POLICY AND PROCEDURES

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EDUCATIONAL GOALS AND PHILOSOPHY

The goal of the Thoracic Residency Program at the West Virginia University is to provide a comprehensive education that encompasses the operative, perioperative, and surgical critical care of patients with acquired and congenital pathologic conditions of the heart, lungs, airways, esophagus, chest wall, and great vessels of the chest. Education and progressive responsibility proceed with the goal that upon completion of the program, graduating residents will be competent in Cardiothoracic surgery to perform procedures within their chosen specialty or meet the requirements for application of additional fellowship training if the resident so desires. This is accomplished by providing both the experiences and environment where residents can develop the surgical skills, medical knowledge, communication, clinical skills, and professional attitudes to become physicians committed to lifelong learning, medical system integration, and excellence in the diagnosis and treatment of diseases of the thorax.

The American Board of Thoracic Surgery (ABTS) considers it inappropriate to exclude its Diplomates from credentialing for care of thoracic surgical patients in a critical care setting based on the Diplomate's training or board certification. Diplomates of the ABTS have been trained in critical care management of thoracic surgical patients and they have successfully completed both written and oral examinations which cover the critical care aspects of the thoracic surgical patients. Critical care management of these patients will therefore be strongly emphasized and will be supported by daily attending teaching rounds in the Cardiothoracic ICU.

Whether residents intend to pursue an academic, hospital-based, or private practice career, the goal of the CT Residency Program is to equip trainees with the ability to critically assess the medical literature, develop an understanding of research, and keep abreast of new developments. Since the acquisition of knowledge in medicine must be lifelong, general principles are emphasized, as well as the importance of independent study, so that residents can continue their education well beyond the period of residency training. Certain character attributes are inherent in the practice of medicine. As such, the importance of professionalism, communication, compassion, reliability, initiative, responsibility and the ability to work harmoniously with all levels of medical personnel is emphasized throughout the duration of training.

The goals described are adjusted for individual residents according to their specific talents and skills. The goals should be regarded, therefore, as only approximation of the progression of training for a particular resident. These goals are structured to conform to the six competency requirements set forth by the Accreditation Council for Graduate Medical Education (ACGME) and Thoracic Surgery Directors Association (TSDA). At all levels of training, residents are expected to participate in teaching junior house officers and medical students, consistent with their own knowledge and experience. Throughout the training of all CT residents, an attending surgeon is scrubbed or immediately available for all operations.

PROGRAM OVERVIEW

**Goals:** The general goals of the program are to provide a learning and training environment which facilitates the development of expert CT surgeons who will have the tools and abilities to be leaders in both the clinical and academic community of CT surgery. Following successful completion of the training program, the trainee will be eligible to sit for the qualifying examination for the ABTS. It is expected that the trainee will be a competitive candidate for the professional position of his or her choice, whether private practice, academic, or a combination of the two. Additionally, it is a goal of the program to graduate physicians competent in all aspects of thoracic care, including diagnosis, medical management, and surgical management of surgical disorders of the thorax.

These goals are accomplished by providing:

* Didactic instruction and research experience in thoracic physiology and pathobiology
* Instruction and direct clinical experience with the technology, clinical applications, and professional interpretation of noninvasive and invasive testing involved in the diagnosis of thoracic disorders
* Instruction, supervision, and direct clinical experience in the performance of interventions for the surgical correction of thoracic diseases
* Use of the STEPS Simulation Center surgical simulation training to develop technical experience and proficiency, improve skills for dealing with stressful situations, and increase intradepartmental communication.

CURRICULUM OVERVIEW

The residency training program in CT Residency at West Virginia University is a two-year program comprised of a balance of all the clinical and academic components of:

* Diagnosis, medical management, and surgical management of acquired disorders of the heart
* Diagnosis, medical management, and surgical management of congenital disorders of the heart
* Diagnosis, medical management, and surgical management of disorders of the lung, esophagus, airways, and chest wall
* Surgical simulation training in common cardiothoracic procedures
* Clinical research

These activities will be conducted at J. W. Ruby Memorial Hospital of West Virginia University.

PROGRAM GOALS AND OBJECTIVES FOR COMPETENCIES

At the completion of the training program, it is expected that the resident will be fully prepared to embark on a career as a cardiothoracic surgeon though education and successful completion in the following areas:

**Medical Knowledge:** Residents must demonstrate knowledge of established and evolving biomedical, clinical and cognate medical sciences, and the application of this knowledge to patient care. Residents are expected to:

* Demonstrate appropriate general medical knowledge of thoracic diseases.
* Know and apply the basic and clinically supportive sciences which are appropriate to the discipline of CT surgery.
* Demonstrate competence in all surgical and technical procedures commonly performed in CT surgery.

**Patient Care:** Residents must be able to provide both inpatient and outpatient care that is compassionate, appropriate and effective for the treatment of thoracic diseases and the promotion of health. Residents are expected to:

* Establish skills in gathering accurate and essential patient data.
* Perform the necessary standard preoperative work-up prior to surgery.
* Recognize risk factors for surgery and take steps to mitigate the impact of potential complications.
* Demonstrate an understanding of informed treatment plans, including up-to-date scientific evidence, clinical, and surgical judgment.
* Demonstrate competence in pre- and post-operative care, the ability to select the procedure most appropriate to the clinical situation, and to recognize his/her limitations.
* Demonstrate competence in all surgical and interventional procedures commonly performed in CT surgery.
* Demonstrate caring and respectful behaviors when interacting with patients and families.
* Accurately interpret labs and diagnostic studies that pertain to thoracic surgery.

**Interpersonal and Communication Skills:** Residents must demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, families, and healthcare professionals. Residents are expected to:

* Communicate openly and effectively with patients, peers, healthcare professionals and ancillary staff.
* Utilize effective listening and questioning skills while providing and receiving patient information.
* Demonstrate effective exchange of information including patient handoff.
* Present clear and concise thoughts at conference and presentations.
* Show the ability to counsel patients and families and accurately document the risks, benefits, and alternatives to surgery.

**Professionalism:** Residents must demonstrate commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a culturally diverse patient population. Residents are expected to:

* Demonstrate acceptance of their accountability to patients, society, their profession, and a commitment to professional development.
* Express a commitment to ethical principles pertaining to provision or withholding of clinical care, the confidentiality of patient information, informed consent, and business practices.
* Articulate sensitivity and responsiveness to patient’s culture, age, gender and disabilities.
* Demonstrate a working knowledge of the requirements of the Health Insurance Portability and Accountability Act (HIPPA).
* Communicate effectively and compassionately with patients and their families.
* Demonstrate punctuality for service activities, including conferences and patient care responsibilities.
* Respond to pages and requests for assistance consistently in a timely manner.
* Demonstrate patience, sensitivity, and tact in dealing with the moral, legal, and ethical issues associated with the care of CT patients.
* Demonstrate integrity and respect for all members of the patient care team.
* Exhibit appropriate attire at all times.
* Demonstrate integrity and respect for all members of the patient care team.
* Consistently maintain medical records in a timely, clear, and concise manner.
* Document regular attendance at seminars of ethics and professionalism.

**Practice Based Learning and Improvement:** Residents must demonstrate the ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve patient care practices. Residents are expected to:

* Demonstrate an ability to effectively utilize systematic methodology to assess practice experience and perform practice based improvement activities.
* Locate, appraise, and assimilate evidence from scientific studies related to patient’s cardiovascular and thoracic problems.
* Demonstrate an ability to obtain and utilize information from patient population and the larger population from which they are drawn to enhance patient care.
* Utilize information technology to manage information, access on-line medical information, and to support their own education.
* Demonstrate an ability to utilize knowledge of study designs and statistical methods to recognize strengths and weaknesses in clinical studies and other information on diagnostic and therapeutic effectiveness.
* Facilitate the education of medical students, residents, and other healthcare professionals.
* Demonstrate ability to practice lifelong learning by reading and discussing topics at CT conferences.
* Prepare for, and perform satisfactorily on the annual in-training examination and mock oral exam.

**Systems Based Practice:** Residents must be aware of their professional responsibilities in the larger context of the healthcare system. Residents must further demonstrate an ability to effectively work utilizing system resources to provide care of optimal value. Residents are expected to:

* Demonstrate understanding of thoracic issues; how they affect other health care providers, the health care organization, and society as a whole.
* Collaborate with healthcare professionals from other disciplines to provide optimal care.
* Exhibit an understanding of how environmental factors impact healthcare organizations and healthcare costs.
* Demonstrate ability to recognize how types of medical practices and delivery systems differ from one another, including methods of controlling health care costs and allocating resources. Utilize this knowledge to insure quality healthcare.
* Perform efficient, timely, and cost-effective practice patterns and resource allocation that does not compromise patient care.
* Demonstrate understanding of clinical practice management and human resource issues as modeled by the faculty and through the attendance of CT Faculty Departmental meetings.
* Express knowledge of hospital and community resources in place to support patients, advocate for quality patient care, and consistently assist patients in dealing with complexities of the healthcare system.

**Technical Skills:** Residents are expected to demonstrate competence in all surgical and technical procedures commonly associated with CT Residency. In particular, competence must be acquired in:

* Detailed thoracic anatomy and physiology.
* Proper history taking and physical examination of the patients with thoracic problems in both the hospital and outpatient clinic setting.
* Early recognition and treatment of complications of CT surgery.
* Proficiency in performing the technical aspects of an operation with a clear understanding of the progression of the operative steps and potential pitfalls.
* Management of resources and personnel in the operating room to optimize communication and improve efficiency.

Year 1 - Adult Cardiac Surgery (PGY-6)

1. Medical management and indications for surgery of ischemic and valvular heart disease
2. Preoperative evaluation of patients
3. Risks of the operations and how to counsel patients appropriately
4. Perioperative management of patients following complicated cardiac and general thoracic procedures
5. ICU care, including ventilator management, nutritional support, inotropic management, and management of intra-aortic balloon pumps
6. Acquire graded responsibilities as primary surgeon to perform operations for coronary revascularization, valve repair and replacement, and aortic disease
7. Acquire graded responsibilities as primary surgeon for heart procurement for transplantation

Year 1 - General Thoracic Surgery (PGY-6)

1. Evaluation and management of thoracic malignancies including lung esophageal and mediastinal tumors
2. Evaluation and management of congenital lesions of lung and esophagus. Develop understanding of workup treatment of benign disorders of the esophagus
3. Staging of thoracic malignancies
4. Utilize appropriate adjunctive protocols for chemo and radiation therapy
5. Intra-operative airway management and planning of major airway resections
6. Acquire graded intra-operative responsibility as surgeon for operations on the lung, chest wall, mediastinum and esophagus

Year 1 - Congenital Cardiac Surgery (PGY-6)

1. Learn the pathophysiology of the common congenital heart anomalies
2. Lean the fundamentals of cardiopulmonary bypass in infants and children
3. Learn the perioperative hemodynamic management for pediatric cardiac surgical patients

Year 2 - Adult Cardiac Surgery (PGY-7)

1. Medical management of heart failure
2. Indications and contraindications for heart transplantation
3. Management of heart transplant recipients
4. Indications for ventricular assist devices
5. Continue to assume more responsibilities as primary surgeon for operations for myocardial revascularization and valvular heart disease
6. Assume responsibility as primary surgeon on heart transplantation
7. Assume graded responsibility as primary surgeon in the placement of ventricular assist devices

Year 2 - General Thoracic Surgery (PGY-7)

1. Evaluation, management, and operative treatment of patients undergoing lung transplantation
2. Acquire graded intra-operative responsibility as surgeon for operations on the lung, chest wall, mediastinum and esophagus
3. Acquire graded responsibility as primary surgeon for lung transplantation

Year 2 - Congenital Cardiac Surgery (PGY-7)

1. Acquire graded intra-operative responsibility as surgeon for operations to correct atrial septal defects, ventricular defects, patent ductus arteriosus, and coarctation of the aorta.

**2018-2019 SALARY SCHEDULE**

* PG 6 - $63,650
* PG 7 - $65,810

FACULTY SUPERVISION – RESPONSIBILITY GUIDELINES

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

The following is a list of faculty guidelines:

1. As a faculty member, you bear the ultimate responsibility for patient care and for providing the documentation in the medical record of the care provided. These responsibilities should be exercised without diluting the educational process.
2. Patient interaction should be real, not theoretical. Bedside, office and operating room clinical skills should be stressed and modeled. Most new patient presentations should occur at the bedside.
3. All patients admitted to the CT service will be seen and formally staffed with the resident on the day of admission. Patients admitted after normal working hours will be seen and evaluated with formal staffing on the following day. If there is an acute change in the patient’s condition during the daytime, the appropriate faculty member is to be notified immediately by the resident. If this occurs after hours, the resident will contact the individual faculty member or the CT Residency faculty member on call at that time. For patients admitted on weekends or holidays, staffing should occur no later than 24 hours after admission. If you are absent, residents must be aware of your designee for patient care issues.
4. You are responsible for informing your residents of when they must contact faculty immediately relative to the following patient care issues: end of life status change, ICU admission, need for emergency operative intervention, any issues where the patient or family need clarity, or any change in the patients clinical condition.
5. You should plan your schedule so you will be available at all times during the day when patient care and teaching activities are proceeding. Residents must be aware of your designee when you are out of town or otherwise absent.
6. Feedback should be given to residents informally on a daily basis and formally at the end of the rotation via the evaluation process. Suggestions for improvement should be made early enough for corrective action to be implemented.
7. Regular chart reviews should be conducted. The focus should be on record completion and avoidance of unnecessary tests and procedures, and assessment of appropriate patient care and documentation.
8. Rotating medical students and residents from other services must be included in teaching and patient care activities. When requested, evaluations on these students and residents should be completed in a timely manner.
9. Insist that residents, fellows, and medical students on your service consult the literature regularly about issues that arise in the context of patient care. Ask them to cite the literature and share their findings with you and other team members.
10. You are responsible for attending and participating in scheduled conferences and other didactic activities of the Division and Department. An attendance log will be kept for program certification purposes.

SUPERVISION POLICY

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

**Responsibilities/Requirements**

The Department of Cardiovascular and Thoracic (CT) Surgery is committed to providing a professional, respectful, and civil environment that is free from mistreatment, abuse, and coercion of residents, faculty, and staff. In accordance with WVU GME, supervision will be provided in a non-retaliatory and supportive manner. The Dept. will educate residents and faculty regarding inappropriate and unprofessional behavior, especially when exhibited toward a resident who is requesting supervision and guidance. Lines of supervision in the Dept. of CT Surgery follow a set of guidelines, which is used throughout all of the rotations.

1. All residents (PGY 6-7) are to be supervised directly or indirectly, with direct supervision immediately available.
2. PGY 6 residents will supervise medical student activities and also communicate with their superiors, either upper-level residents or faculty.
3. PGY 7 residents will also serve in a supervisory role of their PGY 6 junior resident, as well as medical students on each service.
4. Residents 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**: (Direct supervision immediately available) The supervising physician is physically within the hospital and immediately available to provide Direct Supervision.

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

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

The Department of CT Surgery wants to ensure that all residents 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. 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.

The following **Supervision** guidelines have been established. It is again stressed that a resident should never feel intimidated or belittled when asking for assistance.

**SUPERVISION**

Safety of the patient, as well as safety of the resident, are of paramount importance. The Department of CT 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 feel safe and secure at all times while gaining independence. A faculty is always assigned to supervise the residents.

Each patient must have an identifiable, appropriately-credentialed and privileged, attending physician who is responsible and accountable for the patient’s care. This information must be available to residents, faculty, other members of the health care team, and patients. Residents and faculty must inform each patient of their respective roles in that patient’s care when providing direct patient care. 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. 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 PD and faculty. The PD must evaluate each resident’s abilities based on specific criteria, guided by the milestones. Faculty functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of each resident. 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.

WVU Medicine is focused on ensuring all patients receive the highest possible standard of patient care and clinical effectiveness. It is our policy that all incidents/events be reported and investigated as appropriate using Patient Safety Net (PSN), a web-based reporting tool. This includes the reporting of information regarding adverse events, near misses, and unsafe conditions involving patients, staff and visitors. For more information, contact the Director of Risk Management, Jan Manilla at 304-598-4182 or the Coordinator of Patient Safety, Melissa Polito at 304-598-5824. In addition to participation in interprofessional, interdisciplinary, systems-based efforts addressing patient safety and quality improvement (i.e., Morbidity and Mortality Conferences, institutional or departmental level Root Cause Analysis of adverse events, etc.) all residents will be required to complete WVU GME assigned self-directed modules from the Institute for Healthcare Improvement (IHI) Open School. Patient safety and quality improvement instruction will be evaluated by the Program Evaluation Committee annually and resident’s participation and results will be monitored.

**Personal Responsibility:** Residents and faculty are expected to hold themselves up to the highest standards of personal responsibility and accountability. Each resident must know the limits of their scope of authority, and the circumstances under which they are permitted to act with conditional independence. 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. 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.

**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. Residents 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.

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

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

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

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

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

**Notification:** Faculty will be notified of all elective admissions or transfers within 1 hour 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 PD or the chairman of the Department should be contacted in order to make a final decision on the plan and/or treatment. When the residents are called for consults in the Emergency Department or the wards, the attending faculty will be notified immediately following the resident’s evaluation.

EDUCATIONAL CONFERENCES

The conference schedule is designed to cover the comprehensive curriculum for CT Residency topics as recommended by the TSDA.

All residents are relieved of all non-emergent duties to participate in didactic conferences. These conferences are a dedicated period wherein all CT faculty, all residents rotating on the cardiothoracic services, and students meet weekly. Attendance is mandatory and recorded for CT surgical staff and residents. Physician extenders, nursing, perfusionists, and ancillary staff are invited and encouraged to attend as well.

1. Core Curriculum Conference (didactic lectures): Wednesday 6:30-7:30 a.m. - The goal of the core curriculum conference is to provide the trainee with focused instruction on a topic relevant to CT surgery. It consists of a multimodality format designed to instruct the CT residents on the core topics in keeping with the TSDA curriculum. Topics will alternate between Adult Cardiac and General Thoracic topics, every other Wednesday. Congenital topics will be presented on months where there is a 5th Wednesday. A didactic review of the topic in context of the recommended readings will be followed by a short quiz. The formatting will incorporate Written Board questions and an answer session, as well as an Oral Board Exam type case. The curriculum will be covered over a two-year rotating conference schedule. Topics include the full spectrum CT surgery, embryology, biology, physiology and pathophysiology. The conference is organized and monitored by the PD with weekly faculty facilitators. Residents are expected to present at this conference quarterly and will be evaluated on their presentation with regards to content, clarity, review of the literature, and professionalism.
2. CT Morbidity and Mortality (M&M): Tuesday 4:00-5:00 p.m. - The goal of the M&M conference is self-surveillance as practicing CT surgeons, to review best practices, to self-reflect, individually and as a collective, and to develop strategies for self and practice improvement. Morbidities and mortalities from the period two weeks prior to the conference will be accrued. Faculty and residents who participated in the listed cases will be responsible for leading the discussion. The presentation will include salient points of the case’s preoperative, intraoperative, and postoperative period. Associated photography and radiological imaging is anticipated to enhance the discussion. A short literature review can be used to augment the presentation in cases where complications are unusual. The responsible attending physician will be in attendance to participate in the presentation. Residents will be evaluated on their presentation. The goal of the conference is purely for peer review and process improvement. In no way will the conference be used to assign blame. As such, vigorous reporting and participation are encouraged. All deaths will be discussed. Other cases that involve complications, need for return to the operating room, or need for readmission within 30 days of discharge will be reported on the M&M sheet and may be discussed once all deaths have been thoroughly reviewed and time permits. Cardiac and Thoracic M&M will be presented on alternating Wednesdays.
3. Structural Heart Conference: Wednesday 7:30-8:30 a.m. - This conference will coincide with core curriculum topics related to Adult Cardiac surgery and will alternate every other Wednesday with Thoracic Oncology Conference (i.e. Tumor Board). The purpose of the Structural Heart Conference is to provide an environment in which residents and faculty can discuss complex or interesting cases, management decisions, radiologic studies interpretation, subtle points, and general systems-based practice management questions with regards to structural heart disease. This conference will be held bi-weekly. It is not a mandatory conference. It is expected that residents rotating on the Adult Cardiac service will attend. Residents assigned to the General Thoracic or Congenital services may be excused.
4. Thoracic Oncology Conference (Tumor Board): Wednesday 7:30-8:30 a.m. - This conference will coincide with core curriculum topics related to Thoracic surgery and will alternate every other Wednesday with Structural Heart Conference. The goal of this multidisciplinary conference is to discuss the treatment plans for malignancies of the lung, esophagus, and chest wall. The conference is designed to review the latest treatment modalities with respect to surgery, medial therapy, and radiation therapy. It is designed to be a collaborate conference aimed at designing the optimal treatment plan for each individual patient.
5. Journal Club: Monthly on Tuesday 5:00 p.m. - The goal of the journal club conference is to promote active review of peer-reviewed published literature. Topics will alternate between Adult Cardiac and General Thoracic topics. The CT staff will create a repository of recently (within the last 2 years) published papers, as well as seminal articles of the specialty. Four key articles will be selected. The residents are expected to read the articles and be prepared to discuss them in detail with regards to content, statistical analysis, scientific merit, and relevance to the existing body of literature as well as clinical practice. It is expected that they will facilitate discussion by critically reviewing the papers for experimental design, execution, bias, outcomes analysis, and conclusions. All participants are expected to gain a critical understanding of the literature, its content, and its applicability. The CT Residents will be critiqued on their presentations and understanding of the articles.
6. Congenital (Peds) Conference: Thursdays 4:00-5:00 p.m. - This conference is a multidisciplinary conference dealing with congenital cardiac disorders of both pediatric patients and adults. Participants will include Congenital Surgery staff, residents, students, critical care, social work, and cardiology. Optimal treatment plans of preoperative patients will be formulated. The progress and care of postoperative patients will also be reviewed.
7. Esophageal Conference: Every other Thursday 5:00-6:00 p.m. – This conference is designed to discuss the preoperative workup and postoperative care of benign and malignant esophageal disorders. Case discussions will include the patient’s history, physical exam findings, and any psychosocial issues. Residents will gain knowledge in interpretation of anatomic and functional esophageal studies including endoscopy, esophograms, pH monitoring, manometry, and chest radiographs, including CT scans. They will discuss all treatment options to include medical therapy as well as all options for surgical, endoscopic, and minimally invasive procedures. The risks, benefits, and potential complications of each will be reviewed.
8. Congenital (Peds) M&M Conference: Quarterly - Residents will be allowed to attend Congenital M&M conference when rotating on that service. They will participate in the discussion and may be asked to do a short didactic presentation for interesting or complex cases. The goal will be to gain a better understanding of complications in the same manner as the Adult Cardiac M&M conference with a focus on issues unique to congenital cardiac surgery patients.

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

* With approved time off recorded by the PD or Chairman
* With advance notification of absence (via email) to the PD AND his/her approval for said absence. (PM should be copied on the note of approval from the PD)

An attendance rate of 80% at the listed CT Residency conferences is required, excluding vacation, meeting time, etc. During mandatory conferences, clinical responsibilities are waived.

2018-2019 CONFERENCE / CURRICULUM SCHEDULE

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| --- |
| **Cardiac** |
| 6:30 – 7:30 a.m. | Core Curriculum Conference (didactic lectures) |
| 7:30 – 8:30 a.m. | Cardiac M&M |
| 8:30 – 9:30 a.m. | Structural Heart Conference |
|  |
| **Thoracic** |
| 6:30 – 7:30 a.m. | Core Curriculum Conference (didactic lectures) |
| 7:30 – 8:30 a.m. | Thoracic M&M |
| 8:30 – 9:30 a.m. | Thoracic Oncology Conference (Tumor Board) |

* The above Cardiac and Thoracic education days will alternate every other Wednesday.
* Journal Club: Monthly on a Tuesday at 5:00 p.m., alternating Cardiac and Thoracic topics
* Congenital Cardiac Surgery Conference: Every Thursday at 4:00 p.m.
* Simulation Lab: Quarterly on a Tuesday evening from 4:00 - 7:00 p.m. in lieu of CT M&M that week.
* Congenital M&M: Quarterly. Times TBA.

CT CASE LOG POLICY

The resident cases database is managed by a computerized web-based log. The ACGME is the organization responsible for accrediting all residency training programs. The accuracy of the data is very important to the continued accreditation of our program and to the assessment of eligibility of each resident for the CT Residency qualifying examination of the ABTS. It is mandatory that cases be logged throughout the continuum of the resident’s surgical training. It is not acceptable to log the minimal number of required cases and stop recording cases. Failure to maintain an accurate CT Residency case log may result in ineligibility for the CT Residency qualifying examination of the ABTS.

Data collection is the responsibility of the individual resident. To enter your cases, you must go to the ACGME web site and sign-in with your ID and password. Cases should be entered at least weekly. Operative logs are monitored each month by the PD and Program Evaluation Committee (PEC). If cases are not logged and kept current, the resident will not be allowed to operate until the log is updated. Surgical case logs must be completed and available for the entire program upon graduation. No certifications or approvals to sit for the ABTS qualifying exam will be issued until all logs are completed and the final surgical record is signed.

Residents who have not entered their cases in a timely manner will be subject to disciplinary action. Letters may also be placed in the resident’s file addressing the issue of non-compliance and may be discussed during evaluations with the PD. The entry of case logs in a timely manner is one of the factors contributing towards each resident’s “Professionalism” Milestone.

CT RESIDENCY CASE LOG DIRECTIONS

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

* 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.
* Once you receive an email from the ACGME with a User ID, enter the User ID and Password and click on the “Login” button.
* 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 pass-word.
* 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 the CT Residency PM, Brenda Burnette at 304-598-4218.

OPERATIVE MINIMUMS FOR CT RESIDENCY

The RRC of the ABTS has established operative experience minimums for the residents in CT surgery. The minimum number required is 125 major cardiothoracic operations per year, for a total of 250 major cases.

|  |  |
| --- | --- |
| CATEGORY | MINIMUM |
| Congenital Heart Disease | **20** |
| Adult Cardiac | **60** |
| Myocardial Revascularization | **80** |
| Interventional Wire-based Procedures | **15** |
| Conduit Dissection and Preparation | **5** |
| Aortic Procedures | **10** |
| Arrhythmia Surgery | **10** |
| Cardiopulmonary Bypass set up and pump run w/perfusionist | **5** |
| Circulatory Assist | **10** |
| Subtotal Adult Cardiac Experience | **215** |
| General Thoracic/Lung | **60** |
| Pleura | **10** |
| Chest Wall and Diaphragm | **5** |
| Mediastinum | **5** |
| Tracheobronchial – Airway Surgery | **0** |
| Esophagus | **10** |
| Subtotal General Thoracic Experience | **90** |
| Total Major Operative Experience | **305** |
| Bronchoscopy | **30** |
| UGI Endoscopy | **10** |
| Mediastinal Assessment | **15** |
| Subtotal Minor Procedures | **55** |
| Total operative Experience | **360** |
| Consultation Experience | **50** |
| Multidisciplinary Patient Management Conferences | **20** |
| Cardiothoracic Critical Care Case Management | **75** |
| Simulation | **20** |

**The number of index cases required to meet the minimal acceptable standards in the various areas for 5/2 residents starting thoracic training on or after July 1, 2017 are as follows:**

|  |  |  |
| --- | --- | --- |
| **Cardiac Focused** | **Requirements** | **General Thoracic Focused** |
| **Total** | **Subtotal** |  | **Subtotal** | **Total** |
|  |  | **CONGENITAL HEART DISEASE** |  |  |
|  | 5 | Primary Surgeon |  |  |
|  | 15 | First Assistant | 10 |  |
| **20** |  | **Subtotal Congenital Heart Disease** |  | **10** |
|  |  |  |  |  |
|  |  | **ADULT CARDIAC** |  |  |
|  |  |  |  |  |
| 60 |  | **Acquired Valvular Heart Disease** |  |  |
|  | 25 | Aortic Valve Repair/Replacement | 15 |  |
|  | 15 | Mitral Valve Repair/Replacement | 5 |  |
|  | 5 | Tricuspid Valve Repair/Replacement, Annuloplasty | 5 |  |
|  | 5 | TAVR as primary |  |  |
|  | 10 | TAVR as assistant | 5 |  |
|  |  |  |  |  |
| 80 |  | **Myocardial Revascularization** |  | 35 |
|  |  |  |  |  |
|  | 15 | **Re-Do Sternotomy**\*\*\*\*Can be double-counted with any Cardiac procedure | 5 |  |
|  |  |  |  |  |
| 15 |  | **Interventional Wire-based Procedures** |  | 5 |
|  | 5 | Left Heart Catheterization, PCI, TEVAR, Mitral Clip |  |  |
|  | 10 | Intra-aortic Balloon Pump | 5 |  |
|  |  |  |  |  |
| 5 |  | **Conduit Dissection and Preparation**\*\*Open or Endoscopic Saphenous/Radial Vein harvest and preparation\*\*Can be double-counted with CABG |  | 5 |
|  |  |  |  |  |
| 10 |  | **Aortic Procedures**\*\*Any combination of Ascending Aorta/Aortic Root Replacement, Descending Aortic Replacement, Aortic Dissection, Aortic Trauma\*\*Can be double-counted with CABG/Valve Procedures |  | 5 |
|  |  |  |  |  |
| 10 |  | **Arrhythmia Surgery**\*\* |  |  |
|  | 5 | Left Atrial or Biatrial Maze, Pulmonary Vein Isolation, Right-sided Maze, Isthmus Ablation\*\*Can be double-counted with CABG/Valve procedures |  |  |
|  | 5 | Pacemaker insertion or Pacemaker removal |  |  |
|  |  |  |  |  |
| 5 |  | **Cardiopulmonary Bypass set-up and pump run with Perfusionist** |  | 5 |
|  |  |  |  |  |
| 10 |  | **Circulatory Assist**\*\*Any combination of ECMO, VAD\*\*Can be double-counted with another operation |  | 5 |
|  |  |  |  |  |
| **215** |  | **Subtotal Adult Cardiac Experience** |  | **100** |
|  |  |  |  |  |
|  |  | **GENERAL THORACIC** |  |  |
|  |  |  |  |  |
| 60 |  | **Lung** |  | 105 |
|  | 30 | Major Anatomic Resections: Open, VATS, or RATS (Segmentectomy, Lobectomy, Pneumonectomy, Lung Transplantation\*\*)\*\*Only 1 Pneumonectomy can be counted along with Bilateral Lung Transplant. | 50 |  |
|  | 5 | VATS/RATS Lobectomy specifically | 25 |  |
|  | 25 | Open or VATS Lung Biopsy/Wedge Resection | 30 |  |
|  |  |  |  |  |
| 10 |  | **Pleura** |  | 25 |
|  |  | Major (Empyema Decortication, Pleurectomy Decortication, other Pleural Tumor Resection) | 5 |  |
|  |  | Minor (Biopsy, Pleurectomy, VATS Sympathectomy, VATS Bleb Resection, VATS Pleurodesis, Evacuation or Hemothorax | 15 |  |
|  |  | Interventional: In-dwelling Cuffed Pleural Catheter insertion | 5 |  |
|  |  |  |  |  |
| 5 |  | **Chest Wall and Diaphragm**Chest Wall Resection\*\*, Rib Resection, Rib Plating, Pectus Repair, Diaphragm Resection or Plication, Repair of Morgagni, Bochdalek, Traumatic Hernia\*\*Can be double-counted with Pulmonary Resection |  | 10 |
|  |  |  |  |  |
| 5 |  | **Mediastinum**Tumor/Cyst/Mass Resection via Open, VATS, or Robotic Technique |  | 10 |
|  |  |  |  |  |
| 0 |  | **Tracheobronchial – Airway Surgery**\*\*Tracheal Resection, Laryngotracheal Resection, Sleeve Lobectomy, Carinal Pneumonectomy, Transplantation Airway Anastomosis\*\*Sleeve Lobectomy and Carinal Pneumonectomy can be double-counted with Major Anatomic Lung Resection |  | 5 |
|  |  |  |  |  |
| 10 |  | **Esophagus** |  | 35 |
|  | 5 | Esophagectomy (Open or MIE) | 20 |  |
|  | 5 | Benign Esophagus-Repair of Perforation, Drain Perforation, Diverticulectomy, Myotomy, Hiatial Hernia Repair | 10 |  |
|  |  | Laparoscopic Hiatal or Paraesophageal Repair | 5 |  |
|  |  |  |  |  |
| **90** |  | **Subtotal General Thoracic Experience** |  | **190** |
|  |  |  |  |  |
| **305** |  | **TOTAL MAJOR OPERATIVE EXPERIENCE** |  | **290** |
|  |  |  |  |  |
|  |  | **MINOR PROCEDURES**\*\*\*\*All may be double-counted |  |  |
|  |  |  |  |  |
| 30 |  | **Bronchoscopy** |  | 40 |
|  |  | Simple (BAL, Diagnostic, TBBx, Bx) | 30 |  |
|  |  | Complex (Laser, Dilation, Stent, Navigational Bronchoscopy, Photodynamic Therapy, Cryotherapy) | 10 |  |
|  |  |  |  |  |
| 10 |  | **UGI Endoscopy** |  | 30 |
|  |  | Simple (Diagnostic, Bx) | 20 |  |
|  |  | Complex (Dilation, Stent, EUS, EMR) | 10 |  |
|  |  |  |  |  |
| 15 |  | **Mediastinal Assessment** |  | 55 |
|  | 5 | Mediastinoscopy, Chamberlain (Mediastinotomy) | 15 |  |
|  |  | EBUS/FNA | 10 |  |
|  | 10 | Mediastinal Node Dissection/Systematic Sampling during Lung Resection | 30 |  |
|  |  |  |  |  |
| **55** |  | **Subtotal Minor Procedures** |  | **125** |
| **360** |  | **TOTAL OPERATIVE EXPERIENCE** |  | **415** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **ADDITIONAL REQUIREMENTS** |  |  |
|  |  |  |  |  |
| 50 |  | **Consultation Experience** |  | 50 |
|  | 25 | New Patients | 25 |  |
|  | 25 | Follow-up Patients | 25 |  |
|  |  |  |  |  |
| 20 |  | **Multidisciplinary Patient Management Conferences**Any combination of Tumor Board, Cardiac Catheterization Conference, Multidisciplinary Clinics, Transplant Selection Committee Meetings, etc. |  | 20 |
|  |  |  |  |  |
| 75 |  | **Cardiothoracic Critical Care Case Management experience (Provide log sheet for each case with at least one case from each of the seven categories. See details below)** |  | 75 |
|  | 20 | General Thoracic | 20 |  |
|  | 20 | Cardiac and Congenital | 20 |  |
|  | 35 | Any additional Cardiothoracic Critical Care Case | 35 |  |
|  |  |  |  |  |
| 20 hrs |  | **Simulation (Hours required from any technique-based simulation curriculum or simulation of Cardiopulmonary Bypass management)** |  | 20 hrs |

RESEARCH POLICY

The CT Residency recognizes research as an essential and integral component to both training and practice. It promotes academic thought, stimulates self-assessment and evolves new treatment strategies. As such, it is mandatory that each resident participates in at least 2 research projects over the course of two (2) years of CT surgical training. Project completion is defined as a presentation at a regional/national meeting or submission to a peer reviewed medical journal.

Residents have the opportunity to present research projects they have completed before faculty, colleagues and students. The residents will be encouraged to present an abstract and/or case presentations for the annual Gordon F. Murray Leadership Forum to visiting professors. Residents will also have the opportunity to present at the annual Greenbrier Resident Paper Competition at the West Virginia State American College of Surgeons Meeting (typically held in May). Furthermore, residents will have opportunities to submit papers and abstracts at national meetings (STS, AATS, STA, WSTA).

CONFERENCE, ATTENDANCE & CURRICULUM

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

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

The PD 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 90% of residents at the core conferences must be achieved.

\*All surgical residents are required to attend conference each week. Exceptions: vacation, post call or approval from the PD to scrub in on a case that is deemed necessary for the resident to have required experience.

II.A.4.u) 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

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

II.A.4.u).(3) a biweekly M&M or quality improvement conference. (Core)

\*Attendance is taken for all conferences each week by paper method and transferred into the E\*Value program.

CONFLICT OF INTEREST DISCLAIMER

|  |
| --- |
| I am aware that this educational resource has been provided to the West Virginia University Department of CT 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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DISCIPLINE POLICY (201-2017)

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 Residency Programs. Throughout the CT 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 clinical experience and education.
2. Weekly updates of Operative Logs.
3. Yearly CBL’s modules required by WVU and Ruby Memorial Hospital.
4. Reporting for semi-annual evaluation with the PD.
5. Employee Health requirements.
6. Completion of assigned Core Curriculum lectures.
7. Fulfilling research requirements.
8. Completion of M&M Conference rosters.
9. Chart completion within 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 PD or PM and will be given an opportunity for correction. If the deficiencies persist by the 15th of the month the resident will be placed on administrative leave (see below) until the delinquencies are corrected.

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

When a resident is on administrative leave, residents will relinquish all operative assignments during the day but will fulfill all other floor care, clinic assignments and all other non-OR responsibilities. The time freed up from the operative theater will be used to complete the delinquencies. These residents will take call (night time and weekends) as assigned. In addition, if a resident has been placed on administrative leave for a third time in a single year, each day on administrative leave will consume one day of vacation time allotted. If a resident has no vacation remaining or exceeds the number of days remaining, days will be subtracted from the following year’s allotment. Upon completion of the missing documentation, the resident will contact the Residency PM. Upon verification by the Residency PM 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 PD and a note placed into the residents file. Residents accruing three Administrative leaves in any one postgraduate 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 CT 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 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 at least 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 PD 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 ABTS certificate for CT Residency.

##### **Clinical Experience and Education:**

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

Three occurrences of Administrative Leave over 12 months leads to Academic Probation. Any subsequent violation of clinical experience and education 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 postgraduate year or five occurrences during the program, will result in Academic Probation.

# **Academic Discipline and Dismissal Policy**

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

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

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

Corrective or disciplinary actions may include but are not limited to:

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

## Level I Intervention

Oral and/or Written counseling or other Adverse Action:

Minor academic deficiencies that may be corrected at Level I include:  unsatisfactory academic or clinical performance or failure to comply with the policies, rules, and regulations of the SOM/GME by-laws Residency Program or University or other facilities where the resident is trained.

Corrective action for minor academic deficiencies or disciplinary offenses, which do not warrant probation with remediation as defined in the Level II intervention, shall be determined and administered by each Department. Corrective action may include oral or written counseling or any other action deemed appropriate by the Department under the circumstances. Corrective actions for such minor academic deficiencies and/or offenses are not subject to appeal.

## Level II Intervention:

Probation/Remediation Plan or other Adverse Action:

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

## Level III intervention:

Dismissal and/or Non-reappointment:

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

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

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

CLINICAL EXPERIENCE AND EDUCATION POLICY

Beginning July 1, 2017, the ACGME has implemented new regulations regarding clinical experience and education, formerly duty hours. The goal is to enhance the educational experience by allowing the resident adequate time for rest and activities outside the hospital environment.  It is vitally important that we comply with the regulations not only to stay within the guidelines but also to provide a program focused on educational needs not service needs. Therefore, it is important to have a thorough understanding of the rules, so that we can stay in compliance.

The Regulations:

* Clinical experience and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities and clinical work done from home.
* Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
* There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
* Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
* Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.
* Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. Additional patient care responsibilities must not be assigned to a resident during this time.
* In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; humanistic attention to the needs of a patient or family; or, to attend unique educational events. These additional hours of care or education will be counted toward the 80-hour weekly limit.
* Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
* Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). Advanced Practice Providers will fill in for residents for call when necessary, in order to maintain ACGME compliance.
* Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit.
* The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks.
* At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
* Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit.
* Moonlighting is not permitted for CT Surgery residents.

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 CT Residency PM, Brenda Burnette at 304-598-4218.

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 clinical experience and education and is responsible for overseeing that all hours are reported in a timely fashion.

EVALUATION POLICY

The CT residency program follows the Department’s established policy for evaluation and structural feedback in order to enhance the residency training program and institute quality improvement mechanisms.

Formal evaluation of each resident will be based on the following criteria:

* Faculty, peer, nursing, support staff, and patient evaluation forms from each rotation (360 evaluation process).
* The six ACGME Competencies.
* Attendance and participation in conference.
* Oral (Mock) exam by faculty.
* Resident operative experience tracking (record keeping of cases).
* Clinical Experience and Education log (record keeping of hours).
* Clinical Competency Committee (CCC) Meetings (biannually for each resident).

An evaluation form is completed for each resident every month no matter the length of the rotation. Any negative evaluations will be brought to the attention of the PD, who will bring it to the attention of the resident. Measures to correct the problem will be addressed.

Resident performance is evaluated twice a year by the PD and the CCC for each resident. The resident has access to the evaluations at all times through the E\*Value system. The resident will meet with the PD 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 PD may have additional meetings to address any issues.

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 that can be obtained by entering the E\*Value system. The PD is available for discussion and the residents are encouraged to seek guidance for any perceived difficulty or problem. The resident’s evaluations are based on the ACGME competencies and CT Residency milestones. Direct feedback to residents is available at any time upon their demand. Residents will be provided an anonymous mechanism for faculty feedback accessible at any time.

The residents routinely and anonymously complete confidential evaluations of their various rotations, the program, and the faculty. The Department of CT Surgery constantly strives for improvement and welcomes resident input. As such, it is crucial they feel comfortable offering honest, open feedback of the entire program and its faculty. Due to the minimal size of the program, certain measures will be taken to maintain and ensure resident anonymity. Their evaluations will be combined with those of other closely knit programs (i.e., Vascular, Cardiology) to provide a slightly larger pool of data. In addition, the E\*Value program will systematically be set up to have the review/release date occur at a later time. These precautions combined will generate evaluation reports which will protect the identity of the resident, while providing necessary feedback of the program.

FATIGUE 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 Dept. of CT Surgery adopted the following policy in 2017 to address resident fatigue and stress:

* All faculty and residents are required to complete a Sleep & Fatigue CBL course annually which is located in the online education portal entitled SOLE (Study Observe Learn Engage).

**Fatigue Mitigation**

The Dept. of CT Surgery will be responsible for:

* Educating all faculty members and residents on recognizing the signs of fatigue and sleep deprivation
* Educating all faculty members and residents on alertness management and fatigue mitigation processes
* Encouraging residents to use fatigue mitigation processes to manage the potentially negative effects of fatigue on safe patient care and learning.
* Ensuring continuity of patient care by maintaining a back-up system in the event that a resident is unable to perform their patient care responsibilities due to excessive fatigue.
* Ensuring adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

**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 instability - irritability
* Increased conflicts with others
* Lack of attention to proper attire or hygiene
* Difficulty with novel tasks and multitasking
* Impaired awareness

**Response:**

Psychological, emotional, and physical well-being are critical in the development of a competent, caring, and resilient physician. Self-care is an important component of professionalism and is a skill that must be learned and nurtured in the context of other aspects of residency training. The Dept. of CT Surgery will be responsible for addressing and evaluating resident well-being. This responsibility will include:

* Making efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;
* Paying attention to scheduling, work intensity, and work compression that impacts resident well-being;
* Evaluating workplace safety data and addressing the safety of residents and faculty;
* Implementing policies and programs that encourage optimal resident and faculty well-being;
* Paying attention to resident and faculty burnout, depression, and substance abuse;
* Educating residents and faculty in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions;
* Educating residents and faculty to recognize those symptoms in themselves and how to seek appropriate care;
* Encouraging residents and faculty to alert the PD or the GME Office regarding concerns that a resident or faculty may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
* Providing access to appropriate tools for self-screening; and
* Providing access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

The demonstration of resident excess fatigue and stress may occur in patient care settings or in non-patient care settings such as lectures and conferences. In patient care settings, patient safety, as well as the personal safety and well-being of the resident, mandates 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 PM, residency PD, 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 or surgery resident lounge for a sleep interval of no less than 30 minutes. The resident may also be advised to go to the Emergency Department front desk and ask that they call for security, a cab or someone else to provide transportation home. If there is ever an issue with transportation, the resident is to call the PD or Department Chair immediately.

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 PD, residency PM 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 PD.

The residency PD 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 PD.

**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 PD without fear of reprisal.

Residents recognizing 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 PD.

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

Subsequently, the residency PD 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. In matters of resident stress, the residency PD will meet with the resident personally as soon as can be arranged. If counseling by the residency PD is judged to be insufficient, the PD will refer the resident to the FSAP for evaluation.

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

HANDOFF AND TRANSITIONS OF CARE

I. Rationale

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

* CT Residency call schedules are available within the connect call system. These include service specific as well as attending staff contact information.

II. Policy

1. 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 CT Surgery sign-out time each day (M-F) is from 5:30-6:30 pm. Sign out will occur from 6:00-7:00 am on Saturday and Sunday and will conclude upon completion of ICU rounds.
* 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

• Issue regarding family matters or social concerns

1. 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 CT Surgery instituted a “Protected Time” between 5:30-6:30 pm each day for the Handoff/Sign-out of patient care to the on-call night team.
* 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.
* The CT surgery faculty members will receive a CC of the electronic sign-out and will therefore monitor the accuracy and completeness of the transition of care.

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 RRC. Methods of training to achieve competency may include annual review of the program-specific policy by the PD with the residents, departmental or GME conferences, or review of available on-line resources. Programs must include the transition of care process in its curriculum. Residents must demonstrate competency in performance of this task. Programs must develop and utilize a method of monitoring the transition of care process including evaluation of the residents, as well as the process, using E\*Value, and must update this method as necessary.

III. GME Monitoring and Evaluation

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

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

C. Monitoring and assessment of the Handoff process by the program must be documented in the Annual Program Review. In addition, during the annual meeting between the PD, 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 modified: September 13, 2013. Accepted by the Dept. of CT Surgery June 2017.

INTENT NOT TO RENEW CONTRACT

In the event that the Department of CT Surgery elects not to reappoint a resident to the program and the agreement is not renewed, the Department shall provide the resident with a four (4) months advance written notice of its determination of non-reappointment unless the termination is “for cause”.

MATERNITY AND PATERNITY LEAVE POLICY (FAMILY MEDICAL LEAVE)

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

Additional information regarding all leaves can be found at www.hr.wvu.edu

PLEASE NOTE: In addition to WVU leave policies, the ACGME and the ABTS 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 ABTS has no formal policy in regard to medical or maternity leave, but expects that any leave of absence follows the institution’s medical or maternity leave of absence policy. The ABTS requires candidates to complete a minimum of 24 months of residency training in thoracic and cardiovascular surgery in a program accredited by the ACGME's Review Committee on Thoracic Surgery (RC-TS). This must include 12 months of continuous senior responsibility.

Accreditation Council of Graduate Medical Education – www.acgme.org

American Board of Thoracic Surgery – www.abts.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 PD’s prerogative as to whether or not moonlighting is permitted.

**Moonlighting is NOT permitted for CT Surgery residents**. The Department of CT Surgery feels that 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 cardiothoracic residency is a demanding and rigorous experience. It is felt that moonlighting also interferes with the resident’s opportunities for study, relaxation, rest and a balanced life style.

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 West Virginia University Hospital (WVUH) property. There are always permit parking spaces available in resident lots B-1 and E. If you cannot find a space, approach one of the Security Officers and they will direct you to a space.

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.

PRACTITIONER’S 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.

**NEW RESIDENTS/FACULTY**

SUBSTANCE ABUSE POLICY

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 PD/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, PD/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 PD/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 PD/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 PD/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 PD/Chair or Supervisor must immediately accompany 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 PD/Chair or Supervisor must immediately remove the physician from patient care or patient contact.

The PD/Chair or Supervisor must immediately make a mandatory referral to the Employee Assistance Program (EAP), based on the possibility of impaired performance.

The PD/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 PD/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.

SICK LEAVE POLICY

**Accumulation of Leave** – Additional Information regarding leave can be found at www.hr.wvu.edu

There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. The Dept. of Cardiovascular and Thoracic Surgery will ensure that proper coverage of patient care is available in the event that a resident may be unable to perform their patient care responsibilities. On such occasions, the resident who is unable to provide the clinical work will not suffer any negative consequences or repercussions.

Accumulation of sick leave is unlimited. Full-time regular classified staff and 12 month regular faculty accrue 1.50 days of sick leave per month during active employment. If you are sick and need to “call- in” to take a sick day you must do 3 things:

1) Contact the PD

2) Contact the chief resident of your service

3) Contact or leave a voice mail for the Residency PM, Brenda Burnette at 304-598-4218

Sick time may be taken for:

* Appointments for the resident’s medical, dental, or mental health, including those scheduled during their working hours.
* 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 PD.**
* Maternity/Paternity Leave

If you have any questions on whether sick time can be used or not, please contact the Residency PM. **Excessive/unexplained absences may affect your competency evaluation or even your promotion to the next level of training**.

PROGRAM CLOSURE/REDUCTION POLICY

In the event that the Department of CT 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.

PROMOTION POLICY

The Department of CT Surgery has established this policy for the 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/gme/gme-policies/

The decision to reappoint and promote a resident to the next level of postgraduate training is done annually by the PD upon review of the resident’s performance based on program milestones, along with input from the faculty and the CCC.

The CT 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 PD 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 on a yearly basis from faculty and making measurable progress in acquiring didactic knowledge
* Preparation and performance at conferences
* Progress toward research requirements
* Clear demonstration of technical proficiency deemed appropriate for matriculation by the CCC
* A score of at least 50th percentile on the yearly in-training exam

Any resident pending non-promotion due to academic performance will be placed on either departmental remediation or institutional probation. In the event that a resident is on departmental remediation or institutional probation at the time of contract renewal, the PD 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 will either be placed on the next level of discipline or terminated. The resident may request due process in the case of contract extension or non-renewal, as addressed in the Academic Grievance Policy. Additional information regarding the grievance policy can be found at the following website under GME Bylaws: https://medicine.hsc.wvu.edu/gme/gme-policies/

# **ACADEMIC GRIEVANCE POLICY**

**Purpose**. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes and complaints, which may arise between postgraduate residents and their PD or other faculty member. The Department of CT Surgery abides by this policy, which was derived from the WVU/GME website by-laws athttp://medicine.hsc.wvu.edu/gme.

**Policy.**

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

Procedure

## Level I Resolution

A good faith effort will be made by an aggrieved resident and the PD to resolve a grievance, which will begin with the aggrieved resident notifying the PD, 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 PD, the resident and the PD 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 PD informs the aggrieved resident in writing of the final decision. This should occur within 5 working days after the meeting between the resident and PD. A copy of the PD’s final decision will be sent to the Department Chair and to the Designated Institutional Official for GME (DIO). The resident is not entitled to legal representation during the Level 1 meeting.

## Level 2 Resolution

If the PD’s final written decision is not acceptable to the aggrieved resident, the resident may choose to proceed to a Level 2 resolution, which will begin with the aggrieved resident notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the PD’s final decision. If the Department Chairman is also functioning as the PD, 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 PD’s final written decision, and evidence that supports the grievance. Within ten (10) working days of receipt of the grievance, the resident 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 in writing of the final decision. This should occur within 5 working days of the meeting with the resident and the Chairman. Copies of this decision will be kept on file with the PD, in the Chairman’s office and sent to the DIO. The resident is not entitled to legal representation during the Level 2 meeting.

## Level 3 Resolution

If the resident disagrees with the Department Chairman’s final decision, he or she may pursue a Level 3 resolution of the grievance. The aggrieved resident must initiate this process by presenting their grievance, in writing, along with copies of the final written decisions from the PD 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 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 to set a mutually convenient time to meet with them. The Grievance Committee will review and carefully consider all material presented by the resident and his or her PD or the grievable party at the scheduled meeting, following the protocol outlined in Section E. The Grievance Committee will provide the aggrieved resident 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 PD and Department Chair. The resident is not entitled to legal representation during the Level 3 meeting.

## The Grievance Committee

Upon request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents, and three PDs. No members of this committee will be from the aggrieved resident’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.

## Grievance Committee Procedure

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

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

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

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

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

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

## Confidentiality

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

## Conditions for Reappointment:

1. Promotion: Decisions regarding resident promotion are based on criteria listed above, and whether resident has met all departmental requirements. The USMLE is to be used as a measure of proficiency. Passage of the USMLE, step 3 is a requirement for advancement for the 3rd year of residency as indicated in Section VII. Resident Doctor Licensure Requirement.
2. Intent Not to Renew Contract: In the event that WVU School of Medicine elects not to reappoint a resident to the program and the agreement is not renewed, WVU shall provide the resident with a four (4) month advance written notice of its determination of non-reappointment unless the termination is “for cause.”

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).

1. **Health Maintenance Organizations, Managed Care Entities and Other Purchasers of Health Care:** Resident's signature below in acceptance of this appointment shall constitute the authorization by resident for the School of Medicine or Dentistry or affiliated hospitals of the School of Medicine or Dentistry, to release confidential information concerning resident's education, skills, quality of care, utilization, and patient care experience to health, maintenance organizations, managed care entities and other purchasers of health care that contract for the provision of professional medical/dental services by residents. The resident participating in managed care activities shall be subject to all policies, rules, regulations and agreements of said organizations or entities.
2. **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 https://medicine.hsc.wvu.edu/gme/gme-policies/
	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.
	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/](http://www.hsc.wvu.edu/fsap/)
3. **Miscellaneous:**

**WVU Sexual Harassment Policy:** Information may be accessed at [www.wvu.edu/~socjust/sexual.htm**.**](http://www.wvu.edu/~socjust/sexual.htm) **Grievances:**

Information may be accessed at [http://pegboard.state.wv.us](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**.**](http://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.](http://www.hsc.wvu.edu/som/gme)

1. **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.

1. **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

**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-1 Visa Status for Resident Physician positions. In addition, to be eligible for consideration a candidate must be a:

1. Graduate of a medical school in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME).
2. Graduate of a college of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA).
3. Graduate of a medical school outside the United States and Canada who meet at least one of the following qualifications:
4. Have received a currently valid certification from the Educational Commission for Foreign Medical Graduates (ECFMG) or
5. Have a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
6. 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:
7. 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;
8. Have studied at a medical school outside the United States and Canada but listed in the World Health Directory of Medical schools;
9. Have completed all of the formal requirements of the foreign medical school except internship
10. and/or social service;
11. Have attained a score satisfactory to the sponsoring medical school on a screening examination; and
12. 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, 2, and 3 of the United States Medical Licensing Examination (USMLE).
13. Candidates must meet all federal standards as may be required by Centers for Medicare & Medicaid Services (CMS) or other federal and state regulatory agencies. Applicants that are designated by CMS as “excluded providers” shall not be eligible to appointment as a resident. Residents selected outside the normal matching process, whether that is through the match ‘scramble’ or during the ‘off-cycle’ must be reviewed and approved by the Designated Institutional Official (DIO).

PDs 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

USMLE/LICENSE POLICY

The WVU Department of CT 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 departmental policy will be in effect.

Overview:

1. All residents must have completed all three steps of the USMLE exam to be eligible to apply for cardiothoracic residency at WVU.
2. Doctors of Osteopathy participating in residency programs at WVU School of Medicine are also required to be licensed by the State of West Virginia when they are first eligible. They must obtain a license from the osteopathic board upon successful completion of their rotating osteopathic approved internship. They must have passed all three parts of the COMLEX to qualify for this license. Information on rules and regulations, fees, and applications can be obtained from the Board of Osteopathy.
3. All residents must be licensed by the State of West Virginia prior to starting their first year.

Information can be obtained regarding licensure from the following:

*Doctors of Medicine:* *Doctors of Osteopathy:*

West Virginia Board of Medicine State of West Virginia

101 Dee Drive Board of Osteopathy

Charleston, WV 25311 334 Penco Road

(304) 348-2921 Weirton, WV 26062

or (304) 558-2921 (304)723-4638

VACATION POLICY- DEPARTMENT OF CT SURGERY

The ABTS now requires all vacation, meeting and interview days be recorded on the application for the qualifying exam. The ABTS does not have a written policy regarding vacation but expects that any leave of absence follows the institution’s policy. The Dept. of CT Surgery encourages all residents to plan for and use their allotted vacation time each year. The following policies and procedures are in effect and must be followed when requesting allotted time off:

1. All residents (PGY 6-7) will receive 3 weeks of vacation per year.
2. Residents will submit a request for their proposed vacation dates to the PD for the year, prior to July 31st. Alternate dates should be included.
3. All attempts will be made to accommodate each resident’s first choice. The PD will mediate disputes, if needed.
4. NO vacations will be permitted in July, the last 2 weeks of June, the last two weeks of December or the first week of January. Accommodations will be made to work out a holiday schedule with the PD to allow ample family time over the late December and early January holiday time.
5. All vacations must be taken in one-week intervals. Exceptions will be made on a case-by-case basis in consultation with the PD.
6. Only one week of vacation will be allowed per month per resident.
7. Only one week of vacation will be allowed per rotation per resident.
8. A week constitutes 7 consecutive days.
9. Each service will share an equal burden of vacation absences by residents. Congenital will be an exception to this rule, as no vacations will be permitted during this rotation.
10. No vacations will be granted during the week prior to the In-service training exam.
11. Exceptions will be made on a case-by-case basis for unscheduled absences, e.g. deaths, births, or other family emergencies.
12. **\*\*\*\*Vacations are not approved until both signatures (faculty service chief and PD) are obtained on the vacation request form and it is returned to the PD’s office.\*\*\*\***
13. DO NOT make flight arrangements, reservations etc. until you are officially granted your vacation.
14. Two days, not included as vacation time, are granted for travel to conferences for presentations. Copies of meeting and registration forms must be attached to the Travel Authorization form and have the approved signature of the chairman.
15. Each PGY-7 resident 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 job and/or fellowship interviews.) If a resident leaves at noon, ½ day will be charged to that resident.
16. Meeting/travel requests must also be approved by the Department Chair.
17. Requests for changes in vacation dates must be submitted in writing to the PD and will be approved or denied on a case-by case basis.

Revised 6/2017

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

MISCELLANEOUS/FORMS

**VACATION AND MEETING REQUEST FORM**

RESIDENT:

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

DATES OF TRAVEL:

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

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

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

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

**PROGRAM DIRECTOR’S SIGNATURE:**

Please return completed form to: Brenda Burnette

Residency Program Manager

WVU Hospital

1 Medical Center Drive, Box 8003

Morgantown, WV 26506