RESIDENT MANUAL

Department of Surgery
West Virginia University
Morgantown, West Virginia

2022-2023, **Updated 4/6/2023**

****THE MANUAL IS GETTING UPDATED****
FOR UPDATED CONTENT (marked with *) REFER TO
Policy Update | School of Medicine | West Virginia University (wvu.edu) or
Goals and Objectives | School of Medicine | West Virginia University (wvu.edu) or
the direct link for FORMS

PROGRAM AIMS 4
ACGME GENERAL COMPETENCIES 4
*ACUTE CARE SURGERY ROTATION CORE OBJECTIVES (PGY 1-5) 6
*COLORECTAL SURGERY GOALS AND OBJECTIVES (PGY1-5) 11
GENERAL SURGERY GOLD ROTATION CORE OBJECTIVES (PGY1-5) 23
*SURGICAL ONCOLOGY GOALS AND OBJECTIVES (PGY1-5) 31
*BREAST SURGERY GOALS AND OBJECTIVES (PGY1-5) 39
*VASCULAR SURGERY GOALS AND OBJECTIVES (PGY 1 - 5) 45
*PLASTIC SURGERY GOALS AND OBJECTIVES (PGY 1, 2) 50
*TRAUMA SERVICE GOALS AND OBJECTIVES (PGY1-5) 55
*PEDIATRIC SURGERY GOALS AND OBJECTIVES (PGY 1-5) 59
NIGHT FLOAT ROTATION CORE OBJECTIVES (PGY 1-5) 64
*TRANSPLANT ROTATION CORE OBJECTIVES (PGY1-5) 66
THORACIC SURGERY CORE GOALS AND OBJECTIVES (PGY1-5) 72
*SICU GOALS AND OBJECTIVES (PGY 1,2,3) 77
*BARIATRIC & MINIMALLY INVASIVE SURG GOALS & OBJECTIVES (PGY 2-5) 79
CARDIAC SURGERY CORE GOALS AND OBJECTIVES (PGY2,3) 84
~~RESIDENT SALARY 2022-2023 ..... 89~~
POLICIES 89
*ACADEMIC DISCIPLINE AND DISMISSAL POLICY 89
*ACADEMIC GREIVANCE POLICY AND PROCEDURE 93
~~ACGME CASE LOG DIRECTIONS~~ 96
*AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY BOG *TALENT AND CULTURE RULE 3.2 96
*APPROPRIATE USE OF THE INTERNET, ELECTRONIC NETWORKING POLICY AND OTHER MEDIA 98
*ATTENDANCE & PUNCTUALITY & LEAVE Policy 100
*BACK-UP CHIEF POLICY 102
*CASE LOG POLICY 103
*CLINICAL COMPETENCY COMMITTEE (CCC) POLICY 103
*CODE OF PROFESSIONALISM 106
*COMMON GME POLICIES LINK 108
*CONFERENCE, ATTENDANCE & CURRICULUM 108
*CLINICAL & EDUCATIONAL WORK HOURS 111
*CRISIS OF SUDDEN DEATH GUIDELINES FOR A RESIDENT/FELLOW 114
*DISABILITIES ACCOMMODATIONS POLICY 119
*DISASTER RESPONSE POLICY -Graduate Medical Education Council (GMEC) 120
*DIVERSITY POLICY 121
*EMPLOYMENT GRIEVANCE PROCEDURE FOR NON-ACADEMIC ISSUES POLICY 124
*EMPLOYMENT & NON-DISCRIMINATION POLICY 124
*EVALUATION POLICY 124
FATIGUE PREVENTION POLICY 126
FIT FOR DUTY POLICY 128
*FLS/FES CERTIFICATE FEES 129
*HARASSMENT POLICY 129
INTERVIEW POLICY 130
LICENSURE REQUIREMENTS - Resident Physician Policy 130
MEETING POLICY 131
MISTREATMENT, PROFESSIONALISM "THE BUTTON" 132
PARENTAL LEAVE (FAMILY MEDICAL LEAVE) 132
MOONLIGHTING POLICY 133

PARKING POLICY 134
*PATIENT SAFETY POLICY EMS EVENT MANAGEMENT SYSTEM 134
PHYSICIAN DEATH CERTIFICATE POLICY 136
PROGRAM EVALUATION COMMITTEE (PEC) 136
ANNUAL PROGRAM EVALUATION (APE) 136
PRACTITIONERS' HEALTH COMMITTEE 138
PROGRAM CLOSURE/REDUCTION POLICY 142
PROMOTION REAPPOINTMENT/POLICY 143
UNIVERSAL QUALITY IMPROVEMENT CURRICULUM 144
QUALITY IMPROVEMENT POLICY - Surgery 146
RECRUITMENT POLICY - CRITERIA FOR APPOINTMENT/ELIGIBILITY AND SELECTION OF CANDIDATES 146
SICK LEAVE 148
SCHOLARLY/RESEARCH POLICY 148
*SUPERVISION POLICY 148
REAPPOINTMENT: RENEWAL & PROMOTION POLICY 152
RESIDENT CONTRACT Review 153
RESIDENT PROFESSIONALISM STANDARD FOR INTERRUPTION OF PATIENT CARE POLICY 154
TRANSITIONS OF CARE & HAND OFF VI.E.3.a) (b)(c)(d)(e) 155
TRAVEL REIMBURSEMENT POLICY 157
*USMLE/LICENSE POLICY 159
*VACATION POLICY- DEPARTMENT OF SURGERY 160
*VACATION POLICY – OFF SERVICE 161
VENDOR REPRESENTATIVES ON RESIDENT INTERACTION-POLICY 161
WELL-BEING ALERTNESS MANAGEMENT/FATIGUE MITIGATION POLICY 163
***MISCELLANOUS FORMS 167

PROGRAM AIMS

Who are our residents/fellows? Our residents are primarily allopathic and osteopathic US graduates. Our residency is committed to preparing residents in 5 clinical years for general surgery. Our patients are primarily citizens of West Virginia and contiguous states.

ACGME GENERAL COMPETENCIES

- **Patient Care**

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

Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.

- **Medical Knowledge**

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care.

- **Practice Based Learning and Improvement**

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning.

Residents are expected to develop skills and habits to be able to meet the following goals:

a. identify strengths, deficiencies, and limits in one's knowledge and expertise;
b. set learning and improvement goals;
c. identify and perform appropriate learning activities;
d. systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;
e. incorporate formative evaluation feedback into daily practice;
f. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;
g. use information technology to optimize learning; and
h. participate in the education of patients, families, students, residents and other health professionals.

- **Interpersonal and Communication Skills**

Residents must demonstrate interpersonal and communication skills that

result in the effective exchange of information and collaboration with patients, their families, and health professionals.

Residents are expected to:

a. communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;
b. communicate effectively with physicians, other health professionals, and health related agencies;
c. work effectively as a member or leader of a health care team or other professional group;
d. act in a consultative role to other physicians and health professionals; and,
e. maintain comprehensive, timely, and legible medical records, if applicable.

- **Professionalism**

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Residents are expected to demonstrate:

a. compassion, integrity, and respect for others;
b. responsiveness to patient needs that supersedes self-interest;
c. respect for patient privacy and autonomy;
d. accountability to patients, society and the profession; and,
e. sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation.

- **Systems Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

Residents are expected to:

a. work effectively in various health care delivery settings and systems relevant to their clinical specialty;
b. coordinate patient care within the health care system relevant to their clinical specialty;
c. incorporate considerations of cost awareness and risk benefit analysis in patient and/or population based care as appropriate;
d. advocate for quality patient care and optimal patient care

systems;

e. work in inter professional teams to enhance patient safety and improve patient care quality; and,

f. participate in identifying system errors and implementing potential systems solutions.

ACUTE CARE SURGERY ROTATION CORE OBJECTIVES

(PGY 1-5)

GOALS

I. Patient Care

A. Preoperative Care Setting: inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with emergency general surgical conditions. The plan shall include any interventions that will successfully prepare a patient for surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 1-5)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 1-5)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization under emergent circumstances (ie presence of shock, underlying cardiopulmonary disease, nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 1-5)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1-5)

B. Operative Care Setting: 5N and 2W

The following is a list of “core” operations that the resident(s) can be expected to have exposure to by the completion of their general surgery rotation:

Exploratory laparotomy (PGY 1-5)
Exploratory laparoscopy (PGY 2-5)
Peritoneal dialysis catheter insertion (PGY 1-5)
Peritoneal lesion biopsy (PGY 2-5)
Inguinal and femoral hernia – open repair (PGY 1-5)
Ventral hernia – laparoscopic repair (PGY 2-5)
Ventral hernia – open repair (PGY 1-5)
Cholecystectomy w/wo cholangiography – laparoscopic (PGY 1-5)
Cholecystectomy w/wo cholangiography – open (PGY 1-5)
Open splenectomy (PGY 2-5)
Gastrostomy open and percutaneous (PGY 1-5)
Adhesiolysis – laparoscopic (PGY 2-5)
Adhesiolysis – open (PGY 1-5)
Feeding jejunostomy – open (PGY 2-5)
Ileostomy creation/closure (PGY 1 5)

Small bowel resection (PGY 1-5)
Appendectomy – laparoscopic and open (PGY 1-5)
Colectomy, partial – open (PGY 2-5)
Colostomy creation/closure (PGY 2-5)
Anorectal abscess drainage, fistulotomy/Seton placement, Sphinterotomy – internal, hemorrhoidectomy/banding, condyloma excision (PGY 1-5)
Colonoscopy, EGD, Proctoscopy (PGY 1-5)
Soft tissue infections – incision, drainage, debridement (PGY 1-5)

The following is a list of the essential uncommon operations that the resident(s) can be expected to have exposure to by the completion of their general surgery rotations:

Intra-abdominal abscess – drainage (PGY 2-5)
Abdominal wall reconstruction – components separation (PGY 3-5)
Duodenal perforation – repair (PGY 2-5) Gastrectomy – Partial/Total (PGY 2-5)
Colectomy subtotal with ileocolostomy or ileostomy (PGY 2-5)

C. Postoperative Care Setting: inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the general surgical patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; the identification and treatment of common post-operative complications including bleeding, infection, ileus, bowel obstruction, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient general surgery patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY 1-5)
B) After rounds, the chief resident (or senior most available resident) is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called. (PGY 4)
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out of the hospital on the day of discharge by noon (PGY 1, 2, 4)
D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important tests to the chief resident who can then relay the information to the attending of record (PGY 1, 2)
E). All available members of the resident team will make rounds with the attending staff (PGY 1, 2, 4)

2. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying
instances in which deviation from the norm is occurring and how such instances are approached/managed (PGY 1, 2, 4)
B) Residents will see general surgery patients who are in longitudinal surveillance following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of general surgical patients even after their operation has been performed (PGY 1, 2, 4)
C) Residents are required to attend at least one half day of outpatient clinic per week (PGY 1, 2, 4)

II. Medical Knowledge

Resident's fund of knowledge as it relates to general surgery will be expanded through a variety of means, some of which are structured and others of which require independent initiative from the resident(s) rotating on the service. These include 1) Conferences 2) Journal club 3) Assigned readings

1) Conferences – Residents assigned to the general surgery service are required to attend the following conferences: Wednesday morning didactic sessions between the hours of 8a-11a, General and Oncology Surgery Case review (2nd/4th Thursday at 4 pm) (PGY 1-5)

2, 3) Journal club/assigned readings – Residents assigned to the general surgery service are required to participate in monthly journal club as outlined on the yearly curriculum as well as to complete the assigned This Week in Score (TWIS) readings/modules (PGY 1-5)

III. **Practice-based Learning**

Residents are expected to critique their performance and their personal practice outcomes as well as identify areas and implement plans for improvement

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1-5)
2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1-5)
3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1-5)
4. Residents shall review their specific Quality in Training Initiative (QITI) data quarterly (PGY 1-5)

5. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1-5)

IV. **Interpersonal and Communication Skills (All points below apply to PGY 1-5)**

A. Residents shall learn to work effectively as part of the general surgical team.

B. Residents shall foster an atmosphere that promotes the effectiveness of each member of the general surgical team

C. Residents shall interact with colleagues and members of the ancillary services in a professional and respectful manner.

D. Residents shall learn to document their practice activities in such a manner that is clear and concise

E. Residents shall participate in the informed consent process for patients being scheduled
for emergent/urgent procedures or surgery

F. Residents shall gain an experience in educating and counseling patients about risks and expected outcomes of emergent/urgent procedures or surgeries

G. Residents shall learn to give and receive a detailed sign-out for each service

V. **Professionalism**

A. Residents shall maintain high ethical standards in dealing with patients, family members, patient data, and other members of the healthcare team

B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the duty-hour restrictions

C. Residents shall demonstrate sensitivity to age, gender, and culture of patients and other members of the healthcare team

VI. **Systems-based practice**

A. Residents shall learn to practice high quality, cost effective, patient care. This knowledge should be gained through discussions of patient care.

1. Conferences

a. M&M

b. Tumor Board

2. Other

a. General Surgery Rounds

b. Outpatient clinic

Faculty Daily Schedules

	Cassim	**Groves**	**Murken**	**Train**
Monday	x	AD Clinic	AM Endo (1st/3rd) PM OR add on	
Tuesday	x	AM Endo (2nd/4th) PM OR add on	AD Clinic	
Wednesday	Main OR	Main OR	OR assist	
Thursday	AM Clinic	OR add on	OR add on	
Friday	x	OR assist 2W OR (4th)	Main OR	

Onboarding:
We ask that all PGY residents meet independently with at least Dr. Murken, and preferably all faculty, either in the week before or at some time during the first two days on service to go over learning objectives, expectations, and work flow.

Conferences:
1st Tuesday of the month (subject to change) 12-1pm Interdisciplinary IBD conference 5-HSC
Weekly Multidisciplinary tumor board 12-1pm Ground Cancer Center (or WebEx)

Resident coverage:
We ask that the chief resident send out a weekly schedule each week by the preceding Friday. This can be created with assistance from Dr. Murken, although the above grid should help to create a template.

COLORECTAL SURGERY GOALS AND OBJECTIVES (PGY1, 2/3/4, 5)

GOALS

Through rotation on the surgical oncology service, residents shall attain the following goals:

I. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with a variety of benign and malignant colon, rectal, and anorectal conditions. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (All PGY)

i) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (All PGY). There will be an emphasis on understanding the indications for colonoscopy,

interpreting the important details/findings in a report (location, tattoo, endoscopic “resectability”) and translating the endoscopic findings into an operative plan.

ii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 3-5)

- Specifically, the resident should learn to anticipate the “likelihood” that a patient will require a stoma based on patient risk factors for anastomotic complication or anatomic considerations

iii) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1, 3, 4, 5)

B. Operative Care Setting: 5N and 2W

The following are a list of essential common operations that the resident(s) can be expected to have exposure to by the completion of their colorectal surgery (CRS) rotation:

Open, laparoscopic, and robotic right colectomy and sigmoid colectomy (PGY 2 and above)
Open and laparoscopic small bowel resection (All PGY)
Ileostomy creation/closure (All PGY)
Colostomy creation/closure (PGY 3-5)
Rectopexy (PGY 2 and above)
Altmeier procedure (PGY2 and above)
Complex wound closure (All PGY)

Seton placement (All PGY)
Lateral internal sphincterotomy (All PGY)
Anorectal abscess drainage (All PGY)
Hemorrhoidectomy (All PGY)

Proctoscopy (All PGY)
Anoscopy (All PGY)
Flexibile sigmoidoscopy and diagnostic colonoscopy (All PGY)

The following are a list of the complex operations that the resident(s) can be expected to have exposure to by the completion of their CRS rotation:

Strictureoplasty for Crohn’s disease (PGY 4, 5)
Open, laparoscopic, and robotic abdominoperineal resection (APR) (PGY 3, 4, 5)
Open, laparoscopic, and robotic low anterior resection (LAR) (PGY 3, 4, 5)
Open, laparoscopic, and robotic ileal pouch anal anastomosis (IPAA, J-pouch) (PGY 4 and 5

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative colorectal surgery patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; interfacing with stoma nurses (CWOCNs) and other consultants (GI); the identification and treatment of common post-operative complications including bleeding, infection, ileus, bowel obstruction, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a colorectal surgery (CRS) patient who has undergone an elective, same day procedure (All PGY)
B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a CRS patient's pain who has undergone an elective, same day procedure (All PGY). Please note the current emphasis on tailoring narcotic equivalent to procedure.
C) The resident will successfully complete and review with the CRS patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list (All PGY)
D) The resident will successfully coordinate appropriate surgical follow up (All PGY)

2. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient CRS patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (All PGY)
B) **After rounds, the chief resident and mid-level resident are expected to call the attending physicians of record to review the plan of the day for each individual patient <u>before 9am</u>. This work can be divided between the senior residents.** Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called. **The resident can update faculty in person that they are going to see either in clinic or the OR. Routine updates can be provided by text message but any patient with ongoing acuity should be reviewed via telephone call or in person (PGY 2 and above).**
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (All PGY).
D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important

tests to the chief resident who can then relay the information to the attending of record (PGY 1). When clinical obligations warrant the intern and junior resident should feel welcome to contact the involved attending directly in order to expedite patient care.

3. Out-patient clinic

A) **Each resident on service will be expected to attend clinic for one day per week (on average) of the course of the rotation. Learning and exposure to imaging/procedures will be emphasized as will be seeing post-operative patients that the resident operated on. An expectation would be for the resident to see no more than 5 patients per day to maximize educational yield. Unlike some other services CRS clinic includes important ambulatory procedures which should be learned by the resident (All PGY).**

II. Medical Knowledge

Resident fund of knowledge as it relates to colorectal surgery will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned or recommended readings 4) TWIS quizzes.

1. Conferences

   A) Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the CRS service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post- operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable. Presentations should be reviewed in advance with the responsible faculty (All PGY).
   B) Residents are expected to attend weekly multidisciplinary GI oncology (Thursdays at noon) tumor board. These tumor boards serve as a fertile environment for residents to i) gain an appreciation of the multidisciplinary approach that is unique to the care of cancer patients and ii) gain an understanding of staging (both clinical and pathologic), prognosis and practice guidelines as they relate to neoadjuvant, surgical and adjuvant treatment strategies for cancer patients (All PGY who are available). There is also an interdisciplinary IBD conference held once a month which should be attended as able.

2. Journal Club: Residents are expected to lead discussion at monthly combined surgical oncology and colorectal surgery journal club (likely Monday evenings). A yearly curriculum of high yield topics will be formulated by the surgical oncology faculty (Dr. Kledzik). Articles will be assigned to the resident team at least one week in advance and each resident will have article on which to lead discussion. Faculty will be present to facilitate discussion (All PGY).

3. Assigned Readings: Residents will cover various CRS topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. CRS faculty will all participate in leading didactic discussion(s) especially in clinic. Additionally, residents are encouraged to educate themselves upon the scientific information relating to CRS.

   A) **The recommended text is The ASCRS Textbook of Colon and Rectal Surgery, Third Edition, which is available in electronic format from Dr. Murken on request.**

4. TWIS Quizzes: Residents are expected to complete TWIS quizzes that are outlined in the program curriculum. Areas of deficiency as defined by their performance on the TWIS quizzes should serve as the focus for future study plans.

III. **Practice-based Learning**

Residents are expected to engage in critical self -review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (All PGY).

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (All PGY).

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (All PGY).

4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (All PGY).

IV. **Interpersonal and Communication Skills**

The CRS service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A) Residents will be given the opportunity to observe (PGY 1) and eventually participate in (PGY 4, 5) the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis (among others).

B) Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, and other physicians serving as consultants (All PGY).

C) Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medicolegal documentation (All PGY).

D) Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (All PGY). A resident should never feel solely responsible for obtaining consent especially not for a procedure with which they are not familiar. It is encouraged that the resident review any questions or concerns with the faculty with respect to consent for surgery.

E) Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (All PGY). A comprehensive email signout should be sent to all residents and staff for weekend coverage when the service is being transitioned to a new resident. This is NOT required when continuity is in place. Faculty will separately sign out their patients to the on call attending in person, by telephone, or by email.

V. **Professionalism**

The CRS rotation offers many opportunities for residents to hone their skills as the relate to professionalism.

A) Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications (All PGY). In these scenerios it is advised to review the details of the patients care with the staff before addressing the patient so that inconsistency is limited.

B) Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (All PGY).

C) Residents shall learn to maintain patient confidentiality (All PGY).

D) Residents will learn the importance of accurate medical documentation (All PGY).

E) Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and (All PGY).

F) Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (All PGY).

VI. **Systems-based practice**

The CRS rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A) Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, Tumor Boards and journal clubs (see discussion about each of these above) (All PGY).

B) Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of CRS patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients, and other ERAS parameters (All PGY).

C) Residents will be exposed to protocol driven practices as they related to routine post-operative care with ERAS protocols in mind, central line insertion in ICU patients, selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections and C. diff (among others) (All PGY).

D) Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (All PGY).

Other Thoughts Re: The Colorectal Surgery Rotation

The faculty are committed to your education and graduated autonomy. This means taking the time to review imaging, patient plans, literature, surgical plans, and graduated autonomy in the OR with appropriate supervision. We will also give you timely verbal and written feedback, especially when asked.

We ask that you take ownership of our patients and their health. **We also ask that you round with the attending you are working with that day between cases or during clinic breaks. This is a very valuable educational opportunity which has not been fully taken advantage of to date.** The more active and enthusiastic you are to care for our patients, the more we enjoy teaching and giving you autonomy

Case preparation:

We expect you to have reviewed your OR cases in advance. Whenever possible the resident should communicate in advance with the staff that he/she will be working with regarding the OR cases. If this can be done in person the day prior that is best as it enables joint imaging/data review. Reviewing the operative approach/plan and anticipated challenges in advance will allow the resident to maximize education yield and increase autonomy. At the end of this document is a pre-operative worksheet which provides a useful template for case preparation.

Consults

We appreciate your thorough history and physical exams but also want you to start to develop and communicate your own plans.

Things we expect in your consult discussion:

1) Lead in with reason for consult and a statement on acuity; does the patient need surgery-urgently or non-urgently?

2) Colorectal history including past surgeries (when, where, by who, what), colonoscopy history, radiation/chemotherapy (including type and last dose), bowel function (incontinence)

3) Pertinent medical history with emphasis on cardiopulmonary disease and medications

including blood thinners and biologics
4) Current vitals, labs, abdominal exam

Who to consult? **First, make sure that the consult is most appropriate for CRS. There was a triage list (see below) agreed upon by faculty which should help to direct consults based on diagnosis. Consults coming from other services in our own department should include direct attending to attending communication in order to best facilitate patient care. If the patient is known to a CRS attending and it is during working hours 8a-4p, please call that attending. Otherwise please contact the attending on call.**

Diagnosis	ACS	CRS	SO/HPB	Medicine
Anastomotic complication from outside surgeon	XX			
Appendicitis	XX			
Bile duct injury			XX	
C. diff colitis with perforation or toxic colon	XX			
Cecal volvulus	XX	XX		
Cholecystitis, acute	XX			
Cholecystitis, acute with cirrhosis			XX	
Cholecystitis, acute with liver abscess	XX		XX	
Crohn's complications		consult		XX
Dehisence or wound complication from outside surgeon	XX			
Diverticulitis with abscess	XX			
Diverticulitis with perforation	XX			
Diverticulitis, uncomplicated				XX
Fecal diversion for decubitus ulcer, perineal wound, paraplegia	XX			
Fecal impaction	XX			
Fistula-in-ano		XX		
Gastric outlet obstruction, malignant			XX	
Gastric outlet obstruction, ulcer disease			XX	
Hidradenitis with acute abscess	XX			
Incarcerated hernia (incisional, inguinal, femoral, parastomal)	XX			
J pouch patients - bowel obstruction or pouchitis		XX		
Jaundice and cholangitis, benign or malignant			XX	
Large bowel obstruction, benign or unknown cause	XX			
Large bowel obstruction, malignant		XX		
Liver abscess			consult	XX
Lower GI bleeding	consult			XX
Neutropenic colitis		consult		XX
Neutropenic enteritis			consult	XX
Pancreatitis with necroma			consult	XX
Pancreatitis, abdominal compartment syndrome	XX			
Pancreatitis, gallstone	consult			XX
Pancreatitis, uncomplicated				XX
Parastomal hernia, reducible, non-acute		XX		
Perforated gastric or duodenal ulcer, history of Whipple			XX	
Perianal abscess, IBD patient		XX		
Perianal abscess, no IBD	XX			
Perineal necrotizing fasciitis	XX			

Pilonidal abscess	XX			
Rectal foreign body	XX			
Rectal prolapse not reducible		XX		
Sigmoid volvulus	XX	XX		
Small bowel obstruction, malignant or mass			XX	
Toxic colitis due to IBD		XX		
Ulcerative colitis complications		consult		XX
Upper GI bleeding	consult			XX
Perforated ulcers, gastric or duodenal	XX			
Pancreatitis, pseudocyst			consult	XX
Hemorrhoids, acute thrombosis or bleeding		XX		

Notes:

All postop patients within 1 year to primary surgeon first

Prefer personal attending to attending conversation if assigning care not consistent with this guideline

Murken Pathways

Maintenance fluids: ERAS (routine elective cases) patients should be on 50cc per hour mIVF with a goal of turning it off once the patient is tolerating CLD as early as the afternoon of POD1. If there are issues with low UOP or Cr rises then resuscitate as indicated preferably with directed boluses.

Diets: I usually go from CLD to Reg (or diabetic, renal, cardiac as indicated but I do not generally use FLD, soft, or low residue).

Bowel regimens: I do not use stimulant laxatives like senna nor suppositories in patients with anastomoses. There is little data supporting Colace, but I think that it is benign. I usually do not use an empiric regimen but add miralax on if I think that a patient is truly constipated but only once they have passed gas. Patients with chronic constipation benefit from resuming their home regimen when safe.

Multimodal pain control: out of the OR I prefer IV Tylenol, Neurontin if no NGT, IV narcotic (we used 0.4q2 Dilaudid POD0 and a patient had to “fail” this to get approved for a PCA by pharmacy…that was due to PCA shortage issues. I am fine with a PCA on POD0 as long as it is a low dose (dilaudid 0.2-0.4 q15m). PCA may be needed for patients on preop narcotics. *I add on Toradol 15q8 POD1 if labs (Hgb, Cr, PLT) OK and use it for up to 4 days.* Convert to PO 5/10mg Oxy q4h and PO Tylenol once tolerating PO. I am favoring Exparel TAP blocks over catheters.

CRPs: I trend CRPs with daily morning labs in patients with ileocolic, colocolonic, colorectal anastomoses without proximal diversion. There are various endpoints in the literature but I focus on POD3/4 and prefer a value < 150 mg/L…if it is above this I avoid discharge, keep trending CRP, and consider early postop CT.

Stoma rods: I use them if the loop stoma is under tension, so colostomy > ileostomy, and usually aim for removal on POD4 unless patient is going home earlier then out before discharge

Ambulation: Encouraged POD0 evening, mandatory 3 times per day by POD1; consult PT/OT for anyone not walking with minimal assistance by POD1 and for most patients > 65 years old

DVT ppx: I prefer SQH for 12-24 hours given the shorter half life with transition to Lovenox on POD1 if morning Hgb is stable.

Extended DVT ppx: While many use this strategy for 28 days in patients with IBD or cancer who undergo major abdominal surgery I have not found it to be too feasible/worthwhile in our population due to out of pocket expense.

Morning labs: Hgb drops > 2g after laparoscopic colectomy are concerning. It is my practice if this happens to hold SQH/lovenox, hold Toradol, recheck the Hgb that morning. If there is hypotension make sure to turn any anesthesia blocks off so as to not confound the clinical picture.

High output ileostomy: the goal output is < 1200cc daily. If output remains above this for a few days with a patient on a regular fiber containing diet then I start Imodium 2mg BID and titrate as needed.

Loop Ileostomy Closure

POD0: CLD
POD1: Remove foley, add Toradol if labs OK, ADAT if progressing
POD2: Remove betadine packing in wound and do not re-pack only dress with guaze and tape; earliest discharge date if doing well (flatus required for discharge)

Right Colectomy

POD0: CLD
POD1: Remove foley (assuming Cr OK), add Toradol if labs OK, CLD in AM & can get to Reg in PM if doing well
POD2: ADAT; earliest discharge date (flatus required for discharge)

Left/Sigmoid Colectomy

POD0: Sips/chips
POD1: Remove foley (unless had stents and still with hematuria or Cr elevated), add Toradol if labs OK, CLD for the day
POD2: ADAT if doing well and having bowel function
POD3: Usually the earliest discharge except for those who do exceptionally well (BM required for discharge)

LAR/IPAA/APR

POD0: Sips/chips
POD1: Add Toradol if labs OK, CLD for the day
POD2/3: Remove foley, ADAT if bowel/stoma function
POD3: ADAT, CWOCN
POD4: Usually the earliest discharge except for those who do exceptionally well and have ileostomy output < 1200cc if applicable
Drains out before discharge for LARs and IPAAs but drain usually stays until POD10 (outpatient visit) for APR

No sitting x2 weeks for APR

Groves Pathways

Cassim Pathways

Train Pathways

Pre-operative Work-sheet: The resident should review the patient's EMR prior to surgery such that the following information is understood.

Name:		**OR Date:**
Planned Procedure	Combined Case: Cysto/Stents: Flex sig:	
Indication		
Prior Therapy/XRT		
Pre-op CT	Date/Study type: Ab wall/incision: Flexure: Pedicle/Vascular: Incidental:	
Rectal Cancer MRI	Date/Study type: Rectal cancer: *Pre-treatment*:	

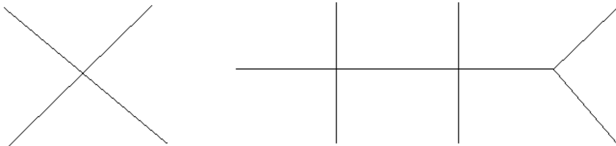
PMH

PSH

Consultant recs &
Clearance data
CWOCN

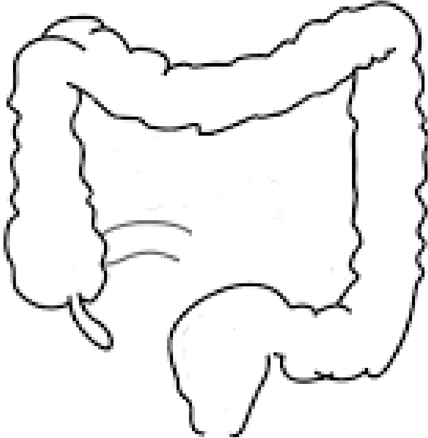
Medications

Pre-op Labs



Albumin:
Prealbumin:
CEA:
T&S:
AB:

Pre-op Scope



Pathology

PENDING:

PLANNED APPROACH:

GENERAL SURGERY GOLD ROTATION CORE OBJECTIVES
(PGY1, 4, 5)

GOALS

I. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with general surgical conditions. The plan shall include any interventions that will successfully prepare a patient for surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 1, 4, 5)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 1, 4, 5)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 1, 4, 5)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1, 4, 5)

B. Operative Care Setting: 5N and 2W

The following is a list of "core" operations that the resident(s) can be expected to have exposure to by the completion of their general surgery rotation:

Exploratory laparotomy (PGY 1, 4, 5)
Exploratory laparoscopy (PGY 1, 4, 5)
Peritoneal dialysis catheter insertion (PGY 1, 4, 5)
Peritoneal lesion biopsy (PGY 1, 4, 5)
Inguinal and femoral hernia – laparoscopic repair (PGY 1, 4, 5)
Inguinal and femoral hernia – open repair (PGY PGY 1, 4, 5)
Ventral hernia – laparoscopic repair (PGY 1, 4, 5)

Ventral hernia – open repair (PGY 1, 4, 5)
Cholecystectomy w/wo cholangiography – laparoscopic (PGY 1, 4, 5)
Cholecystectomy w/wo cholangiography – open (PGY 1, 4, 5)
Open splenectomy (PGY 4, 5)
Gastrostomy open and percutaneous (PGY 1, 4, 5)
Adhesiolysis – laparoscopic (PGY 4, 5)
Adhesiolysis – open (PGY 1, 4, 5)
Feeding jejunostomy – open (PGY 4,
5) Ileostomy creation/closure (PGY 1,
4, 5)

Small bowel resection (PGY 1, 4, 5)
Appendectomy – laparoscopic and open (PGY 1, 4, 5)
Colectomy, partial – open (PGY 4, 5)
Colostomy creation/closure (PGY 4, 5)
Anorectal abscess drainage, fistulotomy/Seton placement, Sphinterotomy – internal, hemorrhoidectomy/banding, condyloma excision (PGY 1, 4, 5)
Colonoscopy, EGD, Proctoscopy (PGY 1, 4, 5)
Soft tissue infections – incision, drainage, debridement (PGY 1, 4, 5)

The following is a list of the essential uncommon operations that the resident(s) can be expected to have exposure to by the completion of their general surgery rotations:

Abdominal wall reconstruction – components separation (PGY 4, 5)
Gastrectomy – Partial/Total (PGY 4, 5)
Colectomy subtotal with ileocolostomy or ileostomy (PGY 4, 5)
Open and laparoscopic adrenalecomy (PGY 4, 5)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the general surgical patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; the identification and treatment of common post-operative complications including bleeding, infection, ileus, bowel obstruction, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a general surgery patient who has undergone an elective, same day procedure (PGY 1, 4, 5)
B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a general surgery patient's pain who has undergone an elective, same day procedure (PGY 1, 4, 5)
C) The resident will successfully complete and review with the general surgery patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list (PGY 1, 4, 5)
D) The resident will successfully coordinate appropriate surgical follow up (PGY 1, 4, 5)

2. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient general surgery patient list (including the consult service)

prior to the start of the day's activities (OR cases, clinic) (PGY 1, 4, 5)

B) After rounds, the chief resident (or senior most available resident) is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called. (PGY 4, 5)
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out of the hospital on the day of discharge by noon (PGY 1, 4, 5)
D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important tests to the chief resident who can then relay the information to the attending of record (PGY 1)
E). All available members of the resident team will make rounds with the attending staff (PGY 1, 4, 5)

3. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying
instances in which deviation from the norm is occurring and how such instances are approached/managed (PGY 1, 4, 5)
B) Residents will see general surgery patients who are in longitudinal surveillance following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of general surgical patients even after their operation has been performed (PGY 1, 4, 5)
C) Residents are required to attend at least one half day of outpatient clinic per week (PGY 1, 4, 5)

VII. **Medical Knowledge**

Resident's fund of knowledge as it relates to general surgery will be expanded through a variety of means, some of which are structured and others of which require independent initiative from the resident(s) rotating on the service. These include 1) Conferences 2) Journal club 3) Assigned readings 4) True learn quizzes

1) Conferences – Residents assigned to the general surgery service are required to attend the following conferences: Wednesday morning didactic sessions between the hours of 8a-11a, General and Oncology Surgery Case review (2nd/4th Thursday at 4 pm) (PGY 1, 4, 5)

2, 3) Journal club/assigned readings – Residents assigned to the general surgery service are required to participate in monthly journal club as outlined on the

yearly curriculum

as well as to complete the assigned This Week in Score (TWIS) readings/modules (PGY 1, 4, 5)

VIII. Practice-based Learning

Residents are expected to critique their performance and their personal practice outcomes as well as identify areas and implement plans for improvement

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1, 4, 5)

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1, 4, 5)

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1, 4, 5)

4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1, 4, 5)

IX. Interpersonal and Communication Skills (All points below apply to PGY 1, 4, 5)

H. Residents shall learn to work effectively as part of the general surgical team.

I. Residents shall foster an atmosphere that promotes the effectiveness of each member of the general surgical team

J. Residents shall interact with colleagues and members of the ancillary services in a professional and respectful manner.

K. Residents shall learn to document their practice activities in such a manner that is clear and concise

L. Residents shall participate in the informed consent process for patients being scheduled

for elective and emergent/urgent procedures or surgery

M. Residents shall gain an experience in educating and counseling patients about risks and expected outcomes of elective or emergent/urgent procedures or surgeries

N. Residents shall learn to give and receive a detailed sign-out for each service

X. **Professionalism**

D. Residents shall maintain high ethical standards in dealing with patients, family members, patient data, and other members of the healthcare team

E. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the duty-hour restrictions

F. Residents shall demonstrate sensitivity to age, gender, and culture of patients and other members of the healthcare team

XI. **Systems-based practice**

B. Residents shall learn to practice high quality, cost effective, patient care. This knowledge should be gained through discussions of patient care.

1. Conferences

    a. M&M

    b. General and Oncology Surgery Conference

2. Other

    a. General Surgery Rounds

    b. Outpatient clinic

SURGICAL ONCOLOGY GOALS AND OBJECTIVES (PGY1-5)

GOALS

Through rotation on the surgical oncology service, residents shall attain the following goals:

III. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with surgical oncologic conditions. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 1-5)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 1-5)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 2-5)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1-5)

B. Operative Care Setting: 5N and 2W

Prior to arriving in the operating room, the resident should have reviewed the case. This includes reviewing PMH, PMS, allergies, imaging, pathology/staging, neoadjuvant treatments AND discussing the operative approach with the attending The following are a list of essential common operations that the resident(s)
can be expected to have exposure to by the completion of their surgical oncology rotation:

Mastectomy partial (with or without needle localization) (PGY 1-5) Sentinel lymph node biopsy (PGY 1, 2, 3, 4, 5)
Modified radical mastectomy (PGY 5)

Axillary dissection (PGY 4, 5)
Simple mastectomy (PGY 1-5)
Duct excision (PGY 1-5)
Excisional and incisional biopsy of skin and soft tissue lesions (PGY 1-5)
Incision, drainage and debridement of skin and soft tissue infections (PGY 1-5)
Wide local excision (PGY 1-5)
Laparoscopic and open cholecystectomy with and without cholangiography (PGY 1-5) Robotic cholecystectomy PGY 2-5

Open and laparoscopic right colectomy and sigmoid colectomy (PGY3-5)
Open and laparoscopic splenectomy (PGY 3-5)
Tunneled and non-tunneled central venous catheter insertion (including US use for access) (PGY 1-5)
Laparoscopic/robotic, open and percutaneous gastrostomy tube insertion (PGY 1-5)
Laparoscopic/robotic, open jejunostomy feeding tube insertion (PGY 1-5)
Small bowel resection (PGY 1-5)
Ileostomy creation/closure (PGY 1-5)
Colostomy creation/closure (PGY 3-5)
Open and laparoscopic liver biopsy (PGY 3-5)
Gallbladder cancer incidentally noted operation (PGY 3-5)
Hepaticojejunostomy (biliary enteric anastomosis) (PGY 4, 5)
Distal pancreatectomy (PGY 3-5)
Pancreatic debridement (PGY 3-5)
Pancreatic pseudocyst drainage (PGY 1-5)
Complex wound closure (PGY 1-5)
Duodenal perforation closure (PGY 3-5)
Gastrectomy - partial/total (PGY 3-5)
Thyroidectomy – partial/total (PGY 1-5)

The following are a list of the complex operations that the resident(s) can be expected to have exposure to by the completion of their surgical oncology rotation:

Retroperitoneal lymph node dissection – open (PGY 3-5)
Bile duct cancer/neoplasm operations (PGY 4, 5)
Bile duct injury repair (PGY 4, 5)
Planned gallbladder cancer operation (PGY 4, 5)
Intraoperative liver ultrasound (PGY 3-5)
Open and laparoscopic liver resection (anatomic and non-anatomic resection(s)) (PGY 3-5)
Intraoperative pancreatic ultrasound (PGY 3-5)
Open and robotic pancreaticoduodenectomy (PGY 4, 5)
Longitudinal pancreaticojejunostomy (Puestow procedure) (PGY 4, 5)
Postgastrectomy revisional procedures (PGY 4, 5)
Abdominoperineal resection (APR) (PGY 4, 5)
Open, laparoscopic and robotic adrenalecomy (PGY 4, 5)
Retroperitoneal sarcoma excision (including multivisceral resection(s) (PGY 4, 5)
Ileoinguinal and femoral lymphadenectomy (PGY 3-5)
Cervical lymphadenectomy (PGY 3-5)
Image guided breast biopsy (PGY 4, 5)
Hepatic Injury resection (PGY 4, 5)
Robotic hepatobiliary intervention (4, 5)
Cytoreduction and heated intraperitoneal chemotherapy (PGY 3-5)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative surgical oncology patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; the identification and treatment of common post-operative complications including bleeding, infection, ileus, bowel obstruction (malignant and benign), thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

4. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a surgical oncology patient who has undergone an elective, same day procedure (PGY 1-5)
B) The resident will successfully choose a multimodal oral analgesic home regimen that will adequately manage a surgical oncology patient's pain who has undergone an elective, same day procedure (PGY 1-5)
C) The resident will successfully complete and review with the surgical oncology patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions, bathing instructions, and reconciliation of the patient's medication list (PGY 1-5)
D) The resident will successfully coordinate appropriate surgical follow up (PGY 1-5)

5. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient surgical oncology patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY 1-5)
B) After rounds, the chief resident on service is expected to delegate attending updates prior to 8 AM on all patients, including consults. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called. CHIEF RESIDENT IS TO CALL THE ATTENDING FOR ANY SICK/CONCERNING PATIENTS (PGY 4, 5)
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY 1-5)

D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important tests to the chief resident who can then relay the information to the attending of record. During work hours, this is the most relevant and available specialist. At night/weekends this should be directed to the on call attending. (PGY 1-3)
E) Friday afternoons the chief on services should email out a summary of surgeries, complications, and plans to the team. The faculty will provide any updates/clarifications, but the expectations is that the chief knowns the patients well enough that this should not be necessary.

6. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying instances in which deviation from the norm is occurring as how such instances are approached/managed (PGY 1-5)
B) Residents will see surgical oncology patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of cancer patients even after their operation is performed (PGY 1-5)
C) All residents are expected to be in clinic if they are not in the operating room unless there is an emergency that cannot be handled by our advanced practice providers. (PGY 1-5)

IV. Medical Knowledge

Resident fund of knowledge as it relates to surgical oncology will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings 4) TWIS quizzes

5. Conferences

A) Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the surgical oncology service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post-operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable (PGY 1-5)
B) Residents are expected to attend multidisciplinary conferences including skin, sarcoma, GI, HPB, and breast. These tumor

boards serve as a fertile environment for residents to i) gain an appreciation of the multidisciplinary approach that is unique to the care of cancer patients and ii) gain an understanding of staging (both clinical and pathologic), prognosis and practice guidelines as they relate to neoadjuvant, surgical and adjuvant treatment strategies for cancer patients (PGY 1-5)

6. Journal Club: Residents are expected to lead discussion at monthly surgical oncology journal club (Last Monday of every Month at 5 pm). A yearly curriculum of high yield topics will be formulated by the surgical oncology faculty. The chief resident on service is expected to meet with the faculty advisor for that month and find 2-3 articles. This should be sent out by the Friday morning prior to journal club. A resident should be assigned to each of them. Faculty will be present to facilitate discussion. JAMA User's Guide may help to interpret the article. This is available through the WVU library. (PGY1-5)

7. Assigned Readings: Residents will cover various surgical oncology topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Surgical oncology faculty all participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when oncology topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to surgical oncology. The recommended text is Cameron's Current Surgical Therapy.

8. TWIS Quizzes: Residents are expected to complete TWIS quizzes that are outlined in the program curriculum. Areas of deficiency as defined by their performance on the TWIS quizzes should serve as the focus for future study plans.

VII. **Practice-based Learning**

Residents are expected to engage in critical self -review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1-5)

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1-5)

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1-5)

4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1-5)

VIII. Interpersonal and Communication Skills

The surgical oncology service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

F) Residents will be given the opportunity to observe (PGY 1) and eventually participate in (PGY 4, 5) the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis (among others)
G) Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, and other physicians serving as consultants (PGY 1-5)
H) Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medicolegal documentation (PGY 1-5)
I) Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (PGY 1-5)
J) Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY 1-5)

IX. Professionalism

The surgical oncology rotation offers many opportunities for residents to hone their skills as the relate to professionalism.

G) Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications (PGY 1-5)
H) Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY 1-5)
I) Residents shall learn to maintain patient confidentiality (PGY1-5)
J) Residents will learn the importance of accurate medical documentation (PGY1-5)
K) Residents will be expected to adhere to the hospital’s code of professional conduct as it relates to appearance and dress (PGY 1-5)

L) Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY 1-5)

X. **Systems-based practice**

The surgical oncology rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

D) Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, Tumor Boards and journal clubs (see discussion about each of these above) (PGY 1-5)

E) Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of surgical oncology patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients (PGY 1-5)

F) Residents will be exposed to protocol driven practices as they related to central line insertion in ICU patients, selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY 1-5)

D) Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY 1-5)

July

2021

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1	2	3
4	5	6	7	8	9	10

Holiday	Breast tumor board @12 Skin tumor board at 4 pm		Sarcoma tumor board @ 730 Benign HPB @ 12	GI tumor board @ noon SO conference @ 1		
11	12 Breast tumor board @12	13	14 Benign HPB @ 12	15 GI tumor board @ noon SO conference @ 1	16	17
18	19 Breast tumor board @12 Skin tumor board at 4 pm	20	21 Sarcoma tumor board @ 730 Benign HPB @ 12	22 GI tumor board @ noon SO conference @ 1	23	24
25	26 Breast tumor board @12 Journal Club @5 pm	27	28 Benign HPB @ 12	29 GI tumor board @ noon SO conference @ 1	30	31

July- Pancreas- Boone
Aug- Melanoma- Kledzik
Sept- Colon Cancer- Train
Oct- Breast cancer -Cowher/Lupinacci
Nov- Endocrine (thyroid/parathyroid/adrenal)- Thomay
Dec- holidays
Jan- Rectal cancer- Groves
Feb- Benign Breast-Cowher/Lupinacci
March- Liver- Schmidt
April- IBD- Murken
May - Sarcoma - Kledzik
June- Gastric- Thomay

BREAST SURGERY GOALS AND OBJECTIVES (PGY1-3)

GOALS

Through rotation on the breast surgery service, residents shall attain the following goals:

I. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with benign and malignant conditions of the breast. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY1-3)

ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY1-3)

iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY1-3)

iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY1-3)

B. Operative Care Setting: 5N and 2W

The following are a list of essential common operations that the resident(s) can be expected to have exposure to by the completion of their breast surgery rotation:

Mastectomy partial (with or without needle localization) (PGY1-3)
Sentinel lymph node biopsy (PGY1-3)
Modified radical mastectomy (PGY1-3)
Axillary dissection (PGY1-3)
Simple mastectomy (PGY1-3)
Duct excision (PGY1-3)
Excisional and incisional biopsy of skin/soft tissue lesions (PGY1-3)
Incision, drainage and debridement of skin and soft tissue infections (PGY1-3)

The following are a list of the complex operations that the resident(s) can be expected to have exposure to by the completion of their surgical oncology rotation:

Image guided breast biopsy (PGY 2, 3)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative breast surgery patient. This plan generally focuses on, but is not limited to: pain control; identification and treatment of common post-operative

complications including bleeding, infection, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center

   A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a breast surgery patient who has undergone an elective, same day procedure (PGY1-3)
   B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a breast surgery patient's pain who has undergone an elective, same day procedure (PGY1-3)
   C) The resident will successfully complete and review with the breast surgery patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list (PGY1-3)
   D) The resident will successfully coordinate appropriate surgical follow up (PGY1-3)

2. Inpatient floor

   A) The resident team is expected to make morning rounds on the inpatient breast surgery patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY1-3)
   B) After rounds, resident is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called (PGY1-3)
   C) The resident will perform the day's work in a manner that is as efficient as possible. This may include delegating responsibility to APPs when appropriate. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY1-3)

3. Out-patient clinic

   A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying

instances in which deviation from the norm is occurring as how such instances are approached/managed (PGY1-3)

B) Residents will see breast cancer patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of cancer patients even after their operation is performed (PGY1-3)

II. Medical Knowledge

Resident fund of knowledge as it relates to breast surgery will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings

A. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the breast surgery service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post-operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable (PGY1-3)

B. Residents are expected to attend weekly multidisciplinary breast (Mondays at noon) tumor board. This tumor board serves as a fertile environment for residents to i) gain an appreciation of the multidisciplinary approach that is unique to the care of cancer patients and ii) gain an understanding of staging (both clinical and pathologic), prognosis and practice guidelines as they relate to neoadjuvant, surgical and adjuvant treatment strategies for breast cancer patients (PGY1-3)

C. Journal Club: Residents are expected to participate in monthly journal clubs as part of the Wednesday morning didactic curriculum (PGY1-3)

D. Assigned Readings: Residents will cover various breast topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Breast surgery faculty will participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when breast surgery topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to breast surgery. The recommended text is Cameron’s Current Surgical Therapy. (PGY1-3)

E. TWIS Quizzes: Residents are expected to complete TWIS quizzes that are outlined in the program curriculum. Areas of deficiency as defined

by their performance on the TWIS quizzes should serve as the focus for future study plans. (PGY1-3)

III. **Practice-based Learning**

Residents are expected to engage in critical self- review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

A) Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, Tumor Boards and journal clubs (see discussion about each of these above) (PGY1-3)
B) Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of surgical oncology patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients (PGY1-3)
C) Residents will be exposed to protocol driven practices as they related to central line insertion in ICU patients, selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY1-3)
D) Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY1-3)

IV. **Interpersonal and Communication Skills**

The breast surgery service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A. Residents will be given the opportunity to observe and eventually participate in the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis (PGY1-3).
B. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, and other physicians serving as consultants (PGY1-3)
C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation (PGY1-3)

D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (PGY1-3)
E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY1-3)

V. **Professionalism**

The breast surgery rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

A. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications (PGY1-3)
B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY1-3)
C. Residents shall learn to maintain patient confidentiality (PGY1-3)
D. Residents will learn the importance of accurate medical documentation (PGY1-3)
E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress (PGY1-3)
F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY1-3)

VI. **Systems-based practice**

The breast surgery rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, Tumor Boards and journal clubs (see discussion about each of these above) (PGY1-3)
B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of surgical oncology patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients (PGY1-3)
C. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY1-3)
D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY1-3)

VASCULAR SURGERY GOALS AND OBJECTIVES (PGY 1-4)

GOALS

Through rotation on the Vascular Surgery service, residents shall attain the following goals:

Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with vascular surgical conditions. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 1-4)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 1-4)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 1-4)
iv)The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1-4)

B. Operative Care Setting: HVI

The following is a list of "core" operations that the resident(s) can be expected to have exposure to by the completion of their vascular surgery rotation:

AAA repair (endovascular and open) (PGY4)
Amputations - lower extremity (PGY1-3)
Aortofemoral Bypass (PGY4)
Emboloectomy/Thrombectomy – Arterial (PGY3, 4)
Extraanatomic Bypass (PGY4)
Femoral-Popliteal bypass (PGY4)
Infrapopliteal Bypass (PGY4) AV graft/fistula (PGY1-4)
Percutaneous Vascular Access (PGY1-4)
Venous Access Device Insertion (PGY1)
Vena Cava Filter Insertion (PGY1-4)
Venous insufficiency/Vericose Veins – Operation (PGY1-4)

The following is a list of “advanced” operations that the resident(s) can be expected to have exposure to by the completion of the their vascular surgery rotation:

Arterial Occlusive Disease – Endarterectomy (PGY4)
Carotid Endarterectomy (PGY4)
Endovascular – Therapeutic including Thrombolysis (PGY4)
Femoral aneurysm repair (PGY4)
Graft-enteric fistula – Management (PGY4)
Infrarenal and Aortoiliac Aneurysm – Repair (PGY4)
Popliteal aneurysm – repair (PGY4)
Psuedoaneurysm – Repair (PGY3, 4)
Suprarenal AAA repair (PGY4)
Visceral Occlusive Disease – Operation (PGY4)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post operative vascular surgery patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; the identification and treatment of common post-operative complications including bleeding, infection, graft thrombosis, neurovascular changes, thromboembolism, heart attack (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center
   A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a vascular patient who has undergone an elective, same day procedure (PGY 1-4)
   B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a vascular surgery patient’s pain who has undergone an elective, same day procedure (PGY 1-4)
   C) The resident will successfully complete and review with the vascular surgery patient who has undergone an elective, same day procedure the patient’s discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient’s medication list (PGY 1-4)
   D) The resident will successfully coordinate appropriate surgical follow up (PGY 1-4)

2. Inpatient floor
   A) The resident team is expected to make morning rounds on the inpatient vascular surgery patient list (including the consult service) prior to the start of the day’s activities (OR cases, clinic) (PGY 1-4)
   B) After rounds, the chief resident (or senior most available resident) is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan

will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called (PGY 1-4)

C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY 1-4)

D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important tests to the chief resident who can then relay the information to the attending of record (PGY 1)

3. Out-patient clinic

A) When circumstance allows, residents will see patient's on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various "core" and "advanced" operations as well as gain experience in identifying instances in which deviation from the norm is occurring as well as how such instances are approached/managed (PGY 1-4)

B) Residents will see vascular surgery patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of patients with vasculopathy even after their operation is performed (PGY 1-4)

Medical Knowledge

Resident fund of knowledge as it relates to vascular surgery will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings

1. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the vascular surgery service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post-operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable. Residents are also expected to attend Wednesday morning didactic sessions which will cover the assigned TWIS topic for the week (PGY 1-4)

2. Residents are expected to attend weekly vascular case conference (Mondays at 3pm) during which one or two cases for the upcoming week

will be reviewed. Topics of discussion will include H/P findings, review of imaging, indications for surgery, and operative approach. (PGY 1-4)

3. Assigned Readings - Residents will cover various vascular surgery topics as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Vascular surgery faculty all participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when vascular surgery topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to vascular surgery.

Practice-based Learning

A. Residents are expected to critique their performance and their personal practice out comes

   1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1-4)

   2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1-4)

   3. Residents shall distribute operative cards to attending's with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1-4)

   4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1-4)

Interpersonal and Communication Skills

A. Residents will be given the opportunity to observe (PGY 1-3) and eventually participate in (PGY 4) the process of delivering bad news to patients and their families/friends.
These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing diagnostic findings and prognosis (among others)

B. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team includes nurses, therapists, APPs, care managers and other physicians serving as consultants (PGY 1-4)

C. Residents shall learn to document their practice activities in such a manner that

is clear, concise and in accordance with the standards of medico-legal documentation (PGY1-4)

D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (PGY 1-4)

E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY 1-4)

Professionalism

A. Residents shall maintain high ethical standards in dealing with patients, family members, patient data, and other members of the healthcare team (PGY1-4)

B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the duty hour restrictions (PGY1-4)

C. Residents shall demonstrate sensitivity to age, gender, and culture of patients and other members of the healthcare team (PGY1-4)

Systems-based practice

The vascular surgery rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, Vascular walk rounds, Vascular case conference and journal clubs (see discussion about each of these above) (PGY 1-4)

B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of vascular surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients (PGY 1-4)

C. Residents will be exposed to protocol driven practices as they related to central line insertion in ICU patients, selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY 1-4)

D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY 1-4)

PLASTIC SURGERY GOALS AND OBJECTIVES (PGY 1, 2)

GOALS

Through rotation on the plastic surgery service, residents shall attain the following goals:

I. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with plastic surgery conditions. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 1, 2)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 1, 2)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 1, 2)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 1, 2)

B. Operative Care Setting: 5N and 2W

The following are a list of essential common operations that the resident(s) can be expected to have exposure to by the completion of their plastic surgery rotation:

Skin/Soft Tissue Lesions – Excisional and Incisional Biopsy (PGY 1, 2)
Soft Tissue Infections – Incision, Drainage, Debridement (PGY1, 2)
Abdominal wall Reconstruction – Components separation (PGY1, 2)
Complex Wound Closure – (PGY1, 2)
Skin Grafting - (PGY 1, 2)

The following are a list of the complex operations that the resident(s) can be expected to have exposure to by the completion of their surgical oncology rotation:

Tendon Repair – (PGY 1, 2)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative plastic surgery patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; resuscitation of critically ill patients; the identification and treatment of common post-operative complications including bleeding, infection, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure. (PGY1, 2)

1. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a plastic surgery patient who has undergone an elective, same day procedure (PGY 1, 2)
B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a plastic surgery patient's pain who has undergone an elective, same day procedure (PGY 1, 2)
C) The resident will successfully complete and review with the plastic surgery patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list
(PGY 1, 2)
D) The resident will successfully coordinate appropriate surgical follow up (PGY 1, 2)

2. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient plastic surgery patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY 1, 2)
B) After rounds, the chief resident (or senior most available resident) is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called (PGY 1, 2)
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY 1, 2)

3. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essentialcommon and complex operations as well as gain experience in identifying instances in which deviation from the norm is occurring as how such instances are approached/managed (PGY 1, 2)

B) Residents will see plastic surgery patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of plastic surgery patients even after their operation is performed (PGY 1, 2)

II. Medical Knowledge

Resident fund of knowledge as it relates to plastic surgery will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings

A. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the plastic surgery service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post-operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable (PGY 1, 2)

B. Journal Club: Residents are expected to participate in the monthly journal club sessions that are part of the weekly Wednesday morning didactic sessions (PGY 1, 2)

C. Assigned Readings: Residents will cover various plastic surgery topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Plastic surgery faculty will participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when plastic surgery topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to plastic surgery (PGY 1, 2)

III. Practice-based Learning

Residents are expected to engage in critical self review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1, 2)
2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1, 2)
3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1, 2)
4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1, 2)

IV. **Interpersonal and Communication Skills**

The plastic surgery service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A. Residents will be given the opportunity to observe (PGY1) and eventually participate in (PGY 2) the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis (among others)
B. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, APPs, care managers and other physicians serving as consultants (PGY 1, 2)
C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medicolegal documentation (PGY1, 2)
D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (PGY 1, 2)
E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY 1, 2)

V. **Professionalism**

The plastic surgery rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

A. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical

complications (PGY1, 2)

B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY 1, 2)
C. Residents shall learn to maintain patient confidentiality (PGY 1, 2)
D. Residents will learn the importance of accurate medical documentation (PGY 1, 2)
E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress (PGY 1, 2)
F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY 1, 2)

VI. **Systems-based practice**

The surgical oncology rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M and journal clubs (see discussion about each of these above) (PGY 1, 2)
B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of plastic surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post- operative patients (PGY 1, 2)
C. Residents will be exposed to protocol driven practices as they relate to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY 1, 2)
D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY 1, 2)

TRAUMA SERVICE GOALS AND OBJECTIVES (PGY1-5)

GOALS

Through rotation on the trauma and emergency surgery service, residents shall attain the following goals:

	PGY 1	PGY 2, 3	PGY 4, 5
Patient Care			
Trauma Resuscitations: the resident should participate in each trauma resuscitation.	Role is as delineated in the trauma resuscitation guidelines and as directed by the chief resident or faculty	Aid the team leader for each resuscitation	The resident is the team leader for each trauma resuscitation. *Implement the trauma resuscitation guidelines. *Direct all members of the team if additional procedures/evaluation needs to be completed
	Collect and document: *pre-hospital information *history and exam *laboratory and radiologic exams.	Collect and document: *pre-hospital information *history and exam *laboratory and radiologic exams.	Discussion an appropriate plan with the trauma attending
	Learn the normal and abnormal values for laboratory tests and learn the appropriate interventions for each	Order appropriate laboratory and radiologic exams and interpret the results *identify and correct coagulopathy	The resident should manage the fluid resuscitation of each patient, i.e. fluid rates and type, fluid boluses, need for blood. Residents should be able to direct resuscitation including use of crystalloids, colloids, vasopressors, and inotropes
	Interpret radiologic tests i.e. CT scans of the head, chest, abdomen and pelvis	Interpret tests and apply to designation of patient disposition	Interpret test and implement appropriate plan of care based on findings and trauma protocols
		Participate in discussions concerning plan of care and status with the patient and/or family	Lead discussion concerning plan of care and status with the patient and/or family
Inpatient Management of the Trauma Patient and Postoperative Patient	Complete daily notes in a timely and accurate manner	Develop a plan for the continued resuscitation of the critically ill trauma or emergency surgery patient	Residents should be able to direct the continued resuscitation of the critically ill trauma or emergency surgery patient. This includes coordination of consult services, direction of junior residents, and continued evaluation of the patient.
			Ensure that daily notes are completed on all patients
	Identify normal vital signs	Should be able to identify deterioration in a patient's status	Residents should be able to independently identify deterioration in a patient's status and be able to develop a plan of intervention that will be discussed with the attending staff.
All residents shall be able to recognize and differentiate the below problems and conditions and be able to formulate and institute a strategy of care with the assistance of more senior residents or staff.			
Through evaluation of the postoperative patient, the resident shall be able to access and manage:	*Wound care and healing *Identify infected wounds *Identify wound seromas *Fluid and electrolyte abnormalities after surgery *Use and care of	*Identify cardiopulmonary complications: myocardial infarction, pulmonary edema, atelectasis, pulmonary embolism, pneumonia *Identify of renal impairment/failure: pre-renal azotemia, acute renal failure, IV-dye associated renal impairment	*Identify cardiopulmonary complications: myocardial infarction, pulmonary edema, atelectasis, pulmonary embolism, pneumonia *Identify of renal impairment/failure: pre-renal azotemia, acute renal failure, IV-dye associated renal impairment

	surgical drains and chest tubes *Identify infection: surgical site, blood, genitourinary, pulmonary, catheter-related		
	Identify a patient's readiness for discharge	Identify a patient's readiness for discharge	Plan ahead of time for patient disposition
	Identify a patient's need for rehabilitation or nursing home placement	Identify a patient's need for rehabilitation or nursing home placement	Plan ahead of time for patient disposition
Clinic	Be present in clinic weekly	Be present in clinic weekly	Be present in clinic weekly
	Complete clinic notes in a timely manner	Complete clinic notes in a timely manner	Complete clinic notes in a timely manner
	Generate an appropriate outpatient plan for the patient	Generate an appropriate outpatient plan for the patient	Generate an appropriate outpatient plan for the patient

	PGY 1	PGY 2, 3	PGY 4, 5
Medical Knowledge			
Didactics: residents are expected to attend and participate in the weekly didactic sessions including the basic science course, case conference, M&M, Grand Rounds, and the Junior resident discussion sessions.	General Surgery residents only	General Surgery residents only	General Surgery residents only
Multidisciplinary Trauma Conference on Thursday at noon.	Attend weekly	Attend weekly	Present at Multidisciplinary Trauma Conference on Thursday at noon once per TES rotation
Morning Report	Arrive on time and prepared for presentation of new patients, all general surgery patients, and patients ready for discharge	Arrive on time and prepared for presentation of new patients, all general surgery patients, and patients ready for discharge	Arrive on time and prepared for presentation of new patients, all general surgery patients, and patients ready for discharge
It is expected that residents will educate themselves upon the scientific information relating to trauma and emergency surgery.	Read Daily	Use additional sources more specific to Trauma and Emergency Surgery	Use additional sources more specific to Trauma and Emergency Surgery
System function: residents shall gain an understanding of the anatomy, physiology, and function of organs and organ systems affected general surgical conditions and operative procedures	Residents shall reacquaint themselves with the basic physiology and function of the organs and systems, and they shall learn how they are affected by trauma and emergency surgery	Residents shall recognize the basic physiology and function of the organs and systems, and they shall learn how they are affected by trauma and emergency surgery	Residents shall recognize and be able to teach the basic physiology and function of the organs and systems, and they shall learn how they are affected by trauma and emergency surgery
Disease process: All residents shall become familiar with the various disease processes and complications affecting the organ systems commonly seen in trauma and emergency surgery patients			
Follow-up therapy: All residents shall gain an understanding of the follow-up needed and recommended for various trauma and emergency surgical procedures			

	PGY 1	PGY 2, 3	PGY 4, 5
Practice-based Learning			
Residents are expected to critique their performance and their personal practice out comes	Morbidity & Mortality Conference – Discussion should center on an evidence-based discussion quality improvement	Morbidity & Mortality Conference – Discussion should center on an evidence-based discussion quality improvement	Morbidity & Mortality Conference – Discussion should center on an evidence-based discussion quality improvement
	Residents shall keep logs of their operative cases and all procedures and track their operative proficiency as gauged by		Residents shall keep a log of all the non-operative trauma cases

	whether they assisted or were the surgeon junior or senior or teaching assistant	in which they were the team leader, complications, and outcomes

	PGY 1	PGY 2, 3	PGY 4, 5
Interpersonal and Communication Skills			
Residents shall learn to work effectively as part of the trauma and emergency surgery team			
Residents shall foster an atmosphere that promotes the time efficiency and each member of the team			
Residents shall interact with colleagues and members of the ancillary services in a professional and respectful manner			
Residents shall learn to document their practice activities in such a manner that is clear and concise			
Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery			
Residents shall gain an experience in educating and counseling patients about risks and expected outcomes of procedures or surgeries			
Residents shall perform an appropriate and effective review and checkout to their colleagues whenever they must be absent, i.e. post call, conferences, night float			
			Residents should be able to independently discuss the patient's status, plan of care, and prognosis with a patient and/or family

PGY 1	PGY 2, 3	PGY 4, 5
Professionalism		
Residents shall maintain high ethical standards in dealing with patients, family members, patient data, and other members of the healthcare team		
Residents shall demonstrate sensitivity to age, gender, and culture of patients and other members of the healthcare team		
Residents shall demonstrate a commitment to the continuity of care of a patient within duty hour restrictions		Holds team members to 80 hour work wee
Arrives to the operating room prepared for the case and the care of the patient		
Demonstrates accountability for ones actions and decisions		

PGY 1	PGY 2, 3	PGY 4, 5
Systems-based practice		
Residents shall learn to practice high quality cost effective patient care. This knowledge should be gained through discussions of patient care		
Attend Conferences • Trauma Multidisciplinary Conference • Surgery Department M&M- General Surgery Residents only • Trauma Performance Improvement- Senior Residents only		
To demonstrate knowledge of risk-benefit analysis		
To assist in the development of a health care plan that provides high quality, cost effective patient care		
To be able to recognize the need for a consultant, make appropriate requests, and provide appropriate information to the consultants		
To recognize and understand the role of other health care professionals in the overall care of the patient		
Follow the protocols outlined in the SICU and Trauma Handbooks		
Arranges appropriate follow up with primary service and consulting services		

A. Operative Care: Gain an experience that will build toward being competent in the performance of urgent and emergent surgeries; emergent procedures, and urgent ICU related procedures. Also, the resident shall gain experience in elective general surgery as performed by the TES Staff. PGY levels indicate the level of resident most appropriate to participate. This does not preclude a more senior or more junior resident from participating if there is no level appropriate resident available.

	PGY 1	PGY 2, 3	PGY 4, 5
	Placement of chest tube		Be able to teach all procedures listed for the PGY 1-2
	Placement of central venous catheter		Be able to teach all procedures listed for the PGY 1-2
	Perform and interpret FAST (Focused Abdominal Sonography in Trauma)		Be able to teach all procedures listed for the PGY 1-2
	Placement of orogastric tube		Be able to teach all procedures listed for the PGY 1-2
	Arterial blood gas sampling: femoral and radial artery		Be able to teach all procedures listed for the PGY 1-2
	Placement of Foley catheter		Be able to teach all procedures listed for the PGY 1-2
	Placement of nasogastric tube		Be able to teach all procedures listed for the PGY 1-2
	Perform open DPL	Know the indications for and a definition of a positive test	
			Discuss and demonstrate cricothyroidotomy
			Discuss and/or demonstrate emergent thoracotomy
			Discuss and/or demonstrate aortic occlusion
			Discuss and/or demonstrate pericardiotomy
		Incarcerated Groin Hernia, open	
		Incarcerated Abdominal wall hernia, open: umbilical, incisional, recurrent	
	Placement of venous catheter		Be able to teach all procedures listed for the PGY 1-2
	Placement of arterial catheter		Be able to teach all procedures listed for the PGY 1-2
	Drainage of intra-abdominal abscess, simple		Be able to teach all procedures listed for the PGY 1-2
	EGD/PEG		Be able to teach all

		procedures listed for the PGY 1-2
	Bronchoscopy	Be able to teach all procedures listed for the PGY 1-2
	Groin Hernia, open	Be able to teach all procedures listed for the PGY 1-2
	Diagnostic laparoscopy	Be able to teach all procedures listed for the PGY 1-2
	Small bowel resection	
	Small bowel repair for trauma	
	Colectomy, left/total	
		Low anterior resection
	Colectomy, right	
	Large bowel resection, anastomosis, or diversion	
	Cholecystectomy, open	
	Cholecystectomy, laparoscopic	
	Enterolysis	
	Soft tissue mass/infection/abscess, simple	Be able to teach all procedures listed for the PGY 1-2
	Soft tissue mass/infection/abscess, complex	
	Exploratory laparotomy	
	Damage control laparotomy	
	Hepatic packing for trauma	
	Pancreatic debridement or drainage for trauma	
	Splenectomy, open for trauma	
	Tracheostomy	Be able to teach all procedures listed for the PGY 1-2
	Percutaneous Tracheostomy	Be able to teach all procedures listed for the PGY 1-2

PEDIATRIC SURGERY GOALS AND OBJECTIVES (PGY 1, 4, 5)

GOALS

Through rotation on the pediatric surgery service, residents shall attain the following goals:

I. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative and post operative pediatric surgery patients. The plan shall include any intervention(s) that will successfully prepare a pediatric patient for surgery as well as facilitate their recovery from surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for

elective as well as urgent/emergent surgery
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie size, weight and age of patient; nutritional status; special considerations such as associated congenital anomalies and their impact on the planned procedure, etc…)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the parents of the child the risks, benefits and alternatives of the planned intervention

B. Operative Care Setting: 5N and 2W

The following are a list of "core" operations that the resident(s) can be expected to have exposure to by the completion of their pediatric surgery rotation:

Inguinal hernia repair (PGY 1, 4, 5)
Intussusception – operation (PGY 1, 4, 5)
Malrotation – operation (PGY 1, 4, 5)
Meckel's diverticulum – excision (PGY 1, 4, 5)
Pyloromyotomy, laparoscopic or open (PGY 1, 4, 5)
Umbilical hernia repair (PGY 1, 4, 5)
Venous access – broviac catheters and ports (PGY 1, 4, 5)

The following are a list "advanced" operations that the resident(s) can be expected to have exposure to by the completion of their pediatric surgery rotation:

Antireflux procedures (PGY 4, 5)
Diaprhragmatic Hernia – Repair (PGY 4, 5)
Esophageal Atresia/Tracheoesophegeal Fistula – Repair
Hirshsprung's disease – operation (PGY 4, 5)
Imperforate Anus – operation (PGY 4, 5)
Intestinal Atresia/Stenosis – operation (PGY 4, 5)
Meconium ileus – operation (PGY 4, 5)
Necrotizing enterocolitis – operation (PGY 4, 5)
Omphalocele/Gastroschisis – operation (PGY 4, 5)
Wilson tumor/neuroblastoma – excision (PGY 4, 5)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative pediatric surgery patient. This plan generally focuses on, but is not limited to: pain control; identification and treatment of common post-operative complications including bleeding, infection, sepsis, identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a pediatric surgery patient who has undergone an elective, same day procedure (PGY 1, 4, 5)
B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a pediatric surgery patient's pain who has undergone an elective, same day procedure (PGY 1, 4, 5)
C) The resident will successfully complete and review with the pediatric surgery patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list (PGY 1, 4, 5)
D) The resident will successfully coordinate appropriate surgical follow up (PGY 1, 4, 5)

2. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient pediatric surgery patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY 1, 4, 5)
B) After rounds, resident is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called (PGY 1, 4, 5)
C) The resident will perform the day's work in a manner that is as efficient as possible. This may include delegating responsibility to APPs when appropriate. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY 1, 4, 5)

3. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying instances in which deviation from the norm is occurring as how such instances are approached/managed (PGY 1, 4, 5)
B) Residents will see pediatric surgery patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of pediatric surgery patients even after their operation is performed (PGY 1, 4, 5)

II. Medical Knowledge

Resident fund of knowledge as it relates to pediatric surgery will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings 4) Truelearn quizzes

A. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the pediatric surgery service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post-operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable (PGY 1, 4, 5)
B. Pediatric case review and teaching rounds – weekly Friday at 8AM. Discuss recent operative interventions, current interesting cases, including initial evaluation, workup, radiology study review and important physical findings.
C. Journal Club: Residents are expected to participate in monthly journal clubs as part of the Wednesday morning didactic curriculum (PGY 1, 4, 5)
D. Assigned Readings: Residents will cover various pediatric topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Pediatric surgery faculty will participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when pediatric surgery topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to pediatric surgery (PGY 1, 4, 5)

III. Practice-based Learning

Residents are expected to engage in critical self review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 1, 4, 5)
2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 1, 4, 5)
3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 1, 4, 5)
4. Residents shall review their specific Quality in Training Initiative (QITI) data quarterly (PGY 1, 4, 5)
5. Residents shall familiarize themselves with evidence based guidelines related to disease/injury prevention, patient safety and quality (SCIP measures) as well

as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 1, 4, 5)

IV. **Interpersonal and Communication Skills**

The pediatric surgery service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A. Residents will be given the opportunity to observe (PGY1) and eventually participate in the process of delivering bad news to patients and their families/friends (PGY4, 5). These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis
B. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, care managers, APPs and other physicians serving as consultants (PGY 1, 4, 5)
C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation (PGY 1, 4, 5)
D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery (PGY 1, 4, 5)
E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY 1, 4, 5)

V. **Professionalism**

The pediatric surgery rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

A. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications (PGY 1, 4, 5)
B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY 1, 4, 5)
C. Residents shall learn to maintain patient confidentiality (PGY 1, 4, 5)
D. Residents will learn the importance of accurate medical documentation (PGY 1, 4, 5)
E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress (PGY 1, 4, 5)
F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY 1, 4, 5)

VI. **Systems-based practice**

The pediatric surgery rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

E. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, case conferences and journal clubs (see discussion about each of these above) (PGY 1, 4, 5)
F. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of pediatric surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients; learning best practice guidelines for reducing catheter associated infections upon central venous catheter (CVC) insertion (PGY 1, 4, 5)
G. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY 1, 4, 5)
H. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY 1, 4, 5)

NIGHT FLOAT ROTATION CORE OBJECTIVES (PGY 1-5)

GOALS

Through rotation on the Night Float service, residents shall attain the following goals:

I. **Patient care:** This rotation offers a unique opportunity for the resident team to evaluate patients in the evening hours independently with specific emphasis on acute operative or post-operative issues. Though all care is supervised, this environment fosters an increased sense of autonomy. Residents are then expected to make an assessment and formulate a plan which will then be reviewed/executed either over the phone or in the case of invasive procedures/operations or trauma, by means of direct supervision with the on call faculty for whichever service the patient in question is being managed.

The Night Float rotation will consist of a senior resident (PGY4 or 5) with a junior resident (PGY2 or 3) and an intern (PGY1) who will have a designated shift: 5:30 pm to 6:00 am Sunday through Thursday or Friday. Wednesday shift is from 7 pm to 6:30 am.

The patient care responsibilities rotating Night Float residents will be the same as those the surgical residents on the: MIS

- Senior residents: ACS, Gold, Oncologic, Pediatric, and Trauma Surgery services
- Junior residents: Vascular, Thoracic, SICU and Breast Surgery services
- Interns: SICU, Pediatrics, Vascular, Oncologic, Breast, ACS and Gold Surgery services

Please see each section above for specifics. One exception for this rotation is that there will be no outpatient clinic requirement.

II. **Medical Knowledge**

The medical knowledge objectives for the residents rotating on Night Float will be the same as those for the respective services the residents are covering, as listed immediately above, with the exception of any outpatient responsibilities. Please see each section for specifics.

III. **Practice-based Learning**

Residents are expected to critique their performance and their personal practice out comes

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY1-5)
2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY1-5)
3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY1-5)
4. Residents shall review their specific Quality in Training Initiative (QITI) data quarterly (PGY1-5)
5. Residents shall familiarize themselves with evidence based guidelines related to disease/injury prevention, patient safety and quality (SCIP measures) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY1-5)

IV. **Interpersonal and Communication Skills**

A. Residents will be given the opportunity to deliver bad news to patients and their families/friends. These opportunities exist in in the context of discussing diagnostic findings and prognosis (PGY1-5)
B. Residents will also be called upon to communicate the plan of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient (PGY1-5)
C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation (PGY1-5)
D. Residents shall participate in the informed consent process for patients being scheduled for emergent/urgent procedures or surgery (PGY1-5)
E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY1-5)

V. **Professionalism**

A. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news (PGY1-5)
B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY1-5)
C. Residents shall learn to maintain patient confidentiality (PGY1-5)
D. Residents will learn the importance of accurate medical documentation (PGY1-5)
E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress (PGY1-5)
F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY1-5)

VI. **Systems-based practice**

The nightfloat rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care (PGY1-5)
B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of adult and pediatric surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; learning best practice guidelines for reducing catheter associated infections upon central venous catheter (CVC) insertion, etc (PGY1-5)
C. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY1-5)
D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY1-5)

TRANSPLANT ROTATION CORE OBJECTIVES (PGY3)

The transplant rotation strives to develop the general competencies of residents by providing an opportunity to take part in all phases of the transplant process from donor selection, to procurement, to actual transplant and postoperative care under direct attending supervision. The resident rotation is primarily focused to provide exposure to transplant surgery and patient management. The residents will directly interact with the transplant surgeons on a daily basis in the operating room and patient floors. Additionally, there are scheduled conferences and multidisciplinary team meetings aimed at increasing the resident's knowledge of transplant surgery.

I. Patient Care (PGY3)

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for patients who are either awaiting solid organ transplantation or those who have already received one in the preoperative and post- operative settings. The plan shall include any intervention(s) that will successfully prepare the patient for surgery or treat their specific post-transplant related condition as well as facilitate their recovery from surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for transplantation
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (comorbidities, medications, appropriate preoperative testing, managing organ failure/dysfunction, immunosuppression related conditions and consequences, acute and chronic rejection, etc…)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient and/or their family the risks, benefits and alternatives of the planned intervention

B. Operative Care Setting: Baylor University Medical Center Operating Suites and Donor Runs

There are no “core” operations that the resident(s) can be expected to have exposure to by the completion of their transplant rotation **(PGY3):**

The following is a list of the “advanced” operations being a resident on the transplant rotation can expect to be exposed to:

En bloc Abdominal Organ Retrieval
Liver Donor Hepatectomy
Live Donor Nephrectomy Liver
Transplantation Pancreas
Transplantation Renal
Transplantation

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic **(PGY 3)**

Residents shall develop and follow through with a post-operative plan of care for the transplant recipient in the acute post-transplant period as well as when they

are admitted with post-transplant related complications such as those to related to rejection (acute and chronic) as well as immunosuppression. This plan generally focuses on, but is not limited to: pain control; identification and treatment of common post-operative complications including bleeding, infection, sepsis, immunosuppression, prophylaxis, treatment of opportunistic infections and others

1. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient transplant patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic)

B) After rounds, the resident team is expected to call the attending physician of record to review the plan of the day for each individual veteran. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called

C) The resident will perform the day's work in a manner that is as efficient as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges.

3. Out-patient clinic

A) When circumstance allows, residents should attend all outpatient clinics as per the schedule of the local transplant team

B) Residents will see patients who are in longitudinal surveillance following their transplant. This experience will provide the resident with an initial exposure to the ongoing care of patients even after their transplant is performed

II. Medical Knowledge (PGY3)

Resident fund of knowledge will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal Club 3) Assigned readings 4) TrueLearn quizzes

A. Conferences: Residents are expected to attend weekly educational conferences in accordance with the schedule which is in place for the Baylor University surgical residents.

B. Journal Club: Residents are expected to participate in journal clubs which may be occurring as part of the Baylor University general surgery residency program while they are rotating on the transplant service

C. Assigned Readings: Residents will cover various topics related to various Core and Advanced Diseases/Conditions as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency.

D. Residents are expected to complete TrueLearn quizzes that are assigned by the program director or program manager in a timely manner. Areas of deficiency as defined by their performance on the TrueLearn quizzes should serve as the focus for future study plans.

III. **Practice-based Learning (PGY 3)**

Residents are expected to engage in critical self-review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant

3. Residents shall familiarize themselves with evidence based guidelines related to disease/injury prevention, patient safety and quality (SCIP measures) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures)

IV. **Interpersonal and Communication Skills (PGY 3)**

The transplant rotation provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A. Residents will be given the opportunity to observe and eventually participate in the process of delivering bad news to veterans and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis

B. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, care managers, APPs and other physicians serving as consultants

C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation

D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery

E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs

V. **Professionalism (PGY 3)**

The transplant rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

A. Residents will have opportunities to learn how to be honest and sincere with patients . Examples include breaking bad news and explaining surgical complications

B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions

C. Residents shall learn to maintain patient confidentiality

D. Residents will learn the importance of accurate medical documentation

E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress

F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day

VI. **Systems-based practice (PGY 3)**

The transplant rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, case conferences and journal clubs (see discussion about each of these above)

B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of pediatric

surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients; learning best practice guidelines for reducing catheter associated infections upon central venous catheter (CVC) insertion

C. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others)

D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large

E. Residents will learn about the workings of a University affiliated program outside the confines of the WVU system in an entirely different state and population center. West Virginia, in general and Morgantown in specific, is much smaller than Texas and Dallas, respectively. Therefore, the resources that are available within this setting are more robust and available than those to which residents are accustomed to dealing with during their core rotations in Morgantown

THORACIC SURGERY CORE GOALS AND OBJECTIVES
(PGY1, 3, 4, 5)

Through rotation on the thoracic surgery service, junior residents shall attain the following goals:

I. Patient Care (PGY 1, 3, 4, 5)

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for patients in the preoperative and post-operative settings. The plan shall include any intervention(s) that will successfully prepare a patient for surgery as well as facilitate their recovery from surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery

ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned

iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (comorbidities, medications, appropriate preoperative testing with specific emphasis on preoperative cardiopulmonary testing)

iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient and/or their family the risks, benefits and alternatives of the planned intervention

B. Operative Care Setting: 5N and 2W operating suites

The following are a list of "core" operations that the resident(s) can be expected to have exposure to by the completion of their thoracic surgery rotation

Chest tube placement and Management (PGY1, 3, 4, 5)
Exploratory Thoractomy – Open and Thoracoscopic (PGY3, 4, 5) Partial Pulmonary Resection (PGY3, 4, 5)
Pericardial Window for Drainage (PGY3, 4, 5)
Bronchoscopy (PGY1,3, 4, 5)
Lymph Node Biopsy (PGY1, 3, 4, 5) Thoracoscopy for management of hemothorax (PGY3, 4, 5)
Esophagogastroduodenoscopy (PGY1, 3, 4, 5)
Laryngoscopy (PGY1, 3, 4, 5)
Feeding Jejunostomy (PGY1, 3, 4, 5)
Antireflux Procedures (PGY3, 4, 5)

Cricopharyngeal Myotomy with Zenker's Diverticulum – excision (PGY 3, 4, 5)
Esophageal perforation – Repair Resection (PGY 4, 5)
Paraesophageal Hernia – Laparoscopic and Open repair (PGY3, 4, 5)
Venous access device – insertion (PGY1, 3, 4, 5)

The list of "advanced" operations being that residents can be expected to have exposure while on the thoracic surgery rotation:

Esophagectomy/Esophagogastrectomy (PGY4, 5) Esophagomyotomy (Heller) (PGY 4,5)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic **(PGY1, 3, 4, 5)**

Residents shall develop and follow through with a post-operative plan of care for the patient who has undergone surgery. This plan generally focuses on, but is not limited to: pain control; identification and treatment of common post-operative complications including bleeding, infection, sepsis, identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

1. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a patient who has undergone an elective, same day procedure

B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a patient's pain who has undergone an elective, same day procedure

C) The resident will successfully complete and review with the patient who has undergone an elective, same day procedure their discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list

D) The resident will successfully coordinate appropriate surgical follow up

2. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient thoracic patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic). Residents are not to round on cardiac floor patients or cardiac patients in the ICU

B) After rounds, the resident is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations, CXR findings, chest tube output. The daily plan will generally consist (among others) of identifying possible discharge appropriate

patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called

C) The resident will perform the day's work in a manner that is as efficient as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges.

3. Out-patient clinic

A) When circumstance allows, residents will see patients on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various core procedures listed above as well as gain experience in identifying instances in
which deviation from the norm is occurring as how such instances are approached/managed
B) Residents will see patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of patients even after their operation is performed

II. Medical Knowledge (PGY 1, 3, 4, 5)

Resident fund of knowledge will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings 4) Truelearn quizzes

A. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the thoracic service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post- operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable

B. Journal Club: Residents are expected to participate in monthly journal clubs as part of the Wednesday morning didactic curriculum

C. Assigned Readings: Residents will cover various topics related to various Core and Advanced Diseases/Conditions as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency.

D. Residents are expected to complete TrueLearn quizzes that are assigned by the program director or program manager in a timely manner. Areas of
deficiency as defined by their performance on the TrueLearn quizzes should serve as the focus for future study plans.

III. **Practice-based Learning (PGY 1, 3, 4, 5)**

Residents are expected to engage in critical self-review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder

4. Residents shall review their specific Quality in Training Initiative (QITI) data quarterly

5. Residents shall familiarize themselves with evidence based guidelines related to disease/injury prevention, patient safety and quality (SCIP measures) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures)

IV. **Interpersonal and Communication Skills (PGY1, 3, 4, 5)**

The thoracic service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

A. Residents will be given the opportunity to observe and eventually participate in the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting and arise in the context of discussing pathology reports, diagnostic findings and prognosis

B. Residents will also be called upon to communicate the daily plan and progress of veterans admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, care managers, APPs and other physicians serving as consultants

C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation

D. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery

E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs

V. **Professionalism (PGY 1, 3, 4, 5)**

The thoracic rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

A. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications

B. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions

C. Residents shall learn to maintain patient confidentiality

D. Residents will learn the importance of accurate medical documentation

E. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress

F. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day

VI. **Systems-based practice (PGY 1, 3, 4, 5)**

The thoracic rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

A. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, case conferences and journal clubs (see discussion about each of these above)

B. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of thoracic surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter

associated urinary infections by early removal of indwelling catheters from post-operative patients; learning best practice guidelines for reducing catheter associated infections upon central venous catheter (CVC) insertion

C. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others)

D. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large

SICU GOALS AND OBJECTIVES (PGY 1,2,3)

Through rotation on the Surgical Intensive Care Service, residents shall attain the following goals:

PGY 1	PGY 2,3
Patient Care	
To be able to admit a patient to the ICU, evaluate current issues and past medical history, establish and execute a plan of care for the patient and current issues	
To be able to identify and implement different resuscitation strategies based on the physiology of the patient	To be able to identify, implement, evaluate, and modify different resuscitation strategies based on the physiology of the patient
To be able to evaluate the poly-trauma patient	To be able to evaluate the poly-trauma patient and prioritize and coordinate interventions
To be able to evaluate the acute neurosurgical patient	To be able to evaluate the neurosurgical patient and institute appropriate care, for example traumatic brain injury, cerebral aneurysm, and acute neurologic decompensation
To be able place a Swan-Ganz catheter	To be able to identify the indications for, place, and interpret a Swan-Ganz catheter
To be able to place arterial catheters	To be able to identify the indications for, place, and interpret arterial catheters
To be able to place central venous catheters	To be able to identify the indications for, place, and interpret central venous catheters

PGY 1	PGY 2,3
Medical Knowledge	
To be able to define shock and give examples of each kind	To know the treatment options for the various kinds of shock
To understand fluid resuscitation and ability to evaluate the response to therapy	To know the appropriate fluid for the appropriate situation
To be able to name the vasopressors and ionotropes and to know indications, dose, effects, and adverse effects of each	
To know the risks and benefits of the Swan-Ganz catheter, arterial catheter, and central venous catheter	
To understand indications, time course, and adverse effects of the most commonly used antibiotic	

To understand the basic modes of mechanical ventilation	To understand PEEP, pressure modes of ventilation, and be able to name some of the newer complex modes
	To be able to identify and manage acute respiratory failure, including non-invasive and invasive ventilation
To be able to define ARDS	To be able to define ARDS and adjust ventilator strategies due to the changes with ARDS
To be able to define and identify acute renal failure	To be able to define and identify acute renal failure, identify possible etiologies; identify various types of renal failure and initiate appropriate therapy
To understand the coagulation cascade and treat abnormalities of it	
To understand indications, risks, benefits, and alternatives to blood transfusion	
	To understand the difference between systolic and diastolic heart failure and be able to institute acute interventions for each
	Understand the placement and management of ICP monitors
	To be able to establish and adjust a patient's nutrition plan including TPN or enteral feeds and understand and utilize nutritional parameters including metabolic cart
	To understand the risk factors, testing and treatment for acute adrenal insufficiency
	To understand diagnosis, work up and treatment of acute hepatic insufficiency/failure

PGY 1	PGY 2,3
Practice-based Learning	
Morbidity & Mortality Conference – Residents are expected to critique their performance and their personal practice outcomes and discussion should center on an evidence-based discussion of complications and their avoidance	Keep of log of patients for the M&M conference and distribute to the junior/intern residents
To be able to evaluate complications, causes and outcomes by participating in ICU Morbidity Conference	
Residents shall keep logs of their cases and track their operative proficiency	

PGY 1	PGY 2,3
Interpersonal and Communication Skills	
Residents shall learn to work effectively as part of the ICU team	
Residents shall foster an atmosphere that promotes the effectiveness of each member of the ICU team	
Residents shall interact with colleagues and members of the multi-disciplinary ICU team, such as pharmacists, dieticians, respiratory therapists, etc in a professional and respectful manner	
Residents shall learn to document their practice activities in such a manner that is clear and concise	
To be able to effectively and compassionately discuss the daily plan of care for each patient to the patient and family	
To participate in end of life family discussion	To provide counsel in end of life family discussions
	To effectively communicate with medical students and junior residents to contribute to the teaching environment
	To be the resident leader of the service responsible for resident hours/call schedule and a back up to the interns/juniors

PGY 1	PGY 2,3
Professionalism	

Residents shall maintain high ethical standards in dealing with patients, family members, patient data, and other members of the healthcare team
Residents shall display the highest levels of professionalism through verbal and non-verbal and all behavior
Residents shall demonstrate sensitivity to age, gender, and culture of patients and other members of the healthcare team
Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the duty-hour restrictions
Completed the Assigned on-line ICU Curriculum in a timely manner
Acceptable attendance at Assigned Educational Activities

PGY 1	PGY 2,3
Systems-based practice	
Attend Conferences SICU M&M	
To demonstrate knowledge of risk-benefit analysis of a health care plan that provides high quality, cost effective patient care	
To recognize and understand the role of other health care professionals in the overall care of the patient	
Residents shall demonstrate proficiency in the Handoff process to ensure seamless patient care	
Follow the protocols outlined in the SICU and Trauma Handbooks	
Turn in the completed signature sheet at the end of the month	

BARIATRIC & MINIMALLY INVASIVE SURG GOALS & OBJECTIVES (PGY 2, 3, 4)

GOALS

Through rotation on the surgical oncology service, residents shall attain the following goals:

V. Patient Care

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for preoperative patients with surgical oncologic conditions. The plan shall include any intervention(s) that will successfully prepare a patient for surgery

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery (PGY 2, 3, 4)
ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned (PGY 2, 3, 4)
iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (ie cardiopulmonary risk assessment; nutritional status; special considerations such as thrombophilias/bleeding disorders, steroid dependent patients, multiple comorbidities, etc…) (PGY 2, 3, 4)
iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient the risks, benefits and alternatives of the planned intervention (PGY 2, 3, 4)

B. Operative Care Setting: 5N and 2W

The following are a list of essential common operations that the resident(s) can be expected to have exposure to by the completion of their bariatric/MIS rotation:

Sleeve Gastrectomy (PGY 2, 3, 4)
Roux-en-Y Gastric Bypass (PGY 2, 3, 4)
Gastric Band Removal (PGY 2, 3, 4)
Hiatal Hernia Repair (PGY 2, 3, 4)
Paraesophageal Hernia Repair (PGY 2, 3, 4)
EGD (PGY 2, 3, 4)

The following are a list of the complex operations that the resident(s) can be expected to have exposure to by the completion of their bariatric/MIS rotation:

ERCP Access (PGY 2, 3, 4)
Gastric Perforation (PGY 2, 3, 4)
Internal Hernia (PGY 2, 3, 4)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic

Residents shall develop and follow through with a plan of care for the post-operative surgical patient. This plan generally focuses on, but is not limited to: pain control; fluid and electrolyte management; diet nuances; the identification and treatment of common post-operative complications including bleeding, infection, ileus, bowel obstruction, thromboembolism (among others); identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

7. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a patient who has undergone an elective, same day procedure (PGY 2, 3, 4)
B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a patient's pain who has undergone an elective, same day procedure (PGY 2, 3, 4)
C) The resident will successfully complete and review with the patient who has undergone an elective, same day procedure the patient's discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list (PGY 2, 3, 4)
D) The resident will successfully coordinate appropriate surgical follow up (PGY 2, 3, 4)

8. Inpatient floor

A) The resident team is expected to ensure morning rounds have occurred on the inpatient patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic) (PGY 2, 3, 4)

B) After rounds, the chief resident (or senior most available resident) is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called (PGY 2, 3, 4)
C) The resident team will divide the work for the day in such a manner that it will be performed as efficiently as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges. The goal for all discharges is out the day by noon (PGY 2, 3, 4)
D) The intern or junior resident should provide as close to real time updates as possible with changes in patients condition, new consults, results of important tests to the chief resident who can then relay the information to the attending of record (PGY 2)

9. Out-patient clinic

A) When circumstance allows, residents will see patient on whom they performed surgery for their 1st outpatient post-operative follow up visit. This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various essential common and complex operations as well as gain experience in identifying instances in which deviation from the norm is occurring as how such instances are approached/managed (PGY 2, 3, 4)
B) Residents will see bariatric patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of patients even after their operation is performed (PGY 2, 3, 4)

VI. Medical Knowledge

Resident fund of knowledge as it relates to surgical oncology will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings 4) TWIS quizzes

9. Conferences

A) Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the surgical bariatric/MIS service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post- operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved

outcomes. Evidenced based practice patterns should be emphasized when applicable (PGY 2, 3, 4)

10. Assigned Readings: Residents will cover various surgical oncology topics, among others, as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency. Bariatric faculty all participate in leading didactic discussion(s) at Wednesday morning education conference at different points in the year when appropriate topics are the assigned topic for the week. Additionally, residents are encouraged to educate themselves upon the scientific information relating to bariatric and MI surgery. The recommended text is Cameron's Current Surgical Therapy.

11. TWIS Quizzes: Residents are expected to complete TWIS quizzes that are outlined in the program curriculum. Areas of deficiency as defined by their performance on the TWIS quizzes should serve as the focus for future study plans.

XI. Practice-based Learning

Residents are expected to engage in critical self -review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on an evidence based discussion of quality improvement (PGY 2, 3, 4)

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant (PGY 2, 3, 4)

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder (PGY 2, 3, 4)

4. Residents shall familiarize themselves with evidence based guidelines related to disease prevention, patient safety and quality (SCIP measures, DVT prophylaxis guidelines, screening colonoscopy guidelines, etc) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures) (PGY 2, 3, 4)

XII. Interpersonal and Communication Skills

A. Residents will be given the opportunity to deliver bad news to patients and their families/friends. These opportunities exist in in the context of discussing diagnostic findings and prognosis (PGY 2, 3, 4)

B. Residents will also be called upon to communicate the plan of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient (PGY 2, 3, 4)

C. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation (PGY 2, 3, 4)
D. Residents shall participate in the informed consent process for patients being scheduled for emergent/urgent procedures or surgery (PGY1-5)
E. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs (PGY 2, 3, 4)

XIII. **Professionalism**

A) Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and explaining surgical complications (PGY 2, 3, 4)
B) Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions (PGY 2, 3, 4)
C) Residents shall learn to maintain patient confidentiality (PGY 2, 3, 4)
D) Residents will learn the importance of accurate medical documentation (PGY 2, 3, 4)
E) Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress (PGY 2, 3, 4)
F) Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day (PGY 2, 3, 4)

XIV. **Systems-based practice**

The rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

G) Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge (PGY 2, 3, 4)
H) Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of surgical patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients (PGY 1, 4, 5)
I) Residents will be exposed to protocol driven practices as they related to central line insertion in ICU patients, selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others) (PGY 1, 4, 5)
G) Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large (PGY 1, 4, 5)

CARDIAC SURGERY CORE GOALS AND OBJECTIVES (PGY1, 4)

Through rotation on the thoracic surgery service, junior residents shall attain the following goals:

III. Patient Care (PGY 1, 4)

A. Preoperative Care Setting: outpatient clinic and inpatient service (primary and consultation)

Residents will evaluate and develop a plan of care for patients in the preoperative and post-operative settings. The plan shall include any intervention(s) that will successfully prepare a patient for surgery as well as facilitate their recovery from surgery.

i) The resident will perform complete and detailed and history and physical examinations of patients being considered for elective as well as urgent/emergent surgery

ii) The resident will learn to obtain and interpret laboratory and radiologic tests that are appropriate for the condition being treated and/or the procedure being planned

iii) The resident will demonstrate an understanding of the principles of preoperative patient selection and optimization (comorbidities, medications, appropriate preoperative testing with specific emphasis on preoperative cardiopulmonary testing)

iv) The resident will participate in the informed consent process for patients being scheduled for elective and urgent/emergent procedures or surgeries. The informed consent process includes identifying and reviewing with the patient and/or their family the risks, benefits and alternatives of the planned intervention

B. Operative Care Setting: HVI operating suites

The following are a list of “core” operations that the resident(s) can be expected to have exposure to by the completion of their cardiac surgery rotation

Sternotomy for mediastinal access
CABG (PGY1, 4)
Tricuspid, aortic, mitral valve replacement (PGY 1, 4)
Robotic Mitral valve replacement with or without Cox-MAZE (PGY 1, 4)

The list of “advanced” operations being that residents can be expected to have exposure while on the cardiac surgery rotation:

Ascending aortic aneurysm repair with tube graft/hemi-arch replacement (PGY 1, 4)
Heart Transplantation (PGY 1, 4)
Robotic atrial myxoma resection (PGY 1, 4)

C. Postoperative Care Setting: outpatient surgery center, inpatient floor, outpatient clinic **(PGY 1, 4)**

Residents shall develop and follow through with a post-operative plan of care for the patient who has undergone surgery. This plan generally focuses on, but is not limited to: pain control; identification and treatment of common post-operative complications including bleeding, infection, sepsis, identification of discharge appropriate patients and coordination of care as they transition back to home following their surgery/procedure.

4. Outpatient surgery center

A) The resident will follow up on any and all pertinent post-operative tests, imaging studies prior to discharging a patient who has undergone an elective, same day procedure

B) The resident will successfully choose an oral analgesic home regimen that will adequately manage a patient's pain who has undergone an elective, same day procedure

C) The resident will successfully complete and review with the patient who has undergone an elective, same day procedure their discharge instructions. Key points will include activity restrictions, wound care/drain instructions and reconciliation of the patient's medication list

D) The resident will successfully coordinate appropriate surgical follow up

5. Inpatient floor

A) The resident team is expected to make morning rounds on the inpatient cardiac patient list (including the consult service) prior to the start of the day's activities (OR cases, clinic).

B) After rounds, the resident is expected to call the attending physician of record to review the plan of the day for each individual patient. Common issues to be discussed should include vital signs (including pain control), Is/Os, physical exam findings, daily labs, medication review, consultant recommendations, CXR findings, chest tube output. The daily plan will generally consist (among others) of identifying possible discharge appropriate patients, advancement of diet, repletion of electrolyte abnormalities, adjustment of medications, drain and tube management, need for diagnostic tests to be ordered or new consults to be called

C) The resident will perform the day's work in a manner that is as efficient as possible. Priority should be given to obtaining and following up on important studies expeditiously as well as discharges.

6. Out-patient clinic

A) When circumstance allows, residents will see patients on whom they performed surgery for their 1st outpatient post-operative follow up visit.

This will provide for continuity of care that will allow the resident to gain an understanding of the anticipated normal recovery from the various core procedures listed above as well as gain experience in identifying instances in
which deviation from the norm is occurring as how such instances are approached/managed

B) Residents will see patients who are in longitudinal surveillance of their disease following their surgical intervention. This experience will provide the resident with an initial exposure to the ongoing care of patients even after their operation is performed

IV. Medical Knowledge (PGY 1, 4)

Resident fund of knowledge will be expanded through a variety means, some of which are structured and others of which require independent initiative from the residents who are rotating on the service. These include: 1) Conferences, 2) Journal club 3) Assigned readings 4) Truelearn quizzes

A. Conferences: Residents are expected to attend weekly Wednesday morning morbidity and mortality conference. Complications from the thoracic service are to be presented by the resident who was involved in the case in front of a group of their peers as well as the surgical faculty at large. This conference will give residents an opportunity to think critically about specific steps in the preoperative workup, operative conduct and/or post- operative care of patients who have experienced a complication and identify opportunities for alternative decisions in similar, future cases that may lead to improved outcomes. Evidenced based practice patterns should be emphasized when applicable

B. Journal Club: Residents are expected to participate in monthly journal clubs as part of the Wednesday morning didactic curriculum

C. Assigned Readings: Residents will cover various topics related to various Core and Advanced Diseases/Conditions as part of their assigned weekly reading curriculum through the program at large. The SCORE curriculum is the chosen curriculum for the general surgery residency.

D. Residents are expected to complete TrueLearn quizzes that are assigned by the program director or program manager in a timely manner. Areas of
deficiency as defined by their performance on the TrueLearn quizzes should serve as the focus for future study plans.

VII. Practice-based Learning (PGY 1, 4)

Residents are expected to engage in critical self-review as it relates to the cases in which they participate, whether it be in the operating room, on the wards or in the outpatient setting.

1. Morbidity & Mortality Conference – Discussion should center on

an evidence based discussion of quality improvement

2. Residents shall keep logs of their cases and track their operative proficiency as gauged by whether they assisted or were the surgeon junior or senior or teaching assistant

3. Residents shall distribute operative cards to attendings with whom they have performed cases so that they can be filled out and placed into said resident's Clinical Competency Committee (CCC) folder

4. Residents shall familiarize themselves with evidence based guidelines related to disease/injury prevention, patient safety and quality (SCIP measures) as well as hospital specific matters related to safety and quality (NSQIP data, QITI data, pharmacy formularies for hospital acquired infections, isolation precaution measures)

VIII. Interpersonal and Communication Skills (PGY 1, 4)

The cardiac service provides unique opportunities for residents to develop their interpersonal and communication skills, both in the context of physician to patient interactions as well as in interactions as part of the health care delivery team.

F. Residents will be given the opportunity to observe and eventually participate in the process of delivering bad news to patients and their families/friends. These opportunities exist in the outpatient as well as the inpatient setting.

G. Residents will also be called upon to communicate the daily plan and progress of patients admitted to the hospital to patients, their family and the entire healthcare team involved in the care of that particular patient. The healthcare team will include nurses, therapists, care managers, APPs and other physicians serving as consultants

H. Residents shall learn to document their practice activities in such a manner that is clear, concise and in accordance with the standards of medico-legal documentation

I. Residents shall participate in the informed consent process for patients being scheduled for elective and emergent/urgent procedures or surgery

J. Residents shall learn to give and receive detailed sign-out to facilitate continuity of care during handoffs

IX. Professionalism (PGY 1, 4)

The cardiac surgery rotation offers many opportunities for residents to hone their skills as they relate to professionalism.

G. Residents will have opportunities to learn how to be honest and sincere with patients. Examples include breaking bad news and

explaining surgical complications

H. Residents shall demonstrate a commitment to the continuity of care of a patient within the confines of the 80-hour duty restrictions

I. Residents shall learn to maintain patient confidentiality

J. Residents will learn the importance of accurate medical documentation

K. Residents will be expected to adhere to the hospital's code of professional conduct as it relates to appearance and dress

L. Residents will be expected to be punctual and prepared for all cases, clinics and conferences that they are participating in on any given day

X. **Systems-based practice (PGY 1, 4)**

The cardiac surgery rotation provides residents with inpatient and outpatient opportunities to grow within the systems based practice core competency.

D. Residents will learn to practice high quality cost effective, evidence based patient care. This knowledge will be gained through participation in the conferences listed above in the medical knowledge competency and include the M&M, case conferences and journal clubs (see discussion about each of these above)

E. Residents will be educated about and held accountable for compliance with the surgical care improvement project (SCIP) standards as they relate to the perioperative care of thoracic surgery patients and include but are not limited to reducing surgical site infection(s) through the appropriate use and choice of perioperative antibiotics; eliminating or reducing catheter associated urinary infections by early removal of indwelling catheters from post-operative patients; learning best practice guidelines for reducing catheter associated infections upon central venous catheter (CVC) insertion

F. Residents will be exposed to protocol driven practices as they related to selection of antibiotics for hospital acquired infections based on institution specific resistance patterns, blood transfusion criteria, and observation of contact precautions for patients with multidrug resistant infections (among others)

G. Residents will be educated about the National Surgical Quality Improvement Project (NSQIP) measures and outcomes and how they relate to the changing landscape of reimbursement patterns for individual providers and hospital systems at large

RESIDENT SALARY 2022-2023

PGY 1 - $55643.00

PGY 2 - $57707.00

PGY 3 - $59571.00

PGY 4 - $61684.00

PGY 5 - $63836.00

POLICIES

ACADEMIC DISCIPLINE AND DISMISSAL POLICY

The Department of Surgery programs (General Surgery and Plastic Surgery) will follow the WVU School of Medicine GME and ACGME policy on academic discipline and dismissal. This policy is derived from the SOM/GME by-laws which can be found at https://medicine.hsc.wvu.edu/media/363881/gmebylawsrevised-1-15-16-oct2017-21318-2-repaired.pdf.

The Department of Surgery may take corrective or disciplinary action including dismissal for cause, including but not limited to the following circumstances:
- Unsatisfactory academic or clinical performance
- Failure to comply with the policies, rules, and regulations of the SOM/GME by-laws House Officer Program, University or other facilities where the House Officer is trained
- Revocation or suspension of license
- Violation of federal and/or state laws, regulations, or ordinances
- Acts of moral turpitude
- Insubordination
- Conduct that is detrimental to patient care
- Unprofessional conduct.

Corrective or disciplinary actions may include but not limited to:
- Issue a warning or reprimand

- Impose terms of remediation or a requirement for additional training, consultation or treatment

- Institute, continue, or modify an existing summary suspension of a House Officer's appointment

Terminate, limit or suspend a House Officer's appointment or privileges

- Non-renewal of a House Officer's appointment

Dismiss a House Officer from the House Officer Program; or

- Any other action that the House Officer Program deems is appropriate under the circumstances.

A. Level I Intervention:

Oral and/or Written counseling or other Adverse Action:

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

B. Level II Intervention:

Probation/Remediation Plan or other Adverse Action:

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

C. Level III intervention:

Dismissal and/or Non-reappointment:

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

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

B. Conduct which directly and substantially impairs the individual's fulfillment of institutional responsibilities, including but not limited verified instances of sexual harassment, or of racial, gender-related, or other discriminatory practices.

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

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

E. Substantial and manifest neglect of duty.

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

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

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

DISIPLINE POLICY – DEPT. OF SURGERY

Administrative responsibilities including accurate and timely documentation are vital to the practice of medicine. Not only in regards to patient care but also in the maintenance of the Surgery Residency Program. Throughout the surgery residency there are numerous administrative tasks in addition to documentation that must be completed. Failure to do so violates the essence of Professionalism, one of the six core competencies. These tasks include:
1) weekly recording of duty hours, 2) monthly updates of Operative Logs, 3) yearly CBL's, 4) reporting for semi-annual evaluation with the program director, 5) completion of USMLE Step III, 6) Employee Health requirements 7) completion of assigned ABSITE topic summaries, 8) fulfilling research requirements, 9) completion of SCORE and 10) completing dictations with in the allotted time frame.

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

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

may return to full clinical status. If vacation days were required, this will be communicated to the Program Director and a note placed into the residents file. Residents accruing three Administrative leaves in any one PGY year or five during their residency, will proceed to the next step.

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

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

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

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

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

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

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

USMLE/WV STATE MEDICAL LISCENCE:
Failure to complete the USMLE Step III exam by Dec 31st of the residents PGY II year results in immediate Academic Probation.

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

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

ACADEMIC GREIVANCE POLICY AND PROCEDURE

Purpose. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes and complaints, which may arise between postgraduate residents and fellows and their Program Director or other faculty member. The Department of Surgery abides by this Policy, which was derived from the WVU/GME website by-laws at https://medicine.hsc.wvu.edu/media/363881/gmebylawsrevised-1-15-16-oct2017-21318-2-repaired.pdf.

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

Definitions

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

Procedure

A. Level I Resolution

A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within 10 working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence that supports the grievance. Within ten (10) working days after notice of the grievance is received by the Program Director, the resident/fellow and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in

writing of the final decision. This should occur within 5 working days after the meeting between the resident/fellow and Program Director. A copy of the Program Director's final decision will be sent to the Department Chair and to the Designated Institutional Official for GME (DIO).

B. Level 2 Resolution

If the Program Director's final written decision is not acceptable to the aggrieved resident/fellow, the resident/fellow may choose to proceed to a Level 2 resolution, which will begin with the aggrieved resident/fellow notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the Program Director's final decision. If the Department Chairman is also functioning as the Program Director, then the Level 2 resolution will be handled by the DIO. If the aggrieved resident is a Transitional Year resident, then the DIO will appoint;

a. Department Chairman to handle the Level 2 grievance. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence that supports the grievance. Within ten (10) working days of receipt of the grievance, the resident/fellow and the Department Chairman or DIO will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Level II of this grievance procedure will be deemed complete when the Department Chairman (or DIO) informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days of the meeting with the resident/fellow and the Chairman. Copies of this decision will be kept on file with the Program Director, in the Chairman's office and sent to the DIO.

C. Level 3 Resolution

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

D. The Grievance Committee

Upon request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents, and three Program Directors. No

members of this committee will be from the aggrieved resident's/fellow's own department. The DIO will choose a faculty member appointed to the Grievance Committee to be the chair of the committee. The Grievance Committee hearing should occur within 20 working days from receipt of the Level III grievance.

E. Grievance Committee Procedure

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

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

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

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

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

F. Confidentiality

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

Conditions for Reappointment:

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

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

ACGME CASE LOG DIRECTIONS

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

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

If you need additional information or help please contact Linda Shaffer at 293-1254.

AFFIRMATIVE ACTION AND EQUAL EMPLOYMENT OPPORTUNITY BOG TALENT AND CULTURE RULE 3.2

SECTION 1: PURPOSE & SCOPE.

1.1 This Rule sets forth the West Virginia University Board of Governors' Affirmative Action and Equal Employment Opportunity Policy.

SECTION 2: POLICY STATEMENT.

2.1 The West Virginia University Board of Governors reaffirms its commitment to the full realization of Affirmative Action and Equal Employment Opportunity in its employment practices.

2.2 It is the policy of the West Virginia University Board of Governors to:

2.2.1 Recruit, hire, train, promote, retain, tenure, and compensate persons in all applicable administrative, Classified, Faculty, Non-Classified, and Student job titles without regard to age, ethnicity, disability status, national origin, race, religion, sex, sexual orientation, protected veteran status, or any other class protected under the University's non-discrimination policy (BOG Policy 44, or successor Rule), unless otherwise prohibited by applicable law;

2.2.2 Base decisions of employment to further the principles of affirmative action and equal employment opportunity;

2.2.3 Ensure that promotion, reappointment and tenure decisions are in accordance with the principles of affirmative action and equal employment opportunity by imposing only valid requirements for promotional, reappointment and tenure opportunities;

2.2.4 Ensure that all personnel action including compensation, benefits, reduction in force, recall, training, education/tuition assistance, social and recreational programs will be administered without regard to age, ethnicity, disability status, national origin, race, religion, sex, sexual orientation, protected veteran status, or

any other class protected under the University's non-discrimination policy (BOG Policy 44, or successor Rule), unless otherwise prohibited by applicable law.

SECTION 3: DEFINITIONS.

3.1 All defined terms for this Rule are contained within the Definitions Section of Board of Governors Talent & Culture Rule 3.1, unless the text clearly indicates a different meaning.

SECTION 4: DELEGATION.

4.1 The Board of Governors delegates to the Vice President for Talent and Culture the ability to adopt internal human resource policies and procedures in order to implement the provisions of this Rule. Any actions taken pursuant to this delegation must be consistent with the guidelines provided by this Rule.

SECTION 5: AUTHORITY.

5.1 W. Va. Code §18B-l-6, §18B-2A-4.

SECTION 6: SUPERSEDING PROVISIONS.

6.1 This Rule supersedes and replaces Higher Education Policy Commission ("HEPC") Series 40 (W. Va. Code R. §§ 133-40-1 to -2), which was adopted November 6, 2013, and any other Rule of the HEPC which relates to the subject matter contained within this Rule. This Rule also repeals and supersedes WVU BOG R. 34 - Affirmative Action and Equal Employment Opportunity, which was adopted on June 2, 2006, and any other Human Resources policy or procedure which relates to the subject matter contained within this Rule

Effective September 28, 2017

APPROPRIATE USE OF THE INTERNET, ELECTRONIC NETWORKING POLICY AND OTHER MEDIA

These guidelines apply to all resident physicians and resident dentists enrolled in a program administered by the West Virginia University School of Medicine. Use of the Internet includes but may not be limited to posting on blogs, instant messaging [IM], social networking sites, e-mail, posting to public media sites, mailing lists and video-sites. These guidelines apply whether using public or private devices and computers.
Background: Social and business networking Web sites or on-line communities are being used increasingly by faculty, students, residents and staff to communicate with each other, and to post events and profiles to reach external audiences. As part of the sponsoring institution's commitment to building a community in which all persons can work together in an atmosphere free of all forms of harassment, exploitation, or intimidation, resident physicians and resident dentists are expected to act with honesty, integrity, and respect for the rights, privileges, privacy, sensibilities, and property of others.

The capacity to record, store and transmit information in electronic format brings responsibilities to those working in healthcare with respect to privacy of patient information and ensuring public trust in our participating hospitals, institutions and practice sites. Significant educational benefits can be derived from this technology but physicians need to be aware that there are also potential problems and liabilities associated with its use. Material that identifies patients, institutions or colleagues and is intentionally or unintentionally placed in the public domain may constitute a breach of standards of professionalism and confidentiality that damages the profession and our institution. Guidance for resident physicians and resident dentists in the appropriate use of the Internet and electronic publication is necessary to avoid problems while maintaining freedom of expression. The sponsoring institution is committed to maintaining respect for patient privacy. Compliance with these guidelines help our residents obtain skills with the ACGME competencies of Interpersonal Communication Skills (ICS), Professionalism (P), and Systems Based Practice (SBP).

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

General Guidelines for Safe Internet Use:
These Guidelines are based on several foundational principles:

- The importance of privacy and confidentiality to the development of trust between the physician and patient,
- Respect for colleagues and co-workers in an inter-professional environment,
- The tone and content of electronic conversations should remain professional.
Individual responsibility for the content of blogs.
- The permanency of published material on the Web, and
- That all involved in health care have an obligation to maintain the privacy and security of patient records under HIPAA (Health Insurance Portability and Accountability Act of 1996)

a) Posting Information about Patients

Never post personal health information about an individual patient. Personal health information has been defined in the HIPAA as any information about an individual in oral or recorded form, where the information identifies an individual including but not limited to name, medical record number, birth date, and demographic data.

These guidelines apply even if the individual patient is the only person who may be able to identify him or herself on the basis of the posted description or image. Residents should ensure that anonymous descriptions do not contain information that will enable any person, including people who have access to other sources of information about a patient, to identify the individuals described. Photographs of patients should not be posted on the internet. Even completely de-identified information about patients should not be posted on any public site.

There is a legitimate public perception that open listings on any private health information, no matter how disguised, lacks professionalism.

b) Posting Information About Colleagues and Co-Workers

Respect for the privacy rights of colleagues and coworkers is an important part of an inter-professional working environment. If you are in doubt about whether it is appropriate to post any information about colleagues and co-workers, ask for their explicit written permission. Making demeaning or insulting comments about colleagues and co-workers to third parties is considered unprofessional behavior. Such comments may also breach the University's codes of behavior regarding harassment.

c) Professional Communication with Colleagues and Co-Workers

Respect for colleagues and co-workers is important in an inter-professional working environment. Addressing colleagues and co-workers in a manner that is insulting, abusive or demeaning is considered unprofessional behavior.

d) Posting Information Concerning Hospitals or other Institutions

Comply with the current institutional policies with respect to the conditions of use of technology and of any proprietary information such as logos or mastheads. Postgraduate trainees must not represent or imply that they are expressing the opinion of the organization. Residents should consult with the appropriate resources such as the Public Relations Department of the sponsoring institution, Graduate Medical Education Office, or their program director who can provide advice in reference to material posted on the Web that might identify the institution.

e) Offering Medical Advice

Do not misrepresent your qualifications or offer medical advice through electronic means listed in these guidelines.

f) Use of social networking sites and blogs

Residents should keep all web postings professional and in accordance with the standard ethical practices of being a resident physician or a resident dentist. Residents should:

1. Not report or confirm official medical activities or personal health information of patients,
2. Not require patients to participate in these activities to influence or maintain the patient-physician relationship,
3. Not electronically friend patients even if they make the request,
4. Not review patient profiles,
5. Not participate in groups with explicit sexual content or opinions that might offend or compromise the patient-physician relationship,
6. Use appropriate discretion for posting personal communications for friends, colleagues, or family knowing that these may be viewed by patients,
7. Not present their opinions or themselves as agents of West Virginia University or the School of Medicine.

Penalties for inappropriate use of the Internet

The penalties for inappropriate use of the Internet include but may not be limited to:
-Remediation, probation, suspension, dismissal or failure to promote or renew by the sponsoring institution
-Prosecution by law enforcement under the requirements of HIPAA.

Enforcement

All professionals have a collective professional duty to assure appropriate behavior, particularly in matters of privacy and confidentiality. A person who has reason to believe that another person has violated these guidelines should approach his/her immediate supervisor/program director for advice. If the issue is inadequately addressed, he/she may complain in writing to the DIO (Designated Institutional Official) for Graduate Medical Education (or Dental equivalent) with the sponsoring institution. Appeals of actions taken for violation of these guidelines shall follow the standard academic grievance processes approved by the GMEC of the sponsoring institution.

All other questions should be directed to Information Technology Services at ITS@hsc.wvu.edu, 304.293.4683.

To view the “HSC ITS Social Networking Sites, Blogs & Instant Messaging Policy” please visit: http://its.hsc.wvu.edu/policies/hsc-its-social-networking-sites-blogs-instant-messaging-policy

ATTENDANCE & PUNCTUALITY & LEAVE Policy

The presence of each resident, when scheduled, is essential for education and providing patient care. The program recognizes that a resident may occasionally become ill or encounter emergencies and be unable to report to work.
The American Board of Surgery now requires all absences, vacations, meetings, and interview days to be recorded on the application for the qualifying exam. **A minimum**

of 48 weeks of full-time surgical experience is required per residency year.

Procedure for Reporting Absences
Prior to the beginning of his or her shift (unless not feasible to hospitalization, etc) or immediately if the resident becomes ill or is unable to work for any reason while at work, the resident is required to:

1) Contact the program director, Dr. David Borgstrom by text or call at 607-282-0754

2) Contact the chief admin resident and the chief resident of service.

3) Contact by text or leave a voice mail message for Residency Program Administrator, Linda Shaffer 293-1254/cell 304-288-6947.

4) Contact the service faculty or chief faculty of the service to make them aware of potential coverage changes for the day.

Tardiness
Showing up late to work (>15 minutes after start shift or sign out) will be monitored. Reports of tardiness will be confirmed with the resident. Recurrent unexcused offenses will be subject to disciplinary action and notation of concern of professionalism in the resident's file.

Failure to do so may result in disciplinary actions.

- Detailed information regarding leave can be found at https://policies.wvu.edu/finalized-bog-rules/bog-talent-and-culture-3-5-employee-leave

Excessive/unexplained absences may affect your competency evaluation, promotion to the next level of training, and/or application to the American Board of Surgery.
Untimely notification of absence, if the resident is not hospitalized (IE after the start of shift), will count as a failure to report the absence and is subject to disciplinary action.

Core Competencies: Professionalism **(Prof)**, System Based Practice **(SBP)**, Interpersonal and Communication Sills **(ICS)**
Events warranting submission
- Late arrivals when on call either during the day, night or 24 hours.

How to Submit
- Log in to eValue
- Select Evaluations → Initiate Ad hoc Evaluations

West Virginia University
Surgery Residency
Program ID:709

Home | Evaluations | Time Tracking | Case Logs | Reports

Evaluation Management

Initiate Ad hoc Evaluations

Select an evaluation type: Concern Card About A Trainee
Who would you like to evaluate? {Select a Subject}
Activity: {Select Activity}
Time Frame: {Select a Time Frame} Sort By Name

Next -->

BACK-UP CHIEF POLICY

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

2. This policy applies to weekdays from 6:00pm to 6:00am and weekends/holidays 6:00am-6:00am.

3. There will be a chief resident (PGY 4 or 5) in house at all times.

4. There will be a published back-up chief call schedule.

5. All off hour cases will be performed by the appropriate level resident. When possible, the PGY-3 resident will also scrub on all senior level cases with the Chief resident.

6. When the in-house chief is required to go to the OR during off hours a discussion will be held with the operating attending prior to beginning the case. Should it be deemed that the case is of such a critical nature that the chief resident's absence would be a detriment to the patient; the back-up chief will be called in from home. If the back-up chief happens to be of the same service as the operating attending, that chief has first option to perform the case to maintain continuity of care. Otherwise, it will be at the in-house chief's purogative to perform the case or pass it to the back-up chief.

Otherwise, when the in-house chief goes to the OR and a P2 Trauma is paged, the PGY-2/3 resident will immediately report to the OR to relieve the chief resident. The chief will break scrub and report to the trauma. After an assessment is made and plan established, the chief will return to the OR and the PGY- 2/3 resident will take over directing the trauma resuscitation.

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

Revised 5/2009

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

CASE LOG POLICY

It is the responsibility of each resident to keep their logs up to date. All cases are logged into the ACGME website. Please see Linda Shaffer if you have forgotten your password or have questions regarding this site.

Operative logs are monitored each month by the program director and Program Education Committee (PEC). If cases are not logged and kept current, the resident will be placed on Administrative leave (please refer to the Department Discipline Policy). Surgical case logs must be completed and available for the entire program upon graduation. No certifications will be issued until all case logs are completed and the final surgical record signed.

It is mandatory that cases be logged throughout the continuum of the resident's surgical training. It is *not* acceptable to log the minimal number of required cases and stop recording cases.

Cases done at the VA Hospital *MUST* be logged in while at the VA. Arrangements cannot be made to retrieve cases after you have completed your rotation and turned in your security codes. *NO* VA patient data will be removed from the VA Hospital premises.

The ACGME requires case logs to be submitted by preliminary residents as well.

CLINICAL COMPETENCY COMMITTEE (CCC) POLICY

Scope: ACGME-accredited Surgery Residency Program sponsored by the West Virginia University School of Medicine.

Background: The assessment of trainees by the Clinical Competency Committee (CCC) is a key element of the Next Accreditation System (NAS). The CCC is designed to bring insight and perspectives of a group of faculty members to the trainee evaluation process. The CCC also serves as an early warning system if a trainee fails to progress in the educational program, and assists in his/her early identification and move toward

improvement and remediation.

Policy: The program director must appoint a CCC, and develop and maintain a written description of the CCC's responsibilities, including charge, membership and procedures [Common Program Requirements V.A.1. & V.A.1.b)]. This policy must be provided to the GME Office by entering into the Program Portfolio.

Membership: The CCC must be composed of at least three faculty members, one of whom may be the program director, who have the opportunity to observe and evaluate trainees [Common Program Requirement V.A.1.a)]. Faculty members should represent all major training sites and should include both junior and senior faculty.

Other members of the CCC may include other physician faculty members from the same program or other programs, or health professionals (e.g., nursing staff, physician assistants) who have extensive contact and experience with trainees in patient care and other health care settings [Common Program Requirement V.A.1.a)(1)(a)].

Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the CCC [Common Program Requirement V.A.1.a)(1)(b)]. Residents who do not meet all of the above criteria, including chief residents in the accredited years of the program, may not serve as CCC members or attend CCC meetings.
The chair of the committee may be either the program director or a faculty member appointed by the program director or voted on by the committee, depending on the program's Review Committee requirements.

Program Administrators may attend CCC meetings to provide administrative support and help document CCC deliberations and decisions. However, program administrators may not serve as members of the CCC. Charge: The members of the CCC are expected to provide honest, thoughtful evaluations of the competency level of trainees. They are responsible for reviewing all assessments of each trainee at least semiannually, and for determining each trainee's current performance level by group consensus [Common Program Requirement V.A.1.b).(1).(a)]. The Surgery program schedules meetings more frequently due to the size of the program. The CCC consensus decision will initially be based on existing, multi-source assessment data and faculty member observations. The CCC will use the Milestone evaluations to inform this process.

The committee must prepare and ensure the reporting of Milestones evaluations of each trainee to the ACGME semiannually in December and June [Common Program Requirement V.A.1.b).(1).(b]). Milestones evaluations must be submitted by the program director or designee(s) via the Accreditation Data System (ADS) website.

The committee is responsible for making recommendations to the program director on promotion, remediation and dismissal based on the committee's consensus decision of trainees' performance [Common Program Requirement V.A.1.b).(1).(c)].2 However, the program director has final responsibility for the evaluation and promotion of trainees.

The committee should inform, where appropriate, the Program Education Committee (PEC) of any potential gaps in curriculum or other program deficiencies that appear to result in a poor opportunity for trainees to progress in each of the Milestones.
The program director or designee(s) must provide feedback to each trainee regarding

his/her progress in each of the Milestones. This feedback is sent to the trainee by email and must be documented in the trainee's file.

The committee is also responsible for providing feedback to the program director on the timeliness and quality (e.g., rating consistency and accuracy) of faculty's documented evaluations of trainees, in order to identify opportunities for faculty training and development.

Finally, the committee is responsible for giving feedback to the program director to ensure that the assessment tools and methods are useful in distinguishing the developmental levels of behaviors in each of the Milestones.

Confidentiality: Proceedings of CCCs are protected by the Department of Surgery. As such, all records generated by the committee as a result of its deliberations are confidential.

Guidelines: The following guidelines are recommended for conducting the CCC review process:

The committee must meet at least semiannually, to review all resident in program and can meet more often for a larger program.

1. Meetings should be kept to two hours or less.
2. The chair serves to guide the committee in its work to provide a consensus decision for Milestones evaluations.
3. Committee members must be oriented to each assessment tool and its relationship to the Milestones evaluations.
4. All committee members are required to participate in committee deliberations regularly (at least 75% of all meetings).
5. Review of each trainee's evaluations should be assigned to specific committee members. Committee members are responsible for: a. Reviewing all evaluations (e.g., faculty, peer, healthcare professionals, operative, patient evaluation, multisource assessments, ACGME case/activity experience logs, duty and clinic hour reports, curriculum performance (SCORE/TWIS/True Learn), in-service exam scores) and performance data for the last six months of training in advance of the meeting, and complete a brief report card to bring to the meeting.
6. The committee must form a consensus Milestones evaluation based on member reviews and the committee's discussion for each trainee.
7. All academic actions, including remediation and dismissal, will be reported to the GME Office.

Resources: ACGME Common Program Requirements (effective July 1, 2015)
ACGME NAS FAQ:

Clinical Competency Committees and Program Evaluation Committees
West Virginia University, Department of Surgery: Effective: 07/1/2019, Linda Shaffer.

CODE OF PROFESSIONALISM

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

The nine primary areas of professionalism are defined as:

- Honesty and Integrity
- Accountability
- Responsibility
- Respectful and Nonjudgmental Behavior
- Compassion and Empathy
- Maturity
- Skillful Communication
- Confidentiality and Privacy in all patient affairs
- Self-directed learning and appraisal skills

Honesty and Integrity

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

Accountability

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

Responsibility

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

Respectful and Nonjudgmental Behavior

- Consistently courteous and civil to all
- Tolerates diversity in culture, country of origin, gender, sexual orientation, religious preference, political views, age, ethnicity, and race
- Works positively to correct misunderstandings

- Listens before acting
- Considers others' feelings, background, and perspective
- Realizes the value and limitations of one's own beliefs, and perspectives
- Strives not to make assumptions

Compassion and Empathy

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

Maturity

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

Skillful Communication

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

Confidentiality and Privacy in all patient affairs

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

Self-directed learning and appraisal skills

- Demonstrates the commitment and ability to be a lifelong learner
- Accomplishes tasks without unnecessary assistance and continues to work and value the team
- Completes academic and clinical work in a timely manner

- Is honest in self-evaluation of behavior, performance, skills, knowledge, strengths, weaknesses, and limitations, and suggests opportunities for improvement
- Is open to change
- Completes in-depth and balanced, self-evaluations on a periodic basis

COMMON GME POLICIES LINK

https://medicine.hsc.wvu.edu/gme/gme-policies/

CONFERENCE, ATTENDANCE & CURRICULUM

ACGME - II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core) The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program;

The program director along with the faculty, will be responsible for the preparation and implementation of a comprehensive, effective, and well-organized educational curriculum; (Core)

(II.A.4.t) ensure that conferences be scheduled to permit resident attendance on a regular basis, and resident time must be protected from interruption by routine clinical duties. Documentation of attendance by 75% of residents at the core conferences must be achieved; (Detail)

> *All surgical residents are required to attend conference each week to include VA MDTV, exceptions are: vacation, post call or approval from the program director to scrub in on a case that is deemed necessary for the resident to have required experience.

(II.A.4.t) ensure that the following types of conferences exist within a program:

II.A.4.u).(1) a course or a structured series of lectures that ensures education in the basic and clinical sciences fundamental to surgery, including technological advances that relate to surgery and the care of patients with surgical diseases, as well as education in critical thinking, design of experiments and evaluation of data; (Detail)

II.A.4.u).(2) regular organized clinical teaching, such as grand rounds, ward rounds, and clinical conferences; (Detail)

II.A.4.u).(3) a weekly morbidity and mortality or quality improvement conference. (Core)

***Attendance is managed for all conferences each week by a mobile Google app method, available to all residents, faculty and guests attending. Residents are given their attendance each quarter.**

2022-2023 Conference /Curriculum Schedule updated 6.24.2022

	7:00-8:00	8:00-8:45	8:45-9:30	9:30 – 10:15	10:15-11:00	11:00-11:45
July 6	M&M	**Grand Rounds** **David Borgstrom, MD** *"A Surgeons Tool Box"*	**TWIS** **Cyndy Graves, MD** *Ventral /Misc Hernia*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
13	M&M	**Grand Rounds** **Alice Race, MD** *It's Just Not a Hernia – When Simple Turns to Complex*	**TWIS** **Lauren Dudas, MD** *Preoperative Evaluation Part 2/2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
20	M&M	**Grand Rounds** **Marguerite Ballou, MD** *HIPPA and WVU Policy in the Age of Social Media*	**TWIS** **Amanda Palmer, MD** *Fluids and Electrolytes*		Research Meeting	
27	M&M	**Grand Rounds** **Salim Abunnaja, MD** *The Food We Eat: Amazing Things I have Learned in and Endless Journey of Exploration*	**TWIS** ***Gregory Schaefer, DO*** *Transfusion and Coagulation*	SIM: Difficult Convo PGY 1-2 **Lauren Dudas, MD**	SIM: basic knot tying/instrument identification PGY3,4,5 **Lauren Dudas, MD**	**Resident Meeting**
Aug 3	M&M	**Grand Rounds** *Alison Wilson, MD*	**TWIS** *Alice Race, MD* *Abdomen*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
10	M&M	**Grand Rounds** *Emily Groves, MD*	**TWIS** *Surg Oncology* *Liver*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
17	M&M	**Grand Rounds** *Molley Keldzik, MD*	**TWIS** *Amanda Palmer, MD* *Wound Healing and Soft Tissue Trauma*	SIM: Difficult Convo PGY 3-5 **Lauren Dudas, MD**		
24	M&M	**Grand Rounds** *Greogry Schaeffer, DO*	**TWIS** *David Borgstrom, MD* *Inguinal and Femoral Hernias*			
31	M&M	**Grand Rounds** *Sabastian Brooke*	**TWIS** *David Borgstrom, MD* *Surgical Infection*	Mentoring-Work/Life Balance **David Borgstrom, MD**	Journal Club	Resident Meeting
Sept 7	M&M	**Grand Rounds** **Visiting Physician**	**TWIS** *Surg Oncology* *Spleen*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
14	M&M	**Grand Rounds** *Brian Boone, MD*	**TWIS** *Ethics, Part 1 of 2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
21	**Covey Lecture** **Samuel Wells, MD**		*Resident Case Presentations*	**TWIS** Surg Oncology Esophagus 1 of 3	Mentoring – Burnout	
28	M&M	**Grand Rounds** *Frederico Siefarth, MD*	**TWIS** *Pediatrics Part 1 of 4*	SIM: Team Communication	**Research Meeting** David Borgstrom, MD Lauren Dudas, MD	Resident Meeting
Oct 5	M&M	**Grand Rounds** **Hannah Hazard-Jenkins, MD**	**TWIS** Surg Oncology *Soft Tissue Part 1 of 2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
12	M&M	**Grand Rounds** *Riaz Cassim, MD*	**TWIS** *Dr Hill* *Small Intestine, Part 1 of 3*	**PGY-3 Robot Training** Brian Boone, MD	**Fresh Tissue Training Lab** David Borgstrom, MD Daniel Grabo, MD	
19	M&M	**Grand Rounds** *Connie DeLa'O*	**TWIS** *Appendicitis and Diverticulitis*		Journal Club	**Resident Meeting**
26	**Grand Rounds** *Mucha Visiting Professor Lecture*		*Resident Case Presentations*	**TWIS** *Critical Care, Part 1 of 3*	**SIM: Anastomosis Creation** PGY 1-5 Lauren Dudas, MD	**Mentoring** *"Career Guidance"*
Nov 2	M&M	**Grand Rounds** *Alan Thomay, MD*	**TWIS** *Colorectal Surgery* *Colon Cancer*			
9	M&M	**Grand Rounds** *Jack Gelman, MD*	**TWIS** *Colorectal Surgery* *Benign Anorectal, Part 1 of 2*			
16	M&M	**Grand Rounds** *Melissa LoPinto, MD*	**TWIS** *Colorectal Surgery* *Anorectal Neoplasms*	**Research Meeting** David Borgstrom, MD Lauren Dudas, MD		
	Mock ABSITE					

30	M&M	**Grand Rounds** James Bardes, MD	**TWIS** *Breast, Part 1 of 3*	ABSITE PREP	ABSITE PREP	Resident Meeting
Dec 7	M&M	**Grand Rounds** *Roberto Lopez, MD*	**TWIS** Melissa LoPinto, MD *Adrenal*	ABSITE PREP	ABSITE PREP	ABSITE PREP
Dec 14	M&M	***Ugly Sweater Breakfast***		**TWIS** David Borgstrom, MD *Interpersonal Skills Part 3 of 4*	ABSITE PREP	ABSITE PREP
21	M&M	**Grand Rounds** *Cyndy Graves, MD*	**TWIS** *Dysmotility*	ABSITE Prep	ABSITE Prep	Resident Meeting
28	Holiday No conference					
Jan 4	M&M	**Grand Round** *Lauren Dudas, MD*	**TWIS** *Urology* *Retroperitoneal Trauma*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
11	M&M	**Grand Rounds** *Patrick Bonasso, MD*	**TWIS** *Vascular Trauma*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
18	M&M	**Grand Rounds** *Kevin Train, MD*	**TWIS** *Thermal Trauma*	ABSITE Prep	ABSITE Prep	ABSITE Prep
25	M&M	**Grand Rounds** *Daniel Grabo, MD*	**TWIS** *Surg Onclogy* *Organ System Dysfunction, Part 3 of 3*	ABSITE Prep	ABSITE Prep	Resident Meeting
Feb 1	M&M	**Grand Rounds** *Lawrence Tabone, MD*	**TWIS** *Chest Trauma*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
8	M&M	**Grand Rounds** *J. Wallis Marsh, MD*	**TWIS** *Thoracic* *Chest Trauma*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
15	*7:30 – 8:30 2023 Tubman Lecture		8:30 – 9:30 Case Presentations	**TWIS** Vascular *Arterial Occlusive Disease, Part 1 of 3*	Journal Club	Resident Meeting
22	M&M	**TWIS** Vascular *Arterial, Part 1 of 2*	Mock Oral Exams			
Mar 1	M&M	**Grand Rounds** *Kerri Woodberry, MD*	**TWIS** *Vascular* *Arterial, Part 2 of 2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
8	M&M	**Grand Rounds** *Amanda Palmer, MD*	**TWIS** *Vascular* *Cerebrovascular Disease*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
15	M&M	**Grand Rounds** *Dr. Hill*	**TWIS** Colorectal Surgery *Large Intestine: Colitis, Obstruction*	SIM: Advanced Laparoscopy PGY2-5 **Lauren Dudas, MD**		
22	M&M	**Grand Rounds** *Douglas Murken, MD*	**TWIS** Vascular *Venous*			
29	M&M	**Grand Round**	**TWIS** *Thoracic, Part 1 of 2*	SIM: Patient Safety Event PGY 3-5 **Lauren Dudas, MD**	**Research Meeting** David Borgstrom, MD Lauren Dudas, MD	Resident Meeting
Apr 5	M&M	**Grand Rounds** *Carl Schmidt, MD*	**TWIS** *Thoracic, Part 2 of 2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
12	M&M	**Grand Rounds** *Lynsey Biondi, MD*	**TWIS** *Urology*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
19	*7:30-8:30 2023 Morton Lecture		8:30-9:30 Case Presentations	**TWIS** *Esophagus, Part 2 of 3*	SIM: TBD Rib Plating PGY 4&5 ->1:00 pm Faculty 1-4 pm	
26	M&M	**Grand Round** *Chief Resident*	**TWIS** *Pediatric, Part 2 of 4*	**Mentoring**	Journal Club	Resident Meeting
May 3	M&M	**Grand Rounds** *Chief Resident*	**TWIS** *Transplantation/Immunology Part 1*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		
10	M&M	**Grand Rounds** *Chief Resident*	**TWIS** *Transplantation/immunology Part 2*	**Fresh Tissue Training Lab** David Borgstrom, MD, Daniel Grabo, MD		

17	*7:30-8:30 2023 Zimmermann Lecture		8:30-9:30 Case Presentations	**TWIS** Alice Race, MD Esophagus Part 3/3	**Research Meeting** David Borgstrom, MD Lauren Dudas, MD	
24	*M&M*	**Grand Round** *Chief Resident*	WVU/Charleston Mock Oral Exams			
31	M&M	**Grand Round** *Chief Resident*	TWIS *Surg Oncology* *Abdominal Masses, Pain, and Infection*	Journal Club		Resident Meeting
Jun 7	M&M	**Grand Round** *Chief Meeting*	Resident Picnic Day (Asset Course June 9)			
14	M&M	**Grand Round** *Conley Coleman, DO*	**TWIS** *Carl Schmidt, MD* *Interpersonal Skills, 2 of 4*			
21	M&M	**Grand Round** *Nova Szoka, MD*	**TWIS** *ENT* *Head and Neck*	**SIM: Ethical Principles** PGY 1-5 Lauren Dudas, MD		
28	M&M	**Grand Rounds** TBD	**Mentoring** *"Succeeding in Academics"*			Resident Meeting

**** Named Visiting Professor lectures in Green - No M&M Scheduled for this day.***

CLINICAL & EDUCATIONAL WORK HOURS

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

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

Tip: Have a mobile phone or device? Log Work Hours on a handheld device by going to www.e-value.net. No App is necessary. eValue will recognize the mobile device and automatically use the mobile interface. Logging tasks, activity, and hours with the mobile version of eValue is similar to using a desktop. Select the applicable dates using a calendar. A list of entries logged will display and tap on an entry to edit.
Time Tracking > Time Tracking Management > Manage Time > Log Time
Logging Time
Step 1: What are the details of the hours worked? Use the select lists to describe the hours worked.
Task: Select the task that best describes the hours being logged. This list is defined by Program Administrators. Please note that the Task selected will impact how violations calculate for the hours logged; see a Program of Hours Administrator for questions on the task(s) that should be logged.

Activity: Programs may require that an activity be selected. If it is required, not entry can be recorded until an activity is selected. If the scheduled activities only box appears and is checked, then the select box will be limited to those activities that appear on a schedule 60 days in the past and 30 days in the future. Uncheck this box to re-populate the select box will all available activities.

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

Site: Optional field - not all programs track Sites. If the field is included, select the site for the hours being logged. If the scheduled sites only box appears and is checked, then the select box will be limited to those sites that appear on a schedule 120 days in the past and 30 days in the future.
Note: When the Site field precedes the Activity field, the Site selection will filter the list of available activities. The reverse is also true - if the Activity field precedes the Site field, the Activity selection will filter the list of available sites.

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

Start and End Time: Indicate the length of time being logged. If a shift length that exceeds the length permitted has been entered for the training rank and program, additional questions may need to be answered. When the shift length form displays, answer each question and enter a comment before saving the entry.
Enter a comment about the shift (optional): Include a comment with the log entry that will be available to supervisors and administrators.

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

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

Calendar Options and Explanations:
Legend: Log entries are color-coded by Task Type; these colors are described in the legend. All checked types will display in the calendar. Uncheck types to filter the calendar entries by task.
Supervision: There are 3 types of supervision available in eValue: None, Active, and Passive.
None - If Supervision is not used, entries will automatically be accepted and they will display the green check mark icon.

Active - If supervision is set to Active, then the selected supervisor will need to validate the entry before it is accepted. The entry will display a red exclamation icon until the hours are validated. Once it is validated, it will display the green check mark icon. Depending on the program setup, validated entries may not be editable.

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

W**ork Hours calendar:** The calendar will populate will entries logged from the Select Dates calendar. Apply any details from the select box above by clicking on a date in this

calendar. To edit an entry on the calendar, click on the linked task.

Shift Length Violations
When a shift is logged with a length that exceeds the permitted shift length for a training rank, but it is within the allotted time for transitioning patient care, a popup window may ask whether or new patient care responsibilities were assigned during this time:
Depending on the answer and the program's setup, additional questions may be asked about the shift. Shifts logged that exceeded the permitted shift length due to transitioning patient care only will display on the Work Hours calendar with a T:

Shift Break Violations
If consecutive shifts have been logged and are separated by a length of time that is less than the required shift break for a training rank and program, then a comment box may appear explain why there was shortened shift break:

Editing an Entry
To edit an existing entry, click the task name on the calendar in the lower portion of the screen. The Edit Work Hours Entry box will display. Please note, programs that track Supervisors for hours logged have the option to lock entries once they have been validated by a supervisor. If a program is configured this way, entries that appear with the green check mark icon may be unable to edit. The following will display when clicking on the entry:

Deleting an Entry
To delete an entry click on the delete entry icon then click the 'OK' button in the confirmation prompt.

Reviewing Statistics and Violations
Click the View Stats Reports link in the lower-left corner of the logging screen to preview Work Hours Statistics and Violations.

The Time Tracking Trainee Reporting window will open:
Select the date range to review. The report can be run by Calendar Month or a date range specified by the Program Administrator.

C**lick the View Time Tracking Statistics button to continue.**
Statistics for the selected date range will display. Any violations that occurred during the period will display by type, as shown in the example below:

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

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

important to have a thorough understanding of the rules, so that we can stay in compliance.

Duty Hour Program Requirement:
Failure to log Duty Hours 2 weeks with in a single month constitutes one violation. Two violations over 2 months will place the resident on Administrative leave.

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

Each resident will log his or her hours into the E-value, online system at www.e-value.net. You will be given a login name and password. If you should forget your name or password please contact the Residency Administrator, Linda Shaffer at 293-1254.

Weekly periods run from Monday through Sunday. The hours are to be logged in upon completion of their Sunday shift. The hours will be retrieved by the program on Monday and compiled. Off-service residents should also record their hours. The administrative chief also monitors resident compliance of duty hours who is responsible for overseeing that all hours are reported in a timely fashion.

CRISIS OF SUDDEN DEATH GUIDELINES FOR A RESIDENT/FELLOW

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

GME Crisis Team and Communication

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

on the crisis. When appropriate, the crisis response team

will notify and/or contact:

1. Resident(s)/Fellow(s)
2. The residency/fellowship program of interest including the chair and program director (see Appendix 1 for sample communications)
3. Family members
4. General counsel for health sciences

5. Risk Manager/Privacy Officer
6. Director, Communications & Marketing, School of Medicine Administration
7. Hospital chaplain
8. WVU Police
9. The home institution if the resident/fellow was a visiting resident/fellow.
10. Faculty and Staff (see Appendix 1 for sample communications)

Crisis Response

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

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

A. Offer assistance.

B. Collaborate with the Vice President of Clinical Programs at WVU Hospitals to provide referrals to counseling services available in family's locale.

C. Solicit information from family about funeral arrangements, family's wishes regarding privacy and confidentiality, family's wishes related to attendance by school community at funeral and any other requests from family. Assist in hotel arrangements near campus.

D. Ask for the name and phone number of an appropriate family representative for the School to maintain communication with the family.

E. Contact general counsel if a resident/fellow was a victim of a crime.

When appropriate, the GME Crisis Team will:

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

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

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

When appropriate, the GME Crisis Team will:

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

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

15. Close academic record.
16. Inactivate all addresses and e-mail lists.

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

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

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

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

When appropriate, the GME Crisis Team will:

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

Appendix 1

Sample Communications to Residents/Fellows, Faculty, and Staff

We are deeply saddened to inform you that Jane Doe, a member of the Class of XXXX,

passed away, on Saturday, December 1, 2018.

Services are scheduled as follows:
Grief counselors will be available on Monday, December 4, 2018 at 12:00 in XXXX.

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

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

Wednesday, January 2, 2018 @12:00 PM

in XXXX Thursday, January 3, 2018 @1:00

PM in XXXXXX

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

As you all know, Jane Doe, Class of 2020, died suddenly on the night of January 7, 2020. As the WVU community mourns the tragic loss of our resident/fellow, some of us may seek more information, asking

how did this happen and why? We have limited ability to answer these questions, in part because we do not know precise answers, and in part out of respect for the privacy of the deceased and his family.

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

C. Richard Doe was killed in an automobile accident on Wednesday, January 7th at approximately 10:15 p.m.

D. The location XXXXX.

E. The Dominion Post has reported this event in one article as a suicide.

F. To our knowledge, no suicide note has been found.

G. The County Prosecutor's Office has not allowed the University to view any evidence gathered.

H. The Police and authorities are conducting an investigation to determine the cause and manner of death. Neither suicide nor accidental death has been confirmed. A final report is not expected for some weeks or months.

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

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

Dean

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

If the death has been declared a suicide:

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

Suspicious death not declared suicide:
This morning we heard the extremely sad news that John Doe died last night from a gunshot wound. This is the only information we have officially received on the circumstances surrounding the event. I know we are all saddened by John Doe’s death, and send our condolences to his family and friends. Counselors will be located today in

Room at_a.m.,_p.m., and_p.m. for residents/fellows,

faculty and staff who wish to talk to a counselor. Information about the funeral will be provided when it is available.

Appendix 2
Signs of “at-risk” residents/fellows:

Close friends and roommates of deceased

Residents/Fellows in clubs and activities with

deceased

Residents/Fellows with antagonistic relationship with deceased

Residents/Fellows who have experienced losses that may be reactivated by the

current death Residents/Fellows with drug/alcohol/emotional problems or previous

suicide attempts or ideation Residents/Fellows preoccupied with death or suicide

Witnesses to the death

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

DISABILITIES ACCOMMODATIONS POLICY

It is the policy of the West Virginia University School of Medicine to provide reasonable accommodations as necessary for qualified individuals with disabilities who are accepted in to our post graduate training programs. We will adhere to all applicable federal and state laws, regulations, and guidelines with respect to providing reasonable accommodations as required in accordance with the policies and procedures of the University as linked below:

http://diversity.wvu.edu/equity-assurance/ada-compliance/employeeaccommodations-the-interactive-process

We will work with the University Department of Human Resources and the ADA Coordinator in determining if a resident has a disability and what accommodations may be reasonable and necessary for the employer to provide. Residents will still be required to meet all program educational requirements with or without accommodations as they must be able to demonstrate proficiency in all the ACGME defined competencies, and programs must certify that they are able to practice the specialty in which they have trained competently and independently upon completion of training. This includes the ability to perform the required technical and procedural skills of that specialty. Patient safety must be assured as a top priority in these determinations.

Residents must request accommodations in writing to the program director. The program director must notify within five working day of the request the Department Chair and Designated Institutional Official that such a request has been made.

The resident will be required to provide medical verification of a medical condition that he or she believes is a disability. The resident is responsible for the costs of verification.

Approved by GMEC Taskforce 12/14/06 ACGME Institutional Requirements
Approved by GMEC 1/12/07 II.D.4.n

DISASTER RESPONSE POLICY -Graduate Medical Education Council (GMEC)

In the event of a disaster or the declaration of extraordinary circumstances by the ACGME (i.e. abrupt hospital closing, natural disasters, catastrophic loss of funding) impacting the graduate medical education programs sponsored by the West Virginia University School of Medicine, the GMEC establishes this policy to protect the wellbeing, safety and educational experience of residents enrolled in our training programs.

The definition of a disaster/extraordinary circumstances will be determined by the ACGME as defined in their published policies and procedures. Following declaration of a disaster/extraordinary circumstances, the GMEC working with the DIO and other sponsoring institution leadership will strive to restructure or reconstitute the educational experience as quickly as possible following the disaster.

As quickly as possible and in order to maximize the likelihood that residents will be able to complete program requirements within the standard time required for certification in that specialty, the DIO and GMEC will make the determination that transfer to another program is necessary.

Once the DIO and GMEC determine that the sponsoring institution can no longer provide an adequate educational experience for its residents, the sponsoring institution will to the best of its ability arrange for the temporary transfer of the residents to programs at other sponsoring institutions until such time as West Virginia University School of Medicine is able to resume providing the experience. Residents who transfer to other programs as a result of a disaster will be provided by their Program Directors with an estimated time that relocation to another program will be necessary. Should that initial time estimate need to be extended, the resident will be notified by their Program Directors using written or electronic means identifying the estimated time of the extension.

If the disaster prevents the sponsoring institution from re-establishing an adequate educational experience within a reasonable amount of time following the disaster, then permanent transfers will be arranged.

The DIO will be the primary institutional contact with the ACGME and the Institutional Review Committee Executive Director regarding disaster plan implementation and needs within the sponsoring institution.

In the event of a disaster/extraordinary circumstances affecting other sponsoring institutions of graduate medical education programs, the program leadership at West Virginia University School of Medicine will work collaboratively with the DIO who will coordinate on behalf of the School of Medicine the ability to accept transfer residents from other institutions. This will include the process to request complement increases with the ACGME that may be required to accept additional residents for training. Programs currently under a proposed or actual adverse accreditation decision by the ACGME will not be eligible to participate in accepting transfer residents.

Programs will be responsible for establishing procedures to protect the academic and personnel files of all residents from loss or destruction by disaster. This should include at least a plan for storage of data in a separate geographic location away from the sponsoring institution.

Approved by GMEC Taskforce 12/14/06 ACGME Institutional Requirements Approved by GMEC 1/12/07 IV.M Revised by GMEC 11/13/15

DIVERSITY POLICY

Graduate Medical Education (GME) Diversity Policy for Recruitment of Residents/Fellows, Faculty and Staff

At West Virginia University Department of Surgery, we believe that the core values of diversity are inseparable from our institutional goals. We are committed to fostering an environment that celebrates the unique ethnic, racial, gender, and sex backgrounds of all individuals. Through fair and deliberate recruitment, hiring practices, promotions, admissions, and education, we will provide the highest quality of care and service to everyone.

Students Underrepresented in Medicine
The West Virginia University Department of Surgery, in conjunction with the School of Medicine, is working to expand clinical opportunities to students with ethnicities traditionally under-represented in medicine (URM). The opportunities include two- or four-week elective rotations on a surgical team at WVU Medicine Hospitals.

The program offers students the opportunity to engage actively with residents and faculty in educational conferences, outpatient clinics, inpatient wards, the emergency department, and the operating room. During their time at WVU, students participate in didactic lectures, assist with bedside procedures, and take advantage of a multitude of simulation experiences. This is an opportunity to meet one on one with faculty of diverse background and interests and gain guidance on how to successfully navigate the surgical residency.

Eligible students include URM fourth-year medical students in good standing, currently enrolled in a U.S. LCME accredited allopathic medical school. URM groups include: Hispanic, African-American, Native American, or Asian Pacific Islander.

Residency and Faculty
The Department of Surgery endeavors to select a gender-balanced, diverse, and tolerant graduate student body, faculty, and staff. Our priority is to recruit key, value-added, underrepresented in medicine groups that include African-Americans, Hispanics, LGBTQ, and Native Americans/Pacific Islanders. The Department also aims to recruit residents/fellows who are included in the socioeconomically and educationally disadvantaged rural Appalachian population.

Minority Resident & Fellow Resources
The West Virginia University Department of Surgery, is dedicated to creating a supportive and nurturing environment for minorities throughout their academic experience. Excellence and innovation only thrive in an environment in which important challenges are take on by individuals who come together from different life experiences and perspectives. Advancing true diversity and inclusion has become an academic necessity; diversity within a medical school markedly increases the quality of medical education, expands and informs the research agenda, and improves the

quality of health care delivered to the surrounding communities.

We strived to offer intellectual, social, and cultural opportunities for all backgrounds through various associations.

- African Student Association https://wvuengage.wvu.edu/organization/asawvu
- International Student Association https://iso.orgs.wvu.edu/
- Chinese Students and Scholars Association https://wvuengage.wvu.edu/organization/wvucssa
- Muslim Student Association https://wvuengage.wvu.edu/organization/wvumsa

For other association that fit your interest, please visit the Student Organization List. https://studentorgs.wvu.edu/

LGBTQI+
The West Virginia University has a diverse and well-connected community. We pride ourselves on the diversity of our Department's training programs and we welcome the opportunity to connect applicants with LGBTQI + trainees.

- Appalachian Queer Film Festival http://www.wviff.org/appalachian-queer-film-festival-2019/
- Division of Diversity Equity and Inclusion https://diversity.wvu.edu/
- Health Professional Advancing LGBT Equality http://glma.org/
- LGBTQ + Center https://lgbtq.wvu.edu/
- Queer Appalachia https://www.queerappalachia.com/
- Student Healthcare Alliance for Promoting Equality (SHAPE) https://medicine.hsc.wvu.edu/md-student-services
- WVU LGBT Community Building Group – lead by Dr. Nova Szoka nova.szoka@hsc.wvu.edu
- WVU Spectrum - https://spectrum.orgs.wvu.edu/

Background: West Virginia has a population of approximately 1.8 million and is a highly rural state with one of the oldest populations in the country. Geographically, it is the only state that rests entirely within the Appalachian mountain region. Historically, large numbers of its citizens have been employed in the extractive industries—mainly timbering and coal mining. This lack of economic diversity has resulted in a weak economy, poor socioeconomic status, and low educational attainment. The state's demographics reflect a small percentage of traditionally underrepresented in medicine.

Policy: The WVU School of Medicine is the flagship institution of medical education, healthcare, and research for the state of West Virginia. As a land grant institution, our goal is to improve the health and wellness of West Virginia residents. The School endeavors to select a gender-balanced, diverse, and tolerant graduate student body, faculty, and staff. Our priority is to recruit key, value-added, underrepresented in medicine groups that include African-Americans, Hispanics, LGBTQ, and Native Americans/Pacific Islanders. The WVU School of Medicine also aims to recruit residents/fellows who are included in the socioeconomically and educationally

disadvantaged rural Appalachian population.

The School's endeavors are congruent with the strategic plan of the School, the Health Sciences Center, and the University. The School believes the recruitment and accommodation of key value-added groups greatly enriches our educational and research missions; the environment for our students, residents/fellows, faculty, and staff; and our goals in improving the healthcare of the citizens of West Virginia.

This policy is implemented to ensure there are no quotas or set-asides. Regardless of an applicant's characteristics, they are considered in the same competitive pool using the same application of University policies and procedures. Each graduate medical education program is required to have their own program specific Diversity Policy as well as monitor their diversity against goals and national statistics for their specific program. Furthermore, GME will evaluate recruitment efforts centrally by monitoring the number of offers made to our defined value-added groups, the number of individuals who decline offers, and the number of individuals who choose to be employed by or be a resident/fellow at West Virginia University's School of Medicine.

Academic and Learning Environments

Graduate Medical Education (GME) ensures its educational program occurs in a professional, respectful, and intellectually stimulating academic and clinical environments; GME recognizes the benefits of diversity; and promotes resident's/fellow's attainment of competencies required of future physicians.

Diversity/Pipeline Programs and Partnerships

GME has effective policies and practices in place and engages in ongoing, systematic, and focused recruitment and retention activities to achieve mission-appropriate diversity outcomes among its residents/fellows, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

Curricular Content

GME faculty will ensure that the graduate medical curriculum provides content of sufficient breadth and depth to prepare graduate medical trainees for entry into the contemporary practice of medicine.

Cultural Competence and Health Care Disparities

GME faculty will ensure that the graduate medical curriculum provides opportunities for residents/fellows to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The graduate medical curriculum includes instruction regarding the following:

- *The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.*
- *The basic principles of culturally competent health care.*
- *The recognition and development of solutions for health care disparities.*
- *The importance of meeting the health care needs of medically underserved populations.*
- *The development of core professional attributes (e.g., altruism, accountability) needed to*

provide effective care in a multidimensional and diverse society.
For more information, please visit https://diversity.wvu.edu/

Approved by GME Taskforce:
Approved by GMEC:

EMPLOYMENT GRIEVANCE PROCEDURE FOR NON-ACADEMIC ISSUES POLICY

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

https://medicine.hsc.wvu.edu/media/363881/gmebylawsrevised-1-15-16-oct2017-21318-2-repaired.pdf

Forms and procedures are available from the Human Resources Department.

EMPLOYMENT & NON-DISCRIMINATION POLICY

Consistent with federal and state guidelines, WVU, Department of Surgery does not discriminate on the basis of race, color, sex, age, ethnicity, religion, national origin, sexual orientation, disability, marital status, or veterans' status in its educational programs or employment. If you are a student or an employee of the Department of Surgery and you consider yourself to be a target of discrimination or harassment, you may file a complaint in writing with the Office of Diversity and Affirmative Action. If you choose to file such a complaint within the University, you do not lose your right to file with an outside enforcement agency such as the State Division of Human Rights, Equal Employment Opportunity Commission, or the Office of Civil Rights.

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.

EVALUATION POLICY

The resident's evaluations are based on the ACGME competencies and surgery milestones.

The Department of Surgery has established this policy for evaluation and structural feedback to enhance the residency training program and institute quality improvement mechanisms.

Formal evaluation of each resident will be based on the following criteria:

1) Faculty, peer, nursing and support staff evaluation forms from each rotation (360° evaluation process)

2) ABSITE scores
3) The six ACGME Competencies
4) Attendance and participation in conference
5) Oral (Mock) exam by faculty and community members (senior residents)
6) Resident operative experience tracking (Record Keeping of Cases)
7) Duty Hour log (Record Keeping of hours)
8) Clinical Competency Committee Meetings (biannually for each resident)

An evaluation form is completed for each resident every month no matter the length of the rotation and expected to be completed within 2 weeks. Any negative evaluations will be brought to the attention of the Program Director, who will bring it to the attention of the resident for discussion and review. Measures to correct any issues will be addressed.

Resident performance is evaluated for each 2 times a year by the program director and the Clinical Competency Committee (CCC). The resident has access to the evaluations at all times through the e- value system.

The resident will meet with the Program Director on a semi-annual basis to discuss his/her progress in the program. These meetings take place in December and May. All rotation evaluations will be reviewed with the resident and if there is an area of concern, the program director may have additional meetings if required.

Each year all residents participate in the American Board of Surgery In-Service Training Examination (ABSITE) given nationally by all Surgery departments to evaluate each individual's progress. These examinations are designed to assess the residents' surgical knowledge and can be a predictor of performance on the American Board of Surgery qualifying exam.

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

Common Program Requirement: V.A. Resident Evaluation, V.A.1. Feedback and Evaluation

Feedback is ongoing information provided regarding aspects of one's performance, knowledge, or understanding. The faculty empower residents to provide much of that feedback themselves in a spirit of continuous learning and self-reflection. Feedback from faculty members in the context of routine clinical care should be frequent, and need not always be formally documented.

Formative and summative evaluation have distinct definitions. Formative evaluation is *monitoring resident learning* and providing ongoing feedback that can be used by residents to improve their learning in the context of provision of patient care or other educational opportunities. More specifically, formative evaluations help:
• residents identify their strengths and weaknesses and target areas that need work
• program directors and faculty members recognize where residents are struggling and address problems immediately

Summative evaluation is *evaluating a resident's learning* by comparing the residents against the goals and objectives of the rotation and program, respectively. Summative evaluation is utilized to make decisions about promotion to the next level of training, or program completion

End-of-rotation and end-of-year evaluations have both summative and formative components. Information from a summative evaluation can be used formatively when residents or faculty members use it to guide their efforts and activities in subsequent rotations and to successfully complete the residency program.

Feedback, formative evaluation, and summative evaluation compare intentions with accomplishments, enabling the transformation of a neophyte physician to one with growing expertise.

Our department utilizes the following monthly evaluations for each resident and faculty. The Self-Evaluation (sent to residents) and the Program Evaluation (sent to residents and faculty) is sent on an annual basis.

Monthly evaluations are expected to be completed within a two-week timeline. The following evaluations are used within the Department of Surgery:

Case Log & Activity Compliance (monthly)	Evaluated by Program Director & Administrator
Duty Hour Compliance (monthly)	Evaluated by Program Director & Administrator
Health and Professionals (monthly)	Evaluated by PA's, Nurse, Staff, Administration
M&M Evaluation (weekly)	Evaluated by Program Director & Faculty
Operative Evaluation (daily)	Evaluated by faculty
Patient Evaluation (bimonthly)	Evaluated by Patients
Peer Evaluation (monthly)	Evaluated by Faculty
Program Evaluation – Annually (June)	Evaluated by Residents & Faculty
Resident Evaluation (monthly)	Evaluated by faculty
Self-Evaluation – Annually (July)	Evaluated by each resident
Transition of Care (monthly)	Evaluated by Resident/Faculty/PA's
Faculty Evaluation - (monthly)	Evaluated by each resident
Rotation Evaluation – (monthly)	Evaluated by each resident

FATIGUE PREVENTION POLICY

Fatigue and Stress Policy Purpose:
Symptoms of fatigue and stress are normal and expected to occur periodically in the resident population, just as it would in other professional settings. Not unexpectedly, residents may experience some effects of inadequate sleep and stress. The West Virginia University, Department of Surgery has adopted the following policy to address resident fatigue and stress: In 2014, the Department of Surgery implemented a Sleep & Fatigue CBL course in SOLE that is a requirement for all residents and faculty to complete.

Recognition of Resident Excess Fatigue and Stress:
Signs and symptoms of resident fatigue and stress may include but are not limited to the following:

Inattentiveness to details Forgetfulness
Emotional Instabiliy Irritabiliy
Increased conflicts with others
Lack of attention to proper attire or hygiene Difficulty with novel tasks and multitasking
Impaired awareness

Response:
The demonstration of resident excess fatigue and stress may occur in patient care settings or in nonpatient care settings such as lectures and conferences. In patient care settings, patient safety, as well as the personal safety and well-being of the resident, mandates implementation of an immediate and proper response sequence. In non-patient care settings, responses may vary depending on the severity and demeanor of the resident's appearance and perceived condition.
The following is intended as a general guideline for those recognizing or observing excessive resident fatigue and stress in either setting:

Patient Care Settings: Attending Clinician:
In the interest of patient and resident safety, the recognition that a resident is demonstrating evidence of excess fatigue and stress requires the attending or senior resident to consider immediate release of the resident from any further patient care responsibilities at the time of recognition.

The attending clinician or senior resident should privately discuss his/her opinion with the resident,
attempt to identify the reason for excess fatigue and stress, and estimate the amount of rest that will be required to alleviate the situation.

In all circumstances the attending clinician must attempt to notify the chief/senior resident on-call, residency manager, residency director, or department chair, respectively of the decision to release the resident from further patient care responsibilities at that time.

If excess fatigue is the issue, the attending clinician must advise the resident to rest for a period that is adequate to relieve the fatigue before operating a motorized vehicle. This may mean that the resident should first go to the on-call room, surgery resident lounge for a sleep interval no less than 30 minutes. The resident may also be advised to go to the Emergency Room front desk and ask that they call for security, a cab or someone else to provide transportation home

If stress is the issue, the attending, after privately counseling the resident, may opt to take immediate action to alleviate the stress. If, in the opinion of the attending, the resident stress has the potential to negatively affect patient safety, the attending must immediately release the resident from further patient care responsibilities at that time. In the event of a decision to release the resident from further patient care activity notification of program administrative personnel shall include the chief/senior resident on call, residency manager, residency director or department chair, respectively.

A resident who has been released from further patient care because of excess fatigue and stress cannot appeal the decision to the attending.

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

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

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

Residents
Residents who perceive that they are manifesting excess fatigue and/or stress have the professional responsibility to immediately notify the attending clinician, the chief resident, and the program director without fear of reprisal.

Residents recognizing resident fatigue and/or stress in fellow residents should report their observations and concerns immediately to the attending physician, the chief resident, and/or the residency director. Residency Director

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

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

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

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

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

FIT FOR DUTY POLICY

Fitness for Duty refers to the ability of a resident physician to perform the essential functions of his or her job without an impairment that may pose a potential risk to patients, a direct threat to the safety of others in the workplace, and/or interfere with the performance of his or her necessary duties, with or without a reasonable accommodation.

There are at least four categories of *impairment* associated with Fitness for Duty:

(1) Impairment associated with the misuse or the suspicion of misuse of prescription medications, alcohol or illegal drugs;

(2) Impairment associated with behavior that may pose a direct threat to the employee, patients or to others in the workplace;
(3) Impairment caused by a medical condition, including mental health, and/or the use of medication for that condition; and

(4) Impairment associated with fatigue/sleep deprivation
The supervisor who receives reliable information that an individual may be unfit for duty, or through personal observation believes an individual to be unfit for duty, will validate and document the information or observations as soon as is practicable. Actions that may trigger the need to evaluate an employee's fitness for duty include, but are not limited to, problems with dexterity, coordination, concentration, memory, alertness, vision, speech, inappropriate interactions with coworkers or supervisors, inappropriate reactions to criticism, or suicidal or threatening statements.

In the spirit of a just culture of safety and well being, any person may report suspicion of impairment to the employee's supervisor or to the compliance hotline. There shall be no retaliation or repercussions towards individuals who have reported such concerns.

Residents and any others are urged to report any concern regarding duty hours, fatigue and other issues to the compliance hotline of the WVUH, the primary teaching hospital at 1-877-298-4376. These concerns will be reported to the GME office.

As a result of impairment the employee may be suspended until fitness for duty is established. Involvement of the Human Resources department, the Employee Assistance Program, and the hospital Practitioner Health Committee is expected.
Approved by the GMEC Taskforce: June 2011 Adopted by the GMEC: July 9, 2011

FLS/FES CERTIFICATE FEES

The American Board of Surgery requires residents to have completed and passed the FLS and FES prior to submitting their board application in their chief year.

- Effective July 1, 2022, the Department of Surgery will pay for the initial exam fee of $525.00 for the following: FES, and FLS.
- Any failures/retakes $125.00 will be at the expense of the resident.

Written 4/2022

HARASSMENT POLICY

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

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

   Those in supervisory positions have a special responsibility to discourage sexual harassment as well as to implement and to enforce this policy. Violators of this policy are subject to disciplinary action that may include sanctions as severe as discharge of an employee or expulsion of a student. In addition, sexual harassment that constitutes sexual

battery or other criminal law violations will be referred to the appropriate authorities for prosecution.

B. Legal Basis: Sexual harassment is prohibited by:

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

INTERVIEW POLICY

*Resident is responsible for clinical coverage and coordinating such with as much advance notice to all affected.

In-person interviews - Each resident (PGY-3 and above) is granted a ***TOTAL*** **of five interview days**. Any days necessary above these five will be taken as vacation days. (These days are only granted for the job and/or Fellowship interviews.) If a resident leaves duty at noon, ½ day will be charged to that resident. If a resident leaves duty before noon, one full day will be charged.

Virtual Interviews – The time allotted for virtual interviews will be calculated as below:

1. ½ days – work out details with the team, which would include at least 4 hours of clinical work.
2. Full day – less than 4 hours of clinical work
3. Submit a copy of the schedule when received to Program Administrator for verification and tracking.

Beyond 5 days- vacation time will be used.
In addition, one day of the 5 days off per month required by WVU GME can be used.

Night Float – If interviewing while on night float, if the program determines that fatigue may compromise care the resident will be relieved of duty and will use one vacation day.

LICENSURE REQUIREMENTS - Resident Physician Policy

As of July 2019, all residents and fellows in training programs sponsored by the West Virginia University School of Medicine must hold at all times during their training either a valid educational training permit or a valid unrestricted license by either the West Virginia Board of Medicine or the West Virginia Osteopathic Board of Medicine. It is the trainee's responsibility to request the initial permit or license from the appropriate board of medicine and to annually renew this authorization during their training. Should the resident or fellow fail to obtain or renew the appropriate authorization from the appropriate board of medicine the resident or fellow will be immediately suspended from all duties and failure to renew the appropriate authorization to practice medicine in a timely manner may result in termination from the training program. Applications for training permits should be submitted to the appropriate board of medicine at least one month prior to the contract start date.

If a resident or fellow holding an educational training permit is terminated for any reason from any graduate medical education program, the program director is obligated to notify the appropriate board of medicine within five days of termination.

Residents or fellows who seek and are granted permission by their program director to moonlight in any capacity must hold a valid license by the appropriate board of medicine. An educational training permit holder may only practice medicine and surgery within the auspices of their training program.

All residents are required to take, and pass, either USMLE Step 3 or COMLEX Step 3 by the end of their second postgraduate year (PG2). Residents will only be advanced or appointed to the level as PG3 or beyond once they have provided written evidence of passing the appropriate Step 3 examination.

Exceptions for extension to these deadlines must be approved by the GMEC Taskforce and the DIO.

Doctors of Medicine: West Virginia Board of Medicine, 101 Dee Drive Charleston, WV 25311 (304) 558-2921
Doctors of Osteopathy: West Virginia Board of Osteopathic Medicine, 405 Capitol Street, Suite 402, Charleston, WV 25301 (304) 558-6095

Visiting residents whose home program is located in a state outside of West Virginia must receive a reciprocal educational permit from the appropriate Board of Medicine before they will be allowed to participate in any rotations at our institution or its clinical affiliates. Application for a reciprocal education permit must be received at least 30 days in advance of the start date for the requested rotation. These reciprocal permits are only valid for up to 60 consecutive days and are non-renewable within the same academic year.

MEETING POLICY

If the Department of Surgery is paying for a meeting the resident is responsible to go to the meeting sessions if not, the resident is responsible for expenses. *Please see the Travel Reimbursement Policy effective July 1, 2022) for additional information.*

The American Board of Surgery now requires all meetings, to be recorded on the application for the qualifying exam. **A minimum of 48 weeks of full-time surgical experience is required per residency year.**

1. Residents will submit a Meeting/Vacation Request form for their proposed meeting dates. The following information is required to be attached to the meeting request form at least 45 days prior to the meeting.
    - Meeting request form
    - Authorization to travel expense form
        - Flights (coach fare)
        - Hotel (2-night maximum for residents–the night prior and night of the presentation)
        - Conference Registration (must be done using early-bird registration if one is available)
        - Meals (federal standard per diem rate – excluding alcohol, no more

than $60.00 per day requires itemized receipts)
    - Mileage to and from airport: (no rental cars; if rental is required, justification must be provided and prior approval from the chairman is required.
- Brochure of the meeting to include the agenda/program
- Time and date of the presentation (if selected to give a presentation)
- Copy of email or letter of acceptance for financial support
- Copy of presentation/slides/poster prior to travel
- Copy of manuscript ready for submission for meeting affiliated journal, prior to travel to Sr. author, program director, and associate program director.

2. Please provide all receipts immediately upon returning from the meeting.
    - Any receipts submitted 30 days after the event will require the chairman's approval for reimbursement.
    - Please note that receipts reimbursed 60+ days after the event is considered by the IRS as taxable income.

3. ***DO NOT*** make flight arrangements, reservations etc. until you are officially granted your vacation.

MISTREATMENT, PROFESSIONALISM "THE BUTTON"

HOW TO REPORT "MISTREATMENT", A "LACK OF SUPERVISION", OR A SITUATION INVOLVING A "LAPSE IN PROFESSIONALISM", OR "EXEMPLARY PROFESSIONALISM"
1. Access the Office of GME website https://medicine.hsc.wvu.edu/gme/mistreatment-form/

2. Click on whichever tab pertains to the issue you need to report, and complete & submit the form. The report is delivered directly to the GME Office. Your identity is confidential (your choice).

3. PLEASE NOTE: The more information you are able to include in your report, the better. *(However, please do not include identifiable patient health information.)* Each report is addressed.

PARENTAL LEAVE (FAMILY MEDICAL LEAVE)

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

West Virginia University adheres to the requirements of the West Virginia state Parental Leave Act. Parental Leave provides qualified employees up to 12 weeks of unpaid family leave during a twelve-month period following exhaustion of all their annual leave.

Parental Leave may be used for the following reasons:

- Birth of a son or daughter
- Placement of a son or daughter for adoption

- To provide care of a son, daughter, spouse, parent or dependent (any person who is living with or dependent upon the income of an employee, whether related by blood or not) who has a serious health condition

Parental Leave may be taken intermittently only when medically necessary. It may be taken on a part-time basis but may not exceed 12 consecutive months. This leave must be scheduled so as not to unduly disrupt the operation of the employer. Employees that meet the eligibility requirements of Parental leave are entitled to return to their original position as long as they return at the end of their leave.

In order to meet eligibility requirements for Parental Leave, employees must have been hired for permanent employment and worked at least 12 consecutive weeks. In addition, employees must submit a Request for Parental Leave to their supervisor for approval at least two weeks in advance of the leave. The employee must provide documentation of the birth, adoption or serious health condition to the Medical Management Unit.

Eligible employees taking Parental Leave may continue their group health insurance provided they pay the full employee and employer premium costs of such health insurance.

Parental Leave Request Form link below:

https://talentandculture.wvu.edu/files/d/72821993-0fec-4540-b974-7151313fa410/request-for-parental-leave-of-absence-rev-may-2015.pdf

WV Parental Leave Act link below:
http://www.wvlegislature.gov/wvcode/code.cfm?chap=21&art=5D

Additional information regarding all leaves can be found
https://wvusharedservices.wvu.edu/s/article/Parental-Leave

PLEASE NOTE: In addition to WVU, leave policies, the Accreditation Council of Graduate Medical Education (ACGME) and The American Board of Surgery (ABS) have requirements that must be followed in order to obtain your certificate and sit for your boards. Additional training as a resident may be required. The ABS (American Board of Surgery) has the following requirements in regard to medical or maternity leave.

The ABS will accept 46 weeks surgical training in one of the first three years, for a total of 142 weeks during the first three years and 46 weeks of training in one of the last two years, for a total of 142 weeks in the first three years and 94 weeks during the last two years.
(American Board of Surgery, Booklet of Information Section II B 2.b) American Board of

Surgery – www.absurgery.org

Accreditation Council of Graduate Medical Education –www.acgme.org

MOONLIGHTING POLICY

At West Virginia University, the rules and regulations governing house staff require all moonlighting activities engaged in by house staff to have the **approval** of the **Program**

Director. It is the individual Program Director's prerogative as to whether or not moonlighting is permitted.

Moonlighting is NOT permitted for general surgery residents. The Department of Surgery feels activities outside the educational program must not interfere with the resident's performance nor must they compete with the opportunity to achieve the full measure of the educational objectives of the residency.

The faculty feels that a surgical residency is a demanding and rigorous experience. It is felt that moonlighting also interferes with the residents' opportunities for study, relaxation, rest and a balanced life style.

PARKING POLICY

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

Do not use patient/visitor parking lots. This is one of the most egregious parking offenses an employee can commit, with the exception of parking illegally in a handicapped space. This practice does not reflect the patient first values of our organization.

Do not park illegally anywhere on WVUH property. Approach one of the Security Officers and they will direct you to a space.

If you have more than one vehicle and you forget to transfer your permit, please obtain a staff temporary, good for one day. You will need to obtain the permit from the Security office.

If you lose your parking permit, please see the Security Office for replacement. There is a fee to replace a lost permit.

If you have been towed, you will need contact the WVUH Security Office or a security officer.

PATIENT SAFETY POLICY EMS EVENT MANAGEMENT SYSTEM

I. Rationale
In accordance to the ACGME Clinical Learning Environment Review (CLER), the West Virginia University Office of Graduate Medical Education must ensure that residents are educated and engaged in patient safety activities or programs.

II. Scope
This policy applies to all graduate medical education programs sponsored by the West Virginia University School of Medicine.

III. Policy
A. Programs should encourage and support residents to work in
Inter-professional teams to enhance patient safety and improve patient care quality. Common Program Requirements VI.A.5.f).(5).

B. Programs should encourage and support residents to participate in identifying system errors and implementing potential systems solutions. This can be achieved through the following activities or program:

Reporting of adverse events and near misses/close calls to improve system of care.

HOW TO REPORT PATIENT SAFETY EVENTS & NEAR MISSES

1. Access **CONNECT** https://connect.wvumedicine.org/
2. On the left-hand menu, choose **Safety Reports**
3. Choose **J.W. Ruby Memorial Hospital**
4. To file a patient safety even report, choose **Event Management System (EMS)** in blue:

   Event Management System (EMS) is an online tool to manage patient incidents, complaints, and claims, as well as provider peer reviews and

5. You can also choose the **EMS Playground** if you want to practice using the system first – but do not use the playground to file a real report:

   Safety Reports **EMS Playground** **Lessons Learned** **Forms**

---

2. Participation in in inter-professional, interdisciplinary, systems-based improvement efforts such as patient safety event reviews and analyses (i.e. department level Morbidity and Mortality Conferences, institution or department level Root Cause Analysis of adverse events)

Adapted from: Common Program Requirements VI.A.5.f).(6).

C. Program directors should provide feedback to residents when they are involved in patient safety events.
D. Programs must develop policies to ensure all residents and fellows are instructed in patient safety.

5) Programs must incorporate patient safety instruction into its curriculum.

2) All residents and fellows must complete the WVU Office of Graduate Medical Education assigned self-directed modules from the Institute for Healthcare Improvement (IHI) Open School.

3) Any alternate format of instruction must be submitted for review by the WVU Office of Graduate Medical Education Patient Safety Subcommittee.

4) It is recommended that residents and fellows receive additional instruction in the form of small or large group discussions or workshops.

E. Programs must develop competency-based goals and objectives that pertain to instruction in patient safety and participation of resident or fellows in patient safety activities.

Adapted from: Program Director Guide to the Common Program Requirements, 2012. Each assignment in which the resident is expected to participate must have a set of competency based goals and objectives. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation.

F. Programs, through the Program Evaluation Committee (PEC), must evaluate instruction in patient safety and participation of resident or fellows in patient safety activities at least annually.

IV. Evaluation

A. Monitor resident and fellow completion of mandatory IHI Learning Modules.

B. Monitor resident and fellow scores and passing and failing rate in the IHI Learning Modules post-test.

Approved by GMEC – 11/18/2016

PHYSICIAN DEATH CERTIFICATE POLICY

https://medicine.hsc.wvu.edu/media/363559/physiciandeathcertificatepolicy.pdf

PROGRAM EVALUATION COMMITTEE (PEC) ANNUAL PROGRAM EVALUATION (APE)

POLICY:
Each ACGME-accredited residency program will establish a Program Evaluation Committee to participate in the development of the program's curriculum and related learning activities; and to annually evaluate the program to assess the effectiveness of that curriculum, and to identify actions needed to foster continued program improvement and correction of areas of non-compliance with ACGME standards.

PROCEDURE:

Program Evaluation Committee

1. The program director will appoint the Program Evaluation Committee (PEC).

2. The Program Evaluation Committee will be composed of at least 2 members of the residency program's faculty (one of which can be the PD), and include at least one resident (unless there are no residents enrolled in the program.) The PEC will function in accordance with the written description of its responsibilities, as specified in item 3, below.

3. The Program Evaluation committee will participate actively in

a. planning, developing, implementing, and evaluating all significant activities of the residency program;

b. reviewing and making recommendations for revision of competency-based curriculum goals and objectives

c. addressing areas of non-compliance with ACGME standards, and

d. reviewing the program annually, using evaluations of faculty, residents, and others, as specified below.

Annual Program Evaluation

The program, through the PEC, will document formal, systematic evaluation of the curriculum at least annually, and will render a full, written, annual program evaluation (APE).

1. The annual program evaluation will be conducted between mid-May, and mid-June of each academic year, unless rescheduled for other programmatic reasons.

2. **Approximately two months prior to the review date**, the Program Director will:

   - facilitate the Program Evaluation Committee's process to establish and announce the date of the review meeting
   - notify the program manager to assist with organizing the data collection, review process, and report development
   - notify the program manager to send out the program evaluations to all residents/fellows, and faculty via E-Value

3. At the time of the initial meeting, the Committee will consider (including, but not limited to):

   - achievement of action plan improvement initiatives identified during the last annual program evaluation
   - achievement of correction of citations and concerns from last ACGME program survey/letter of notification, and any recommendations from special program reviews by the GMEC.
   - residency program goals and objectives
   - didactic schedules/lectures
   - rotation evaluations
   - faculty members' confidential written evaluations of the program
   - the residents' annual confidential written evaluations of the program and faculty
   - resident performance and outcome assessment, as evidenced by:

  - aggregated data from general competency assessments
  - aggregated data from milestone evaluation (when/if available)
  - aggregated in-training examination performance
  - case/procedure logs – adequate volume?
  - involvement in institutional & departmental improvement and safety committees
  - aggregated patient satisfaction data
  - scholarly activity, research, involvement in quality improvement projects, patient safety initiatives

- graduate performance, including performance on the certification examination, 1-year out surveys, employer surveys, attrition rates

- faculty development/education needs and effectiveness of faculty development activities during the past year – what was offered, who participated?

- faculty scholarly activity, mentoring activities, and academic productivity

- program strengths

4. Additional meetings may be scheduled, as needed, to continue to review data, discuss concerns and potential improvement opportunities, and to make recommendations. Written minutes will be taken of all meetings.

5. As a result of the information considered and subsequent discussion, the Committee will prepare a written plan of action to document initiatives to improve performance in one or more of these areas:

  - resident performance
  - faculty development
  - graduate performance
  - program quality
  - continued progress on the previous year's action plan

The plan will delineate how those performance improvement initiatives will be measured and monitored.

6. The final report and action plan will be reviewed and approved by the program's teaching faculty, and documented in faculty meeting minutes. A report will be provided to the GMEC, and discussed at a full meeting of the GMEC.

PRACTITIONERS' HEALTH COMMITTEE

The Practitioners' Health Committee serves as a resource in the management of impaired physicians. Impairment includes any physical, psychiatric or emotional illness that may interfere

with the physicians' ability to function appropriately and provide safe patient care. In an effort to ensure consistency in our approach to these difficult problems, the Practitioners' Health Committee has formulated the following guidelines. This information can also be found at https://medicine.hsc.wvu.edu/media/363881/gmebylawsrevised-1-15-16-oct2017-21318-2-repaired.pdf.

RESIDENTS/FACULTY
Substance Abuse

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

After receiving an evaluation, and consulting with the Department Chairperson, the Practitioners' Health Committee will make a recommendation concerning:

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

Decision to grant Hospital staff privileges or allow residents to treat patients at WVUH, and under what terms are at the discretion of the WVUH Board of Directors through the Joint Conference Committee and based upon the recommendation of the Departmental Chairperson, the Vice-President of Medical Staff Affairs and the Practitioners' Health Committee.

These recommendations will be communicated to the GME office and the Program Director/Chair (for residents), the Vice-President of Medical Staff Affairs and the Practitioners' Health Committee.

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

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

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

Practicing Residents/Faculty

It is the responsibility of all faculties, residents, or any other person, to immediately report any inappropriate behavior or other evidence of substance abuse/health problems that could impact on

professional/clinical performance in the Hospital. In addition, a resident or faculty member can and is required to self-refer to the Practitioners' Health Committee in the event that he/she experiences any substance abuse/health problem which could impact on professional/clinical performance in the Hospital.

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

If a Program Director/Chair or Vice-President of Medical Staff Affairs receives a report suggesting impairment of a physician (faculty or resident) or observes behavior suggesting impairment, then the following actions are required:

The Program Director/Chair or Vice-President of Medical Staff Affairs will do the best of his/her ability to ensure that the allegation of impairment is credible.

The Program Director/Chair or Vice-President of Medical Staff Affairs must notify the Dean, the Vice-President of Medical Staff Affairs (the Chairperson), and the Practitioners' Health Committee (within twenty-four (24) hours or within the next business day) in writing of any reported incidents or observed behavior suggesting impairment.

The Program Director/Chair or Supervisor must immediately send the physician to Employee Health or the Emergency Department for blood and urine drug screening, as set forth in WVUH policy. Refusal to cooperate with testing is grounds for dismissal from the medical staff for faculty and removal of residents form providing any patient care within the hospital.

The Program Director/Chair or Supervisor must immediately remove the physician from patient care or patient contact.

The Program Director/Chair or Supervisor must immediately make a mandatory referral to the Employee Assistance Program (EAP), based on the possibility of impaired performance.

The Program Director/Chair or Supervisor must immediately send the physician to Employee Health or the Emergency Department for blood and urine drug screening, as set forth in WVUH policy. Refusal to cooperate with testing is grounds for dismissal from the medical staff for faculty and removal of residents form providing any patient care within the hospital.

The Program Director/Chair or Supervisor must immediately remove the physician from patient care or patient contact.

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

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

Other impairments (physical, emotional or psychological)

Any resident or faculty who requests an appointment to practice at WVUH where there is a

physical, emotional or psychological impairment that may interfere with the physicians' ability to function appropriately and provide safe patient care must be initially referred to the Practitioners' Health Committee. The Practitioners' Health Committee will determine whether the resident or faculty needs additional evaluation from a psychiatrist or other person specializing in the specific condition.

The same process will apply as above, however, there may be different or additional monitoring required besides random blood and urine drug screens. POLICY ON QUALITY IMPROVEMENT - GME

I. Rationale

In accordance to the ACGME Clinical Learning Environment Review (CLER), the West Virginia University Office of Graduate Medical Education must ensure that residents are engaged in quality improvement activities. CLER consist of regular site visits that entail site visitor participation in programs or institutional quality assurance and quality improvement activities.

II. Definition

Quality improvement activities include active participation on a Quality Improvement committee through at least one of the following:

1. Planning;
2. Implementation;
3. Analysis of an intervention on a practice outcome;
4. Incorporation into practice if improvement has occurred;
5. Initiation of a new Plan-Do-Study-Act (PDSA) cycle if improvement has not occurred.

Adapted from: Program Director Guide to the Common Program Requirements, 2012

III. Scope

This policy applies to all graduate medical education programs sponsored by the West Virginia University School of Medicine.

III. Policy

A. Programs should encourage and support residents and/or fellows participation in the following West Virginia University Healthcare quality and safety committees:

    1. Blood Utilization
    2. Cancer Review
    3. Care Management Steering
    4. Carotid Angioplasty
    5. CPR
    6. Ethics
    7. Infection Control
    8. Legal E.H.R.
    9. Med Exec
    10. Ongoing Professional Practice
    11. Pain Management

12. Peer Review
13. Pharmacy, Nutrition, & Therapeutics
14. Practitioner Health
15. Quality & Patient Safety
16. Council of Surgical Chairs
17. Quality of Care
18. Performance Improvement

B. Programs must develop policies to ensure all residents and fellows are instructed in quality improvement, and, are involved in quality improvement activities.

1. Programs must incorporate quality improvement instruction into its curriculum. The format of instruction could be in the form of a lecture, self- directed modules (i.e. Institute for Healthcare Improvement), small or large group discussion, or workshops.
2. Programs must ensure each resident or fellow is engaged in quality improvement activities. The level of participation can vary depending on the activity.

Adapted from: Common Program Requirements VI.A.3. The program director must ensure that residents are integrated and actively participate in interdisciplinary clinical quality improvement and patient safety programs. (Core)

C. Programs must develop competency-based goals and objectives that pertain to instruction in quality improvement and participation of resident or fellows in quality improvement activities.

Adapted from: Program Director Guide to the Common Program Requirements, 2012. Each assignment in which the resident is expected to participate must have a set of competency- based goals and objectives. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation.

D. Programs, through the Program Evaluation Committee (PEC), must evaluate instruction in quality improvement and participation of resident or fellows in quality improvement activities at least annually.

1. Residents and fellows must have the opportunity to evaluate instruction in quality improvement confidentially and in writing.
2. Programs must provide a report of resident or fellow quality improvement activities to the Office of Graduate Medical Education. This includes submission and acceptance to the West Virginia University Quality and Safety Fair and other regional or national conferences.

PROGRAM CLOSURE/REDUCTION POLICY

In the event that the Department of Surgery's program is closed, reduced or discontinued, the department will:

Inform the residents in writing as soon as possible. If a resident is unable to complete his/her

training in the program, the department will make a good faith effort to assist the resident in enrolling in an ACGME accredited program in the same specialty at the appropriate PGY level;

Exercise proper care, custody and disposition of the resident's education records, and appropriately notify licensure and specialty boards. Additional information can be found at office of GME.

PROMOTION REAPPOINTMENT/POLICY

The Department of Surgery has established this policy for the General Surgery Residency Training Program to use in the promotion of residents to the next level of training. Additional information regarding the policy can be found at the following website under GME Bylaws: https://medicine.hsc.wvu.edu/media/363881/gmebylawsrevised-1-15-16-oct2017-21318-2-repaired.pdf

The decision to reappoint and promote a resident to the next level of postgraduate training is done annually by the Program Director upon review of the resident's performance and with input from the faculty.

The Surgery Resident is expected to make and maintain satisfactory progress in appropriately developing sound surgical and non-surgical treatment plans, good communication skills, patient management for surgical and non-surgical care, effectively and completely assuring the role of surgical consultant to a wide variety of referring physicians, and mastery of technical skills for performing required procedures independently (with faculty support).

The Program Director shall consider the following factors in the decision to promote a resident to the next level of training:

- All evaluations of the resident's performance (refer to the Policy of Evaluation of Residents) – by making satisfactory progress in the program as documented by evaluations semi-annually and a yearly basis from faculty and making measurable progress in acquiring didactic knowledge.
- Performance on the American Board of Surgery In-Training Examination (ABSITE).
- Preparation and performance at conferences.
- Second year residents must pass Step 3 of the USMLE examination in order to advance to the third year of training.
- Progress toward research requirement.
- Any other criteria deemed appropriate by the Program Director.

Any resident pending promotion due to academic performance will be placed on either department remediation or institutional probation. In the event that a resident is on departmental remediation or
institutional probation at the time of contract renewal, the program director may choose to extend the existing contract for the length of time necessary to complete the remediation process or to promote the resident to the next level of training. If the resident's performance continues to be

unsatisfactory, he/she either will be placed on the next level of discipline or terminated. The resident may request a Fair Hearing in the case of contract extension or non-renewal.

UNIVERSAL QUALITY IMPROVEMENT CURRICULUM

Required Learning Modules: IHI Open School

Period 1: ***Why did you start?***

Activity:

- Identify a local problem or intended improvement Goal:
- Identify a Clinical Aim

Preparation

QI 101: Fundamentals of Improvement

Lesson 1: Errors Can Happen Anywhere – and to Anyone (15 minutes)

Q1 102: The Model for Improvement: Your Engine for Change

Lesson 1: An Overview of the Model for Improvement (12 minutes)
Lesson 2: Setting an Aim (11 minutes)

Period 2: ***What did you do?***

Activity:

- Identify the clinical setting and patient group that will be affected by your Clinical Aim
- Planning the study of the intervention Goal:
- Create a Process map or Key driver diagram

Preparation: Innovation and Pilot

Q1 102: The Model for Improvement: Your Engine for Change

Lesson 3: Measuring for Improvement (12 minutes)

Lesson 4: Developing Changes (10 minutes)
Lesson 5: Testing Changes (15 minutes) QI

103: Measuring for Improvement

Lesson 1: Measurement Fundamentals (20 minutes)

Activity and Goal:

- PDSA Cycle **Preparation:**

Implementation

- QI 106: Level 100 Tools

  Lesson 1: Using the Plan-Do-Study-Act (PDSA) Cycles (Part 1) (35 minutes)
  Lesson 2: Using the Plan-Do-Study-Act (PDSA) Cycles (Part 2) (35 minutes)

Period 3: ***What did you find?***

Activity and Goal:

- Graphs of measurement over time (e.g. run charts or control charts)

Preparation:

QI 106: Level 100 Tools

Lesson 4: Run Charts (Part 1) (45 minutes)
Lesson 5: Run Charts (Part 2) (25minutes)

Period 4: ***What do the findings mean?***

Activity:

- Summarize the most important successes and difficulties in implementing intervention components, and main changes observed in care delivery and clinical outcomes.
- Explore possible reasons for differences between observed and expected outcomes.
- Suggest steps that might be modified to improve future performance.

Goal:

- Summary and share you "Improvement Story" at GME Week
- **Preparation:**

QI 105: The Human Side of Quality Improvement

Lesson 1: Overcoming Resistance to Change (25 minutes)

Evaluation

- Evaluation Method 4.1: Monitor resident completion of mandatory IHI Learning Modules.
- Evaluation Method 4.2: Monitor resident scores and passing and failing rate in the IHI Learning Modules post-test.

- Evaluation Method 4.3: Monitor resident participation in “Period-specific” workshops.
- Evaluation Method 4.3: Quantity and Quality of projects submitted from consideration to the GME and WVUH Quality and Safety Fair.

Timeline

Tasks	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Resident Education in Quality Improvement												
IHI Open School Curriculum Period 1	■	■										
Worshop 1		■										
IHI Open School Curriculum Period 2		■	■	■	■							
Worshop 2			■									
IHI Open School Curriculum Period 3						■	■					
Mentor Meeting 1			■									
IHI Open School Curriculum Period 4								■	■			
Mentor Meeting 2								■				
GME and WVUH Quality and Safety Fair										■		

QUALITY IMPROVEMENT POLICY - Surgery

1. Residents are expected to work in interprofessional teams to enhance patient safety and improve patient care quality.
2. Residents are expected to participate in a quality improvement project in each year of their residency.
3. Residents are to be engaged in the use of data to improve systems of care, reduce health care disparities and improve outcomes.
4. Residents are expected to participate in all quality improvement didactic sessions and teaching modules.
5. Residents are expected to review their own personal quality outcomes through quarterly quality in training initiative (QITI) reports.
6. Residents are expected to attend, participate in and present at weekly morbidity and mortality conference.
7. Each quality improvement project will be submitted to the annual GME QI Fair.

RECRUITMENT POLICY - CRITERIA FOR APPOINTMENT/ELIGIBILITY AND SELECTION OF CANDIDATES

For Graduate Medical Education at the West Virginia University School of Medicine:

The primary source of candidates for entry into graduate medical education programs will be graduates of Liaison Committee for Medical Education (LCME)-accredited medical schools. All

programs participate in an organized matching program. **WVU School of Medicine only accepts J-1Visa Status for Resident Physician positions**. In addition, to be eligible for consideration a candidate must be a:

A. Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
B. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
C. Graduate of a medical school outside the United States and Canada who meet at least one of the following qualifications:
   a. Have received a currently valid certification from the Educational Commission for Foreign Medical Graduates (ECFMG) or
   b. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
D. Graduate of medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school. A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who
   a. Have completed, in an accredited U.S. college or university, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school;
   b. Have studied at a medical school outside the United States and Canada but listed in the World Health Directory of Medical schools;
   c. Have completed all of the formal requirements of the foreign medical school except internship and/or social service;
   d. Have attained a score satisfactory to the sponsoring medical school on a screening examination; and
   e. Have passed either the Foreign Medical Graduated Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).
E. Candidates must meet all federal standards as may be required by Centers for Medicare & Medicaid Services (CMS) or other federal and state regulatory agencies. Applicants that are designated by CMS as “excluded providers” shall not be eligible to appointment as a resident

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

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

Approved by GMEC Taskforce 5/1/08 ACGME Institutional Requirements Approved by GMEC 5/9/08

SICK LEAVE

Accumulation of Leave – Additional Information regarding leave can be found at www.hr.wvu.edu

Accumulation of sick leave is unlimited. Full-time regular classified staff and 12 month regular faculty accrue 1.50 days of sick leave per month during active employment. If you are sick and need to "call- in" to take a sick day you must do 3 things:

6) Contact the program director by

7) Contact the chief resident of your service

8) Contact or leave a voice mail message for Residency Program Administrator, Linda Shaffer 293-1254.

Sick time may be taken for:

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

If you have any questions on whether sick time can be used or not, please contact the Residency Program Administrator. **Excessive/unexplained absences may affect your competency evaluation or even your promotion to the next level of training.**

SCHOLARLY/RESEARCH POLICY

The Department of Surgery has established the following research policy. Over the course of their 5- year surgical training, residents will be required to complete three research projects. Completion being defined as presentation at a regional/national meeting or submission to a medical journal. It will be expected that one project be completed by the end of the PGY-3 year. The remaining two projects will be completed by the end of the PGY-5 year.

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

WVU's surgical training program provides optimal opportunities for residents to engage in basic and clinical research. Residents may take a year off to conduct a research project during the course of their residency training.

SUPERVISION POLICY

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

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

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

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

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

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

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

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

<u>Levels of Supervision *[Section VI.A.2.c)]*</u>
To promote oversight of resident supervision while providing for graded authority and responsibility. Lines of supervision in the Department of Surgery follow a set of guidelines, which is used throughout all of the rotations. PGY 1's are to be supervised directly or indirectly with direct supervision immediately available. Junior (PGY 2-3)

residents will supervise intern activities and also communicate with their superiors, either upper-level residents or faculty. Senior (PGY 4-5) residents will also serve in a supervisory role and will communicate with faculty. Ultimately the decisions rest upon the faculty. Levels of supervision are defined as:

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

Indirect Supervision:
…with direct supervision immediately available:
The supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.

…with direct supervision available:
The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.

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

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

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

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

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

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

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

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

The following "SUPERVISION" guidelines have been established. It is again stressed that a resident should never feel intimidated or belittled when asking for assistance.
Approved by GMEC Taskforce July 5, 2017
Approved by GMEC July 14, 2017

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

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

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

E Expiration. It is inevitable that at some point in a resident's career they will have to deal with the death of a patient. In this event the resident will notify their senior resident and/or attending immediately. Resident will be given proper training in regards to end of life issues, death pronouncements, communicating death to families and necessary paper work. Attending faculty will be available at all times to provide support to residents following the death of a patient.

R "Ready or Not". PGY-1 residents will participate in a supervisory evaluation at the completion of their PGY-1 year. The evaluation will consist of video modules, patient scenarios and a written assessment regarding various procedures and patient situations. These evaluations will be scored by supervising faculty. Successful completion of the evaluation will be necessary for the resident to be given supervisory privileges for the upcoming year.

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

I

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

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

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

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

N Notification. Faculty will be notified of all elective admissions or transfers within 2-4 hours of arrival. All discharges will be discussed with the attending surgeon. All changes in care plans will be communicated to the attending faculty. If she/he is unavailable, then the program director or the chairman of the department should be contacted in order to make a final decision on the plan and/or treatment. When the residents are called for consults in the Emergency Department or the wards, the attending faculty will be notified immediately following the resident's evaluation

REAPPOINTMENT: RENEWAL & PROMOTION POLICY

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

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

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

must also be notified in writing. Intent not to renew is subject to academic grievance as outlined in XI.

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

RESIDENT CONTRACT Review

NOTIFICATION OF TERMS AND CONDITIONS OF APPOINTMENT
MEDICAL AND DENTAL RESIDENTS

Name: «Name»

Annual Salary: «PGSALARY».00
Administrative Supplement: «SUPPLEMENT».00

College	Title	Start	Stop
College of Medicine	*Medical Resident*	*«start_date»*	*«end_date»*

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

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

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

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

2. **Health Maintenance Organizations, Managed Care Entities and Other Purchasers of Health Care:** Resident's signature below in acceptance of this appointment shall constitute the authorization by resident for the School of Medicine or Dentistry or affiliated hospitals of the School of Medicine or Dentistry, to release confidential information concerning resident's education, skills, quality of care, utilization, and patient care experience to health, maintenance organizations, managed care entities and other purchasers of health care that contract for the provision of professional medical/denial services by residents. The resident participating in managed care activities shall be subject to all policies, rules, regulations and agreements of said organizations or entities.

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

3.1 **WVU Human Resources Policies:** WVU Policies regarding leaves include annual leave, sick leave, parental leave, leave of absence policy accommodations for disabilities, etc. and information about insurance may be found at www.hr.wvu.edu/benefits/benefits,cfm Policy on effects of leaves on satisfying criteria for program completion is determined by each department and subject to grievance process.
3.2 **WVU Faculty and Staff Assistance Program:** WVU Faculty and Staff Assistance Program is available for WVU employees and additional information may be accessed at www.hsc.wvu.edu/fsap/

2. **Miscellaneous:**

WVU Sexual Harassment Policy: Information may be accessed at www.wvu.edu/~socjust/sexual.htm. **Grievances:** Information may be accessed at http://pegboard.state.wv.us for Human Resources issues. Grievance procedure and due process for Academic issues may be accessed at www.hsc.wvu.edu/som/gme.

Other policies:
Information on duty hour policies and procedures, policy on moonlighting, policy on other professional activities outside the program, counseling, medical, psychological support services, harassment, program closures & reductions, restrictive covenants, & policy on physician impairment and substance abuse may be found at www.hsc.wvu.edu/som/gme.

3. **Specific Assignments:**
Specific assignments of this appointment will be determined by the President or the President's designated representative and employment in the appointed position is contingent upon the fulfillment of the responsibilities assigned.

4. **Acceptance of Appointment:**
This notification of terms and conditions of appointment must be signed, dated and returned to the Office of the Dean of the West Virginia University School of Medicine or Dentistry within ten (10) days of its receipt in order to indicate acceptance of the appointment.

I hereby accept the appointment described above, subject to all the specified terms and conditions.

____
Employee Signature Date

RESIDENT PROFESSIONALISM STANDARD FOR INTERRUPTION OF PATIENT CARE POLICY

I. Rationale

To assure continuity of care and patient safety, ACGME requires a minimum number of patient care transitions and readily available schedules listing residents and attending physicians responsible for each patient’s care. In addition to resident-to-resident patient transitions, residents must care for patients in an environment that maximizes effective communication among all individuals or teams with responsibility for patient care in the healthcare setting.
To assure that residents are well-equipped to accept responsibility for the health and safety of future patients, and to assist with a seamless transition from observing to providing quality patient care, every resident must be accountable for the treatment of any patient he/she encounters as though he/she were the sole provider of care and must treat all patients as the resident’s own patients.

II. Policy

A. If a resident is aware of any conflict that may arise during the course of any upcoming procedure or patient care activity, whether such a procedure or activity is scheduled or emergent, that resident must inform the attending physician and/or Residency Program Director in advance to allow the physician or service to determine whether patient safety will allow for reasonable accommodations. It may be necessary to alter a resident's rotation schedule if breaks cannot be reasonably accommodated.

B. In surgical settings and other patient care activities, residents may not scrub out of surgical procedures, leave the operatory or any patient care setting for any non-emergent reason (e.g. medical conditions, breast feeding, or child or adult care). While emergencies will sometimes arise, in the event of an unforeseen emergency, residents must appropriately notify the attending physician of the emergency and seek the necessary permission to be excused only when and if the circumstances warrant. In absolutely no instance should a resident scrub out of surgery or leave the operatory without first informing the attending physician and obtaining permission to exit. Residents are expected to be compliant with current duty hour standards and program duty hour policies and procedures.

Consequences for failure to comply will be at the discretion of the Residency Program Director.
GMEC Taskforce approved: 11-3-11
GMEC approved: 11-11-11

TRANSITIONS OF CARE & HAND OFF *VI.E.3.a) (b)(c)(d)(e)*

I. Rationale

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

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

II. Policy

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

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

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

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

- Patient name
- Age
- Room number
- ID number
- Name and contact number of responsible resident and attending physician
- Pertinent diagnoses
- Allergies
- Pending laboratory and X-rays
- Overnight care issues with a "to do" list including follow up on laboratory and X-rays
- Code status
- Other items may be added depending upon the specialty.

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

- The Department of Surgery instituted a “Protected Time” between 5:30-6pm each day for the Handoff/Sign-out of patient care to the Night Team. The On Call” paging system reads: “Please hold Non-Urgent Pages between 5:30-6pm for Surgery Sign-out”.
- All surgery residents will be excused from the floors and the operating room during the handoff/transition time period. The nurse managers of the floors have been notified to
  hold all non-urgent pages and calls until after this time.
- Once a month a Surgery faculty member is assigned to moderate and document the sign- out process of the surgery teams.

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

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

well as the process, using E*Value, and must update this method as necessary.

III. GME Monitoring and Evaluation

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

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

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

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

TRAVEL REIMBURSEMENT POLICY

Reminder: 4th and 5th- general surgery residents and 5th/6th year plastic residents are allocated $1,500 for meeting expenses. Residents below these levels do not have monies allocated for travel but will be considered based on the meeting/presentation type, etc.

Allocated CME money can be spent on approved items as determined by the recipient. However, it is often the case that monies could be saved for the department/individual if travel plans were made in advance. Hopefully, everyone will do this going forward, but for the residents who have no allocated funds and for everyone once their allotted CME funds have been exhausted, the meeting registration and hotel accommodations must be made during early registration; air transportation should also be arranged as early as possible to save money (just as we would all do if we were paying this personally).

- **Travel Costs Eligible for Reimbursement**
  - Flights (coach fare)
  - Hotel (2-night maximum for Residents without allocated CME funds -- the night before and night of the presentation)
  - Conference Registration, if applicable—THIS MUST BE DONE USING EARLY-BIRD REGISTRATION—meetings are never arranged at the last minute, and there is rarely a reason to plan attendance after early registration has closed; if the registration is made after early-bird registration closes, this requires approval from the chairman.

    - Meals (federal standard per diem rate – excluding alcohol, no more than $60 a day and require itemized receipts)
    - Mileage for transportation to/from airport: (no rental cars; if a rental car is required, justification must be provided and prior approval from the chairman is required)

- **Travel Request Form Submission**
  The following must be provided for approval:
    - Request Form Signed by the Program Director and or Division Chief must be received by the Business and Grants Manager two weeks prior to the early-bird registration for the conference/meeting. Requests received less than two weeks in advance will require approval by the chairman and may be denied. The submitted form must be complete with accurate estimated costs and dates.
    - Conference Documentation – attach a copy of the meeting Program/Agenda and completed registration form with the request.
    - All estimated costs require specific/detailed documentation including the source of the estimate.
    - Airfare – travel dates must be submitted along with screenshots of preferred flights and/or flight numbers of preferred flights. These should be done as early as possible to save money.
    - Hotel – accurate estimates of hotel costs with the room rate and taxes/fees included. If staying somewhere other than the host hotel, documentation (screenshot or link to site) of hotel room rates must be included.
    - Acceptance letter or email for oral/poster presentations.
- **Reimbursements**
  The following must be provided:
    - Copies of all paid receipts must be provided within 30 days of the conference (conference registration, airfare, itemized hotel folio, and itemized receipts).
    - Receipts submitted 30 days after the event will require the chairman's approval for reimbursement.

Please note that receipts reimbursed 60+ days after the event is considered by the IRS as taxable income.

Written: April 2022

USMLE/LICENSE POLICY

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

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

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

2. All PGY 1 residents have to complete first attempt of USMLE step 3 prior to the end of PGY1 year. Failure to complete, will result in immediate Level 1 intervention at the beginning of PGY2 year.

3. If the resident has not passed USMLE III, by December 31st of PGY2 year, the resident will be placed on immediate Academic Probation (level II intervention) and will remain on probation until they reapply, complete and pass the exam.

Time Limit and Number of Attempts Allowed to Complete All Steps

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

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

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

Information can be obtained regarding licensure from the following:

Doctors of Medicine:
West Virginia Board of
101 Dee Drive
Charleston, WV 25311

Doctors of
State of West
Board of
334 Penco Road

VACATION POLICY- DEPARTMENT OF SURGERY

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

1. Residents (PGY 1-5) will receive 3 weeks of vacation per year.
2. Residents will submit a request for a "Vacation Form" for their proposed vacation dates to the administrative chief, and program administrator prior to July 31st. Alternate dates should be included.
3. Any resident not submitting requested dates by July 31st; will be assigned vacation dates by the program director.
4. All attempts will be made to accommodate each resident's first choice. The administrative chief resident and the program directors, if needed, will mediate disputes.
5. *NO* vacations will be permitted on outside rotations (transplant, Jefferson rotation, etc.), night-float, the last 2 weeks of June, the month of July, the week of Thanksgiving, Memorial Day, Labor Day, the month of December, or the first week of January.
6. Residents will be assigned days off during either Christmas or New Year. Residents will get a total of 7 days off in December to include GME days off and holiday schedule.
7. **Chief residents: Vacation in the last week of June is NOT guaranteed.** Considerations such as start of fellowship or relocation will be taken into account.
8. No vacations will be granted during the week of the In-service training exam.
9. All vacations must be taken in one-week intervals. Exceptions will be made on a case-by-case basis in consultation with the administrative chief resident and the program director.
10. A week constitutes **no more** than 7 consecutive days. This credits one GME required off day.
11. Only one week of vacation will be permitted per month per resident.
12. A maximum of 2 residents are permitted vacation on any given service each month.
13. Vacation is NOT permitted on the same rotation on different months throughout the year except as the week rolls over in the next month (i.e. at the end of one month and the beginning of the next).
14. Each service will share an equal burden of vacation absences by residents.
15. Only one resident per PGY year may be gone at the same time. Exceptions will be made on a case-by-case basis.
16. Exceptions will be made on a case-by-case basis for unscheduled absences, e.g. deaths, births, or other family emergencies.
17. Vacations are not approved until all three signatures (admin chief resident, program administrator, and program director) are obtained on the vacation request form and it is returned to the program administrator's office)
18. ***DO NOT*** make flight arrangements, reservations, etc. until you are officially granted your vacation.
19. Requests for changes in vacation dates must be submitted in *writing* to the admin resident, program administrator, and program director and will be approved or denied on a case-by case basis.

Revised 4/6/23

VACATION POLICY – OFF SERVICE

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

1. Vacation requests must be submitted 4 months in advance. Requests for vacation during the months of August, September, and October should be submitted by no later than July 31st.
2. Vacations are not approved until all three signatures (service chief resident, faculty service chief, and Surgery program director) are obtained on the vacation request form and it is returned to the program director or residency administrator's office.
3. ***DO NOT* make flight arrangements, reservations, etc. until you are officially granted your vacation.
4. All attempts will be made to accommodate each resident's first choice. The administrative chief resident and the program directors, if needed, will mediate disputes.
5. *NO* vacations will be permitted on Night-float, the last 2 weeks of June, the month of July, the week of Thanksgiving, Memorial Day, Labor Day, the month of December, or the first week of January. Residents will be assigned days off during either Christmas or New Year. Residents will get a total of 7 days off in December to include GME days off and holiday schedule.
6. *NO* vacations will be granted during the week prior to the General Surgery In-service training exam (the last week in January).
7. All vacations must be taken in one-week intervals. Exceptions will be made on a case-by-case basis in consultation with the administrative chief resident, residency administrator, and the program director.
8. Only one week of vacation/conference time will be allowed per month per resident.
9. **Residents are allowed one week off per 3 months of service within the department of general surgery.**
10. A maximum of 2 residents are permitted vacation on any given service each month.
11. Vacation is NOT permitted on the same rotation on different months throughout the year except as the week rolls over in the next month (i.e. at the end of one month and the beginning of the next).
12. A week constitutes no more than 7 consecutive days (including weekends). This credits one GME required day off.
13. Only one resident per rotation may be on vacation at a particular time.
14. Exceptions will be made on a case-by-case basis for unscheduled absences, e.g. deaths, births, or other family emergencies.
15. All requests must be made on the Surgery department's vacation request form. This form can be obtained from the program administrator (Linda Shaffer 293-1254).
16. Meeting/travel requests (presenting resident) must be submitted one month prior to the rotation. These will be considered on an individual basis. Only the days of the meeting and one travel day will be granted. Additional days will be considered a vacation.
17. **If a resident is away from the service to attend a meeting, they will not be permitted to take a separate vacation that same month.**
18. Requests for exceptions to the above guidelines must be submitted in *writing* to the program director and will be approved or denied on a case-by-case basis.

We appreciate your co-operation and hope that by following the above guidelines, we will be able to accommodate all resident's vacation requests. Please see that each of your residents rotating with us receives a copy of these guidelines.

Revised 4/6/23

VENDOR REPRESENTATIVES ON RESIDENT INTERACTION-

POLICY

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

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

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

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

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

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

Approved by GMEC Taskforce 12/14/06 ACGME Institutional Requirements
Approved by GMEC 1/12/07 111.B.13

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

GIFT:____

INDUSTRY/COMPANY:__________________________

DATE:____

NAME(print):____

NAME(signature):____________________________________

EDUCATIONAL RATIONAL:___________________________

PROGRAM DIRECTOR:________________________________

DATE:

WELL-BEING ALERTNESS MANAGEMENT/FATIGUE MITIGATION POLICY

The West Virginia University School of Medicine (WVU SOM) is committed to preparing our residents and fellows for a lifetime of caring for others and themselves. Therefore, one of the most important lessons we must teach them is the crucial importance of the physicians' own physical and mental well-being to their ongoing practice of medicine. Initiating learning in well-being and self-care, and normalizing these pursuits, is crucial for residents and fellows at this stage of training because

GME is the time when they begin to establish the practice habits they will have for the rest of their lives.
The WVU SOM's GME Well-being Program requires each training program to provide instruction in well-being as an integral part of their ongoing curriculum. This instruction must take place at least annually, although best practice would be more frequently and on a regular basis with different sessions provided for each. An ideal set up would be to provide a well-being session for Grand Rounds in order to educate supervising teaching faculty in addition to residents and fellows, as this is an ACGME mandate.

In addition, although residents and fellows are no longer required by WVU SOM to complete an annual well-being screening, we are asking training programs to continue the call to wellness initiated in the 2017 guidelines by encouraging and supporting their residents and fellows to schedule a well-being screening on their own should they feel a need to do so.

The Faculty and Staff Assistance Program (FSAP) and Spiritual Care remain the two available free options for screening at this time. Spiritual Care offers group training didactics and experiences

(Appendix A) should individual programs wish to use this as a part of their wellness curriculum.
FSAP, though their staffing is more limited, is also able to provide group training didactics, as their schedules permit. To contact FSAP, please refer to their flyer (Appendix B) at the end of this policy.

As each program sets their individual well-being policy, they will use the "fill-in-the-blank" program-specific well-being policy (to define how well-being will be integrated into their program, and to clarify the expectations for residents, fellows, and supervising faculty.

The GME Office will be assessing the overall well-being of our residents, fellows, and supervising teaching faculty on a regular basis utilizing the annual ACGME Well-being Survey, and other instruments including, but not limited to, the Mini Z 2.0, and the PHQ-9. This required GME oversight will be done in collaboration with our training programs as we strive to make continual improvements to our clinical learning environment.

Approved by Wellness/Work Hours Committee: 8/1/2018
Approved by GMEC Taskforce: 10/4/2018
Approved by GMEC: 10/12/2018

WELL-BEING ALERTNESS AND FATIGUE - SURGERY

Burnout: Long-term exhaustion and diminished interest in work. Dimensions of burnout include emotional exhaustion, depersonalization, and feelings of lack of competence or success in one's work. Burnout can lead to depression, anxiety and substance abuse disorders.

Resident: Any physician in an ACMGE-accredited graduate medical education program including residents and fellows.

Resilience: The ability to withstand and recover quickly from difficult conditions or situations. During training, Residents may face difficult patient care, educational or personal events which have the ability to negatively affect their Well-being. Decompressing after such situations, through conversation with peers, mentors or family, and self-care activities, can increase Resilience.

Well-being: Refers to the state of being healthy, happy and successful. Well-being may be positively increased by interacting with patients and colleagues at work, being intellectually stimulated and by feeling that one is making a difference/helping. In addition, self-care activities, including exercise, getting plenty of rest and connecting with others, is beneficial.

Residents' physical, psychological and emotional Well-being is of paramount importance to our training program. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth. To that end, we provide the following strategies to support trainee health, Well-being and Resilience:

Department Support

- Through our department we have initiated the Live And Work Well (LAWW) program that directs and provides information to our residents, employees and their families with resources and services that motivate, encourage, and promote healthy lifestyles and foster Resilience that include:
  - Health Improvement and Employee Wellness: including Health Risk and Wellness Assessment, MindStrength mindfulness training, health and lifestyle coaching, diet and nutrition resources, fitness rooms, onsite fitness classes and others.
  - Employee Assistance Program (EAP): Confidential and free counseling services which include up to three in-person free visits/year and 24/7 telephonic counseling.
  - Primary Care: Coordinated, primary care option for state insured employees and their dependents.
  - Occurrence Reporting: Patient and employee safety reporting for actual events and near misses.

- Residents have access to healthy food and beverage options at the Ruby cafeteria and from other on-campus food vendors including 24/7 service on the go deli located within Ruby Hospital.

- The office of the Program Director/Chair and GME is a safe place where Residents can ask for and receive help with various needs including academic counseling, coaching, and mentoring.

- The GME sponsors an annual Resident and Fellow Appreciation Week where Residents have the opportunity to participate in daily wellness activities and shared meals. During the week.

- Residents may become members of, or participate in, the GME Resident Forum and other committees. The GME Resident Forum membership is composed of a group of peer-elected representatives from each of the core residency programs which comes together to discuss issues affecting Resident life. The Resident Forum seeks to promote harmonious and collaborative relationships amongst Residents, faculty and staff and enhance the Resident community through advocacy, volunteer, and social activities.

- The hospital delivers fruit and snacks to the Resident call rooms in late afternoons and evenings. The first day of each month is celebrated for any resident that may have a birthday in that month. A cake, cupcakes and cookies are left in the workroom.

- The last Wednesday of the month the department provides a lunch for the residents free of charge. Meal card support is also provided to Residents taking overnight in-house call and for Residents who must return to the hospital to provide care when scheduled to home call.

- Each month the “Social Event Resident” has an event planned for the residents, residents that are not on call attend. The Residents have tried the following: white

water rafting, axe throwing, wine/dine night, cooking class, paint and sip, volleyball team game, softball ball team, fire arm safety and shooting, bow shooting, horseback riding and volunteering as a group for an organization.

- Residents may take advantage of free taxi service from the hospital by contact the Emergency Room front desk and ask for the service. This is to be used in the event that they are too fatigued to drive home after a clinical shift.

- All Residents and core faculty complete an annual learning module on “Sleep and Fatigue mitigation”.

- There are circumstances in which Residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program has policies and procedures in place to ensure coverage of patient care in the event that a Resident may be unable to perform their patient care responsibilities. These polices will be implemented without fear of negative consequences for the Resident whom is unable to provide the clinical work.

- Residents have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Residents must follow the program’s procedures for scheduling and notification of these appointments.

- Residents are encouraged to alert the program director, associate program director, a faculty mentor, program manager, or Chief Resident when they have concern for themselves, a resident colleague or a faculty member displaying signs of Burnout, depression, substance abuse, suicidal ideation or potential for violence.

MISCELLANOUS FORMS

VACATION AND MEETING REQUEST FORM 2022/2023

RESIDENT: ____

Circle One: VACATION / MEETING (*- see required information below)

DATES OF TRAVEL: ____________________

*** Dept. of Surgery Residents only: If attending a meeting, name of meeting and Location:**

____

____

*** Dept. of Surgery Residents only: Attach copy of acceptance letter/email.**
(Please Print) TITLE OF ABSTRACT/PAPER OR POSTER

1. **Please complete and attached an Authorization to Travel Form (outside Linda's Office) The Authorization Form must be approved prior to making any travel arrangements (registrations, hotel reservations, flights, etc.).**

____

____

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

____

Information below completed by Surgery Residency Administration office:

- ○ **Email approval received from chief faculty member of service.**
- ○ **Email approval received from chief resident of Service.**
- ○ **Request reviewed by Linda Shaffer and Ben Reed, MD (Admin Chief).**

Final Approval: Lauren Dudas, MD, Program Director

PROGRAM DIRECTOR'S SIGNATURE: ____________________

Please return completed form to: Linda Shaffer, C-TAGME
Senior Residency Program Administrator
Department of Surgery

P.O. Box 9238
West Virginia University, Morgantown, WV lishaffer@hsc.wvu.edu

REQUEST FOR AUTHORIZATION TO TRAVEL

DEPARTMENT OF SURGERY

DATE: ____________

APPLICANT: ____________

REQUISITIONER: ____________

DESTINATION: ____________

PURPOSE (Attach brochure or meeting announcement): ____________

DATES OF MEETING/OFFICIAL BUSINESS:

FROM ____________ TO ____________

DATES OF ABSENCE FROM WORK INCLUDING TRAVEL AND VACATION:

FROM ____________ TO ____________

ESTIMATED COST:

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

APPROVAL GRANTED: ____________

Dept of Surgery Administration

JC9502