Vice President of Medical Affairs.

vii. If at any time the Practitioner fails to comply with the indicated terms and conditions, the Practitioner Health Committee will immediately report this information to the Vice President of Medical Affairs, which will report to the Department Chair. The Vice President of Medical Affairs has the authority to do one or more of the following:

   a. Terminate immediately.

   b. Demand compliance or be terminated.

   c. Precautionarily suspended until in compliance.

CONFIDENTIALITY

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

Faculty and Staff Assistance Program (FSAP):

A. The FSAP is a confidential problem-solving resource for WVU employees and their family members. This program provides a safe place to sort through problems and determine the best resources available. FSAP services are free to WVU employees. FSAP is designed to help meet the challenges presented by such problems as stress, family concerns, emotional difficulties, parenting issues, etc. The WVU FSAP website may be accessed by using CTRL click here.

Moonlighting Policy:

A. All programs must have their own detailed Moonlighting policy.

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

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

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

E. The Program Director should acknowledge in writing that s/he is aware that the resident/fellow is moonlighting, and this information should be part of the resident's/fellow's electronic file with copies

provided to the Central GME Office. The Program Director may revoke the right and privilege to moonlight at any time for any reason.

F. Time spent by residents/fellows in Internal and External moonlighting **DOES** count toward the ACGME 80-hour/week maximum hourly limit.

G. THOSE AUTOMATICALLY PROHIBITED FROM MOONLIGHTING: PGY-1 residents are not permitted to moonlight. J-1 physician trainees may not moonlight, either internally or externally, as decreed by ECFMG regulations.

Employment Grievance Procedure for Non-Academic Issues:

A. Residents/Fellows are encouraged to seek resolution of non-academic employment-related grievances relating to Resident's/Fellow's appointment or responsibilities, including any differences between Resident/Fellow and WVUH, or WVU SOM with respect to the interpretation of, application of, or compliance with the provision of the agreement, in accordance with the grievance procedures set forth in this document and on the WVU website, (CTRL + click).

B. Forms and procedures are available from Talent & Culture Department – Employee Relations website, (CTRL + click).

Title IX - Harassment:

Policy Statement:

1. 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 an atmosphere created by an intimidating, hostile, or offensive work or learning environment. Therefore, harassment, in any manner or form, of West Virginia students, residents, fellows, faculty, and employees is a violation of University policy and expressly prohibited.

2. 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.

3. Those in supervisory positions are mandatory reporters and have a special responsibility to discourage sexual harassment as well as to implement and to enforce Title IX. 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.

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 Right Act, and

4. The Board of Governors Policy Bulletin No. 9: Policy Regarding Sexual Harassment.

A. This information can be found on the West Virginia University Division of Diversity, Equity, and Inclusion website by (CTRL + click) here.

Program and Institution Closure/Reduction Policy:

A. If the WVU School of Medicine intends to reduce the size of a program, or to close a residency/fellowship program, the Department Chair or Program Director shall inform the residents/fellows as soon as possible of the reduction or closure. In the event of such reduction or closure, the department will make reasonable efforts to allow the residents already in the program to complete their education or to assist the resident in enrolling in another program in which they can continue their graduate medical education.

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

Resident Forum:

A. For details, please reference the Resident Forum Charter at this link (CTRL + click): Resident Forum Charter

Other Policies:

A. These Bylaws provide authority to the GMEC to establish other policies to govern the activities of graduate medical education sponsored by the WVU School of Medicine to protect the well-being and educational experiences of residents in these programs and to maintain compliance with the ACGME Institutional, Common Program, and Specialty-Specific Program Requirements. Residents have the right to receive and review all policies and procedures of the sponsoring institution in written or electronic format. Many, but not all, policies are located on the WVU GME website, (CTRL + click).

Revisions to the Bylaws:

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