

UROLOGY RESIDENCY HANDBOOK



**WEST VIRGINIA UNIVERSITY
UROLOGY**

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Program Aim

The goal of the Urology Residency Training Program is to train excellent Urologic surgeons, by providing flexibility to pursue either an academic or private-practice career path. Pursuit of excellence in clinical care, discovery in research, and integrity of character are stressed. The resident will be competent in clinical science, practice-based learning, interpersonal skills and communication, professionalism, and systems-based practices.

Program Description/Overview of Urology Training Program

Goals and Objectives and Competencies/Evaluation of Outcomes

Each resident will, by the end of the residency attain sufficient knowledge of etiology and management of Urologic disease in the following domains: andrology, infertility, impotence, sexuality, calculus disease, Neurourology, obstructive diseases, Oncology including laparoscopic and robotic urology, Pediatric Urology, Endourology, ESWL, Female Pelvic Medicine and Reconstructive Surgery, infectious diseases, renovascular diseases, surgery of the adrenal gland, trauma, and urodynamics.

The resident will be able to provide total care to the patient with graded responsibility by level of training, which include initial evaluation, diagnosis, use of information technology, selection of appropriate therapy, performance of high-caliber surgical technique, management of any adverse events, delivery of service aimed at preventive Urologic care, and collaboration with all health-care professionals for patient-focused care.

1. The resident will learn basic and clinical Urologic research.
2. The resident will demonstrate competency as defined by faculty review in patient care, teaching, leadership, organization, and administration.
3. The resident will learn to evaluate their patient-care practices in light of new scientific evidence.
4. The resident will learn to develop productive and ethically appropriate relationships with patients and families.
5. The resident will learn to work effectively as a member of the entire health-care team.
6. The resident will learn to be sensitive to patients' culture, age, gender, and disabilities.
7. The resident will learn to demonstrate integrity and responsibility in their professional activities.
8. The resident will learn to understand the multiple modalities of health-care delivery systems and strive to be cost effective in their selections of care.

Educational Goals and Objectives by PG Level

- | | |
|--------------|---|
| PGY1: | The PGY1 resident does rotations through General Surgery but spends up to 6 months with the Urology team. |
| URO1 (PGY2): | Focus on General Urology, Pediatric Urology, and Minimally Invasive Urology. |

- URO2 (PGY3): Focus on Endourology and General Urology.
- URO3 (PGY4): Focus on advanced cases in Endourology/minimally invasive surgery and female Urology/Neurourology. Introduction to Reconstructive Urology and Andrology.
- URO4 (PGY5): Focus on Urologic Oncology and Advanced Reconstructive Urology with significant exposure to robotic urology and advanced cases in all other disciplines.

Professionalism

[School of Medicine Code of Professionalism](#)

Resident Selection Process

Purpose

To establish a policy that ensures a fair and non-discriminatory process for the selection of residents into the Residency Training Programs.

Criteria for Selection of Candidates

The primary source of candidates for entry into graduate medical education programs will be graduates of Liaison Committee for Medical Education (LCME)-accredited medical schools. Candidates will be evaluated on the basis of their academic credentials, preparedness, aptitude, communication skills, letters of reference and recommendation, by national qualifying examinations when available, and by personal interview if possible. It is strongly suggested that all programs participate in an organized matching program. ([WVU Criteria for Appointment/Eligibility and Selection of Candidates Policy](#))

Residents must be:

- 1) Graduates of medical schools in the United States and Canada accredited by the Liaison Committee on Medical Education (LCME); or
- 2) Graduates of colleges of osteopathic medicine in the United States accredited by the American Osteopathic Association (AOA); or
- 3) Graduates of medical schools outside the United States who have received a currently valid certificate from the Education Commission for Foreign Medical Graduates or have a full and unrestricted license to practice medicine in a United States licensing jurisdiction; or
- 4) Graduates of medical schools outside the United States who have completed a Fifth Pathway Program by an LCME-accredited medical school. [A Fifth Pathway program is an academic year of supervised clinical education provided by an LCME-accredited medical school to students who.
 - a.) have completed, in an accredited college or university in the United States, undergraduate premedical education of the quality acceptable for matriculation in an accredited United States medical school.
 - b.) have studied at a medical school outside the United States and Canada but listed in the World Health Directory of Medical schools.
 - c.) have completed all of the formal requirements of the International medical school except internship and/or social service.

- d.) have attained a score satisfactory to the sponsoring medical school on a screening examination; and
- e.) have passed either the Foreign Medical Graduate Examination in the Medical Sciences, Parts I and II of the examination of the National Board of Medical Examiners, or Steps 1 and 2 of the United States Medical Licensing Examination (USMLE).

5) WVU only accepts J-I Visa Status for Resident Physician positions.

6) DO's participating in residency programs at WVUH are required to be licensed by the State of West Virginia prior to beginning their allopathic PGY1 year.

Recruitment

The Department of Urology programs will sponsor activities such as student interest groups, continuing education conferences and receptions for students at the Schools of Medicine in West Virginia. They will maintain web pages that will provide basic information and recruitment information for students outside West Virginia.

Application Process

- All applications are accepted through ERAS and must include:
- Minimum three letters of reference
- Personal Statement
- USMLE Scores
- Dean's letter
- Transcripts
- CV
- Valid ECFMG for international graduates
- Visa Status
- Completed application will be reviewed by the program director. The program director, or designee, will evaluate and select the candidates he/she believes to be the most qualified for the positions available within the training program.

Interview

The Program Director in conjunction with the selection committee will select candidates to be offered an interview. The candidates will be notified by email that they have been invited for an interview.

All candidates invited for interview will receive the following information at the interview:

- Salary information
- Benefits information
- Information about the area
- Sample Contract

All candidates will interview with the Program Director, members of the faculty and current residents. Candidates will be evaluated on their written application materials as well as the in-person interview.

Requirements

The Department of Urology has the following criteria for residency selection.

- The residents for Urology will no longer enter under the General Surgery Program at the PGY1 level.
- The Urology Residents must have successfully completed the clinical General Surgery rotations at WVU prior to beginning their training under the Urology Department at the PGY II level.
- The applicant for Urology is selected through the American Urological Association (AUA) match.
- A candidate will not be ranked on the match lists for either program unless he/she has had a formal interview.

Conditions of Employment

An official offer letter will be sent via email after Match Day. As soon as the offer letter is signed and returned, the Program Coordinator will communicate with the new resident to initiate completion of the onboarding requirements. These include but are not limited to the following:

- Copy of medical school diploma
- A copy of an up-to-date certificate of BLS, ACLS and ATLS training
- Copy of social security card
- Immunization records
- Background check
- NPI Number
- Copy of driver's license

West Virginia University is an equal opportunity/affirmative action institution and will not discriminate with regard to sex, race, age, religion, color, national origin, disability or veteran status.

<h2 style="text-align: center;">Re-appointment/Promotion/ Extension/Remediation/Probation/Dismissal Policy</h2>

Resident Promotion

Purpose

To establish a policy for the Residency Training Programs to use in the promotion of residents to the next level of training.

Responsibilities/Requirements

The decision to re-appoint and promote a resident to the next level of post-graduate training shall be done annually by the Clinical Competency Committee upon review of the resident's performance and with input from the program faculty. The final recommendation of the CCC is given to the Program Director who has the final decision in this process.

The resident is expected to make and maintain satisfactory progress in appropriately developing plans, good communication skills, patient management, effectively and competently assuring the role of consultant to a wide variety of referring physicians, and mastery of technical skills for performing required procedures independently (with technologist support).

The CCC shall consider the successful completion of the Urology Milestones commensurate with their level of training as the major factor in the decision to promote a resident to the next level of training. Additional information may be used in this regard including:

- All evaluations of the resident's performance (refer to the Policy for Evaluation of Residents) – by making satisfactory progress in the program as documented by evaluations on a semiannual basis from faculty and making measurable progress in acquiring didactic knowledge.
- Performance on the In-Service (required to achieve a minimum 20th percentile) and End-Year Examinations.
- Second year residents must pass Step 3 of the USMLE examination in order to advance to the third year of training.
- Research Requirement – 1 paper per year
- Any other criteria deemed appropriate by the Program Director.

Any resident pending promotion due to academic performance will be placed on a remediation or probation plan. In the event that a resident is on departmental remediation or probation at the time of contract renewal, the program director may choose to extend the existing contract for the length of time necessary to complete the remediation process, not to exceed six months, or to promote the resident to the next level of training. If the resident's performance continues to be unsatisfactory the remediation/probation may be extended, or the resident may be terminated.

A resident may request an Appeal of Probation/Remediation first with the Department Head and if the aggrieved is not satisfied may appeal to the DIO.

Institutional Academic Discipline & Dismissal Policy

Resident Academic Discipline and Dismissal

The Department of Urology developed this disciplinary system, which was derived from the WVU/GME website by-laws at [WVU GME By-Laws](#) to ensure residents are competent, professional and ethical within the standards of care. The Department of Urology will follow the WVU School of Medicine GME and ACGME policies.

The Department of Urology may take corrective or disciplinary action including dismissal for cause, including but not limited to:

- Unsatisfactory academic or clinical performance
- Failure to comply with the policies, rules, and regulations of the House Officer Program, University or other facilities where the House Officer is trained.
- Revocation or suspension of license
- Violation of federal and/or state laws, regulations, or ordinances
- Acts of moral turpitude
- Insubordination
- Conduct that is detrimental to patient care.
- Unprofessional conduct.

Corrective or disciplinary actions may include but not limited to:

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

A. Level I Intervention:

Oral and/or Written counseling or another Adverse Action:

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

B. Level II Intervention:

Probation/Remediation Plan or another Adverse Action:

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

for which probation was implemented. Failure of the House Officer to comply with the terms of the plan may result in termination or non-renewal of the House Officer's appointment.

C. Level III intervention:

Dismissal and/or Non-reappointment:

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

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

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

[WVU GME By-Laws](#)

Institutional Academic Grievance Policy

Academic Grievance Policy and Procedure

Purpose. The purpose of this policy is to provide a mechanism for resolving disagreements, disputes and complaints which may arise between postgraduate residents and fellows and their Program Director or other faculty member. The Department of Urology developed this Policy, which was derived from the WVU/GME website by-laws at [WVU GME By-Laws](#)

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

Definitions

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

Procedure

A. Level 1 Resolution

A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within 10 working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence which supports the grievance. Within ten (10) working days after notice of the grievance is received by the Program Director, the resident/fellow and the Program Director will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Step I of the grievance procedure will be deemed complete when the Program Director informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days after the meeting between the resident/fellow and Program Director. A copy of the Program Director's final decision will be sent to the Department Chair and to the Designated Institutional Official for GME (DIO).

B. Level 2 Resolution

If the Program Director's final written decision is not acceptable to the aggrieved resident/fellow, the resident/fellow may choose to proceed to a Level 2 resolution, which will begin with the aggrieved resident/fellow notifying the Department Chairman of the grievance in writing. Such notification must occur within 10 working days of receipt of the Program Director's final decision. If the Department Chairman is also functioning as the Program Director, then the Level 2 resolution will be handled by the DIO. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence which supports the grievance. Within ten (10) working days of receipt of the grievance, the resident/fellow and the Department Chairman or DIO will set a mutually convenient time to discuss the complaint and attempt to reach a solution. Level II of this grievance procedure will be deemed complete when the Department Chairman (or DIO) informs the aggrieved resident/fellow in writing of the final decision. This should occur within 5 working days of the meeting with the resident/fellow and the Chairman. Copies of this decision will be kept on file with the Program Director, in the Chairman's office and sent to the DIO.

C. Level 3 Resolution

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

Section E. The Grievance Committee will provide the aggrieved resident/fellow with a written decision within five working days of the meeting and a copy will be placed on file in the Office of Graduate Medical Education, and with the Program Director and Department Chair. The decision of the Grievance Committee will be final.

D. The Grievance Committee

Upon request for a formal resolution at Level III, the DIO will form a Grievance Committee composed of at least two residents, and three Program Directors. No members of this committee will be from the aggrieved resident's/fellow's own department. The DIO will choose a faculty member appointed to the Grievance Committee to be the chair of the committee. The Grievance Committee hearing should occur within 20 working days from receipt of the Level III grievance.

E. Grievance Committee Procedure

1. Attendance: All committee members should be present throughout the hearing. The aggrieved resident/fellow must personally appear at the Grievance Committee meeting.
2. Conduct of Hearing: The chair will preside over the hearing, determine procedure, assure there is reasonable opportunity to present relevant oral or written information, and maintain decorum. The Chair will determine if information is relevant to the hearing and should be presented or excluded. The aggrieved Resident may present any relevant information or testimony from any colleague or faculty member. The Resident is NOT entitled to legal representation during the grievance committee hearing. The Program Director and Department Chair may be requested by the Committee to also be present for oral testimony. The committee chair is authorized to exclude or remove any person who is determined to be disruptive.
3. Recesses and Adjournment: The committee chair may recess and reconvene the hearing by invoking the right for executive session. Upon conclusion of the presentation of oral and written information, the hearing record is closed. The Grievance Committee will deliberate in executive session outside the presence of the involved parties.
4. Decisions: Decisions are to be determined by vote of a majority of members of the Committee and are final. After deliberation, the Chair will prepare a written decision to be reviewed and signed by all of the Committee members. The aggrieved resident/ fellow should be notified within 5 working days of the hearing.
5. Meeting Record: A secretary/transcriptionist may be present for the purpose of recording the meeting minutes. Minutes and the final written decision of the Committee will be placed on file in the Office GME, and by the Department in the resident or fellow's academic file.

F. Confidentiality

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

Conditions for Reappointment:

1. Promotion: Decisions regarding resident promotion are based on criteria listed above, and whether resident has met all departmental requirements. The USMLE is to be used as a measure of

proficiency. Passage of the USMLE, step 3 is a requirement for advancement for the 3rd year of residency as indicated in Section VII. Resident Doctor Licensure Requirement.

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

Employment Grievance Procedure for Non-Academic Issues

Resident is encouraged to seek resolution of non-academic employment-related grievances relating to Resident’s appointment or responsibilities, including any differences between Resident and WVUH, or WVU School of Medicine with respect to the interpretation of, application of, or compliance with the provision of the agreement, in accordance with the grievance procedures set forth on the WVU website. Forms and procedures are available from the Human Resources Department. [WVU Public Employees Grievance Procedure](#)

Practitioners Health

[West Virginia Medical Professionals Health Program](#)

ACGME Core Competencies and Assessment

At the February 1999 meeting of the ACGME, general competencies for residents were endorsed. Suggested was that Residency Programs incorporate these competencies into their Training Programs. Each Program would then develop methods of assessment and evaluation in each of these core competencies. In the next several paragraphs, each core competency and our methods of assessment and evaluation are described. [Core Competencies](#)

Patient Care

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

Residents are expected to communicate effectively with staff and patients, gather essential/accurate information about patients, and make informed decisions regarding diagnostic and therapeutic interventions based on their assessment. They also are required to develop/carry out patient-management plans, counsel and educate patients/families, and use technology to support patient-care decisions in a competent fashion. The residents must provide health-care services aimed at preventing health problems and maintaining health. They must work with health-care professionals, including those from other disciplines to best care for the patients.

In our Residency Training Program, this ACGME competency will be assessed in the following manner: First, faculty will provide a formal evaluation of the residents on a semi-annual basis. Questions regarding this evaluation specifically evaluate the resident’s performance in this competency assessment. Second, the patient-satisfaction surveys done periodically in the institution will be reviewed; these are geared toward enhancing patient satisfaction with the general hospital experience. If a Urology resident is mentioned in this survey, that information can be used in their evaluations.

Interpersonal and Communication Skills

This competency assessment requires residents demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates. Residents are expected to create and sustain a therapeutic and ethically sound relationship with patients. They also are expected to use listening skills effectively, and elicit and provide information using effective nonverbal, explanatory questioning and writing skills. Faculty will review resident operative, hospital, and Clinic notes with residents periodically to ensure they achieve success in the area of written communication. Finally, they must work effectively with others as a member of a health-care team or professional group.

In our Residency Training Program, this ACGME competency will be assessed in the following manner: First, faculty provides a formal evaluation of the residents semi-annually. Questions related to this evaluation specifically evaluate the resident's performance in this competency assessment. Second, the resident is evaluated by faculty and their peers semi-annually when they are the main presenter at the Urology Conference. A standard evaluation form is used, and the results are reviewed with the resident during their semi-annual meetings with faculty. Third, the patient-satisfaction surveys done periodically also are used in the institution. These surveys are geared toward enhancing patient satisfaction with the general hospital experience and can be applicable in assessing resident competency if residents are mentioned by name regarding their performance. Finally, the resident is assessed semi-annually by the support staff that may include the following: administrative staff, clinical support staff and nurses, and OR support staff and nurses. A composite evaluation is generated, reviewed with the resident at their semi-annual meeting, and then placed in the resident's permanent file with the Department of Urology.

Medical Knowledge

In this competency assessment, residents must demonstrate knowledge regarding established and evolving biomedical, clinical, and cognate sciences, as well as application of this knowledge to patient care. Residents are expected to demonstrate an investigatory and analytic thinking approach to clinical situations, as well as be knowledgeable of, and apply, the basic and clinical supportive sciences appropriate to their discipline.

In our Residency Training Program, this ACGME competency is assessed using several methods. As mentioned previously, faculty evaluation of residents takes this competency into consideration on our standardized evaluation form. Second, residents are assessed on their performance on 3 written examinations. The first is the USMLE Step III Examination. Residents must achieve a passing score on this examination to continue beyond the first year in the Urology Residency Program. The next examination is the Annual AUA In-Service given in November. Residents receive a full score report from this examination given to them at their semi-annual meetings with faculty. Specific guidelines regarding performance criteria on this examination are provided in the Urology Resident Manual and remediation guidelines also are reviewed. The third examination—the AUA SASP. This AUA constructed examination of approximately 100 to 150 questions serves to update the resident on their strengths/weaknesses since the November examination. A score report from this test is given to residents at their semi-annual meeting with faculty. Finally, residents are evaluated on their research presentations, written and oral, and critiqued on their performance.

Practice-based Learning and Improvement

This competency assessment requires that residents are able to investigate and evaluate their patient-care practices, appraise and assimilate scientific evidence, and improve their patient-care practices. Residents are expected to analyze practical experience and perform practice-based improvement activities using a systematic methodology. They must locate, appraise, and assimilate evidence from scientific studies, as

well as obtain and use information from their patient population and the larger population from which patients are drawn. They must apply knowledge of study designs and statistical methods to the appraisal of clinical studies, as well as use information technology to manage information, access on-line medical information, and facilitate the learning of students and other health professionals.

In our Residency Training Program, this ACGME competency is assessed primarily through the use of faculty/peer evaluations. Residents are evaluated on a standardized evaluation form during their presentations at Journal Club, regional and national scientific meetings at which they were asked to present, and an informal review of their billing and coding knowledge through a review of the patients' charts. In addition, the general faculty/peer evaluation forms provide some specific insight into the resident's competency in this area.

Professionalism

In this competency assessment, residents must demonstrate a commitment to carrying out professional responsibilities, adhering to ethical principles, and having sensitivity to a diverse patient population. Residents are expected to demonstrate respect, compassion, and integrity. They must demonstrate a responsiveness to the needs of patients and social interests that supersede self-interest, as well as accountability to patients, society, and the profession. They must demonstrate a commitment to excellence and ongoing professional development. Residents must demonstrate a commitment to ethical principles that pertain to provision or withholding of clinical confidentiality of patient information, informed consent, and business practices.

In our Residency Training Program, this ACGME competency is assessed using evaluations of the resident's performance by faculty, office support staff, Clinic staff and nurses, OR staff, and nurses, as well as patients. A composite evaluation is generated and reviewed with residents at their semi-annual meeting with the faculty. Informal evaluations from the above areas also are requested when the situation warrants.

Systems-based Practice

In this competency assessment, residents must demonstrate an awareness of, and responsiveness to, the larger context and system of health care and the ability to effectively call on system resources to provide care of optimal value. Residents are expected to understand how their patient care and other professional practices affect other health-care professionals, the health-care organization, and the larger society. Residents must know how types of medical practice and delivery systems differ from one another. They must be able to practice cost-effective health care and resource allocation that does not compromise the quality of care. They must be an advocate for quality patient care and assist patients in dealing with system complexities. Finally, they must know how to partner with health-care managers and health-care providers to assess, coordinate, and improve health care, as well as the way in which these activities can affect system performance.

In our Residency Training Program, this ACGME competency is assessed primarily by the resident's ability to obtain a license to practice medicine in West Virginia. This process must be complete by the end of the second year of Urology residency. In addition, evaluations by Clinic support staff and nurses, operating support staff and nurses, as well as floor nurses and administrators also may be used.

ABMS - American Board of Urology

www.abu.org

General Requirements

Applicants must be a graduate of a medical school approved by the [Liaison Committee on Medical Education \(LCME\)](#) or a school of osteopathy approved by the [Bureau of Professional Education of the American Osteopathic Association](#), and have completed a urology residency program accredited by the [Accreditation Council for Graduate Medical Education \(ACGME\)](#) or [Royal College of Physicians and Surgeons of Canada \[RCPS\(C\)\]](#). ACGME training programs in urology are described in the American Medical Association Graduate Medical Education Directory, Section II, “Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements.”

The American Board of Urology mandates a minimum of 5 clinical years of postgraduate medical training. Training must include:

- 48 months in an ACGME- or RCPS(C)- approved urology program spent in clinical urology.
- 3 months of general surgery in an ACGME- or RCPS(C)- approved surgical program.
- 3 months of core surgical training (e.g., intensive care unit, trauma, vascular surgery, cardiac surgery, etc.) in an ACGME- or RCPS(C)- approved surgical program.
- 6 months of other rotations, not including dedicated research time, in an ACGME- or RCPS(C)- approved core surgery program.

Research rotations cannot interfere with the mandated 12 months of general surgery or the 48 months of clinical urology.

Residents must comply with the guidelines in place at the time of enrollment in the program.

All rotations listed above that are not part of the core urology training must have been approved by the candidate’s program director. As part of the core urology training, the candidate must have completed at least 12 months as a chief resident in urology with the appropriate clinical responsibility and under supervision during the last two years of training in an ACGME-approved program.

WVU SOM USMLE

WV licensure policy for MDs and DOs

Resident USMLE/License Policy

Purpose: The Department of Urology will follow the WVU School of Medicine, Graduate Medical Education by-laws which can be found at the WVU/GME website by-laws at [WVU GME By-Laws](#)

Responsibilities/Requirements:

Effective July 1, 2005, all new incoming residents (graduates of US, Canadian and International medical schools) are required to take and pass Step 3 before the end of their second year to be eligible to advance to the third year. It is the policy at the Robert C. Byrd Health Sciences Center that all residents obtain a West Virginia Medical License as soon as they are eligible to do so under state law. This means that graduates of US and Canadian medical schools, eligible for licensure after one year of postgraduate education are required to take, and pass, Part 3 of the USMLE by the end of their second year. These residents will not be advanced to the third year unless they have passed the USMLE and have applied for

West Virginia licensure. Graduates of medical schools outside the US and Canada (IMGs) are also required to take, and pass Part 3 of the USMLE by the end of their second year. They will not be advanced to the third year unless they have done so. For graduates of osteopathic schools of medicine, a license must be obtained from the Osteopathic Board of Medicine for all training beyond the AOA approved internship.

Information can be obtained regarding licensure from the following:

Doctor of Medicine:

West Virginia Board of Medicine
101 Dee Drive
Charleston, WV 25311
(304) 348-2921 or (304) 558-2921

Doctors of Osteopathy:

State of West Virginia
Board of Osteopathy
334 Penco Road
Weirton, WV 26062
(304) 723-4638

WV State Board of Licensing Eligibility Requirements

Attempt Limit: Unlimited.

Time Limit: Must complete USMLE Steps 1, 2, & 3 within SEVEN (7) years of the first sitting; exceptions for MD/PhDs require board approval.

Hospital Dress Code Policy

Residents are **not to wear** WVU imprinted scrubs outside the hospital. This is in violation of an OSHA regulation and significant sanctions can be placed on both the department and institution. Scrubs with a protective outer covering (white coat or anesthesia coverlet-gown) are permitted in the Emergency Department, OR, ICUs and Same Day Surgery Center, and Clinics. Residents are to wear the hospital provided “green” scrubs to be used when entering and leaving the hospital.

Educational Curriculum and Duties by Year

PGY-1 YEAR – 12 months

PGY-1 residents will obtain the knowledge and skills required for preoperative evaluation of surgery patients, perioperative care, and basic surgical techniques. General abdominal surgery, critical care, and trauma are essential components of education in General Surgery. Rotations in Urology, General Surgery, Night Float, Surgical Intensive Care Unit, Surgical Oncology, and Plastics are provided. Rotations are 1–2-month blocks.

The educational goals of this year include expand knowledge of basic perioperative surgical care, critical care and fluid and electrolyte balance, learn basic principles of general, trauma, and vascular surgery, gain preliminary skills in surgical techniques, and refine interpersonal skills with support personnel.

The educational objectives of this year include: (1) conduct proficient preoperative evaluations of general surgical patients; (2) provide postoperative care for general, vascular, and trauma patients, which includes fluid and electrolyte management; (3) master techniques of insertion and evaluation of invasive monitoring of postoperative or critically ill patients; (4) assist or perform surgical procedures in general, vascular, and trauma; (5) develop surgical skills in minor procedures, and opening/closing surgical wounds; (6) initiate personal surgical log of cases; and (7) work effectively with support staff in pre-operative, operative, and postoperative settings.

PGY-2 YEAR – 12 months

PGY-2: General Urology. The goals of this experience are to develop a knowledge base of general Urologic diseases such as BPH, erectile dysfunction, and evaluation of hematuria and urinary tract infection. The resident will gain outpatient experience with the medical management of common Urologic diseases. They will gain surgical skills associated with treatment of General Urologic diseases as described above. They will gain experience in the spectrum of postoperative care and long-term follow up of patients after surgical procedures. By the end of this rotation, residents will be able to: evaluate and treat patients in the outpatient setting who present with General Urologic problems, as well as patients who have erectile dysfunction and infertility. They will demonstrate competency in basic Urologic procedures such as cystoscopy and prostate needle biopsy. They also will demonstrate competency in the area of urodynamics.

Pediatric Urology. Residents in this formative year will have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. Residents will demonstrate competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain exposure to some of the more complex cases such as hypospadias, congenital anomalies, and major urinary tract reconstruction. Pediatric urology is taught over all four years of the urology residency with a gradation of complexity of cases as the resident's knowledge and skills grow.

Competencies & Evaluation of Outcomes

1. **Patient Care:** Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of General Urology. They will learn basic Urologic procedures such as cystoscopy and prostate needle biopsy, as well as ureteral catheterization, and how to counsel patients and families. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. **Medical Knowledge:** Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the General Urology patient. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. **Practice-Based Learning & Improvement:** Residents are expected to demonstrate continuous learning in General Urology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. **Interpersonal & Communication Skills:** Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-2: Introduction to Endourology: An introduction to Endourology is provided in the PGY-2 year. This experience is incorporated into the PGY-2 year for approximately 2 to 3 months. Residents will develop a knowledge base for decision-making regarding the use of Endourology therapies for stone disease. Residents will learn basic cystoscopic Endourologic procedures and introductory exposure to ureteroscopy. By the end of the year, residents will be able to evaluate patients at the time of presentation for possible Endourologic therapies. Residents will demonstrate competency in basic ureteroscopy, which includes stone manipulation. They will be able to identify potential postoperative complications and management thereof.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Endourology/minimally invasive surgery. They will learn basic ureteroscopic techniques, including stone manipulation. They will learn to counsel patients and families. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate patients who require. Endourologic/minimally invasive surgery. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records, and work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.

PGY-3 YEAR – 12 months

PGY-3: Advanced Endourology/Minimally Invasive Surgery. Residents will further their knowledge base for decision-making regarding the use of Endourology therapies for stone disease. Residents will advance their basic cystoscopic Endourologic procedures and further their exposure to ureteroscopy. They will learn basic principles of Urologic laparoscopic surgery. They will be introduced to basic principles of access to the kidney, and percutaneous Endourologic procedures. By the end of the year, residents will be able to evaluate patients at the time of presentation for possible Endourologic therapies. Residents will demonstrate competency in basic ureteroscopy including stone manipulation. They also will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. Residents will demonstrate competency in ureteroscopic treatment of the ureteropelvic junction and ureteral strictures. They will further their knowledge of percutaneous treatment of stone disease, obstruction, and urothelial neoplasms. They will be able to identify potential postoperative complications and management thereof.

Pediatric Urology. Residents in this second year of urology will again have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. Residents will demonstrate their previously acquired competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain operative experience with increasing participation in some of the more complex cases such as hypospadias, congenital anomalies, and major urinary tract reconstruction. As mentioned previously, Pediatric urology is taught over all four years of the urology residency with a gradation of complexity of cases as the resident's knowledge and skills grow.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Endourology/minimally invasive surgery. Residents will advance their basic cystoscopic Endourologic procedures and further their exposure to ureteroscopy. They will learn basic principles of Urologic laparoscopic surgery. They will be introduced to basic principles of access to the kidney, and percutaneous Endourologic procedures. They will learn to counsel patients and families. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs advanced Endourological surgery. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This

outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, which includes continuity of care, and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4 YEAR – 12 months

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Pediatric Urology. Residents will demonstrate competency in surgical management of common Pediatric Urologic surgical problems such as vesicoureteral reflux and cryptorchidism. Residents will obtain surgical skills in treatment of complex Pediatric problems such as hypospadias, congenital anomalies, and major urinary tract reconstruction. They will learn to counsel patients and families. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the Pediatric Urologic patient. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Pediatric Urology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with children, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records, and work effectively as members of the health-care team.

This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4: Female Urology/Neurourology

The goals of this experience are to expand the knowledge of the preoperative evaluation of incontinence and Neurourology. Residents will develop surgical skills in management of female Urologic problems and incontinence. Residents will learn about postoperative management and long-term care of patients with female Urologic incontinence and Neurourologic problems. They will develop a knowledge base of management of patients with neurogenic bladders resulting from a spinal cord injury. By the end of this experience, residents will be able to evaluate patients at the time of presentation to the Clinic with an emphasis on history taking, examination, and evaluation of women with Urologic diseases, including incontinence, pelvic-floor strengthening exercises, endometriosis, interstitial cystitis, neurogenic problems, recurrent UTIs, management of urethral diverticuli and fistulas, pelvic pain, estrogen-replacement therapy, osteoporosis, and urodynamics. Residents will demonstrate competency in the surgical treatment of female incontinence. Residents will be able to follow patients in the Outpatient Clinics and postoperatively after treatment for the above-mentioned conditions. Residents will be able to evaluate spinal-cord injured patients and initiate management. Residents will be able to evaluate and manage Urologic aspects of patients with longstanding lower urinary tract dysfunction secondary to spinal-cord injury.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of female Urology/Neurourology. Residents will demonstrate competency in the surgical treatment of female incontinence. Residents will be able to follow patients in the Outpatient Clinics and postoperatively after treatment for the above-mentioned conditions. Residents will be able to evaluate spinal-cord injured patients and initiate management. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for various causes of incontinence. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in female Urology/Neurourology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is

measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. **Interpersonal & Communication Skills**: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. **Professionalism**: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
6. **Systems-Based Practice**: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4: Advanced Endourology/Minimally Invasive Surgery/Introduction to Robotics. Residents will further their experience in this area. Introductory skills in robotic urology are taught. They will continue to learn principles of access to the kidney, and percutaneous Endourologic procedures. By the end of this year, they will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. Residents will demonstrate competency in ureteroscopic treatment of the ureteropelvic junction and ureteral strictures. They will further their knowledge of percutaneous treatment of stone disease, obstruction, and urothelial neoplasms.

Competencies & Evaluation of Outcomes

1. **Patient Care**: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of advanced Endourology/minimally invasive surgery. They will continue to learn principles of Urologic laparoscopic surgery. They will continue to learn principles of access to the kidney, and percutaneous endourologic procedures. They will be able to demonstrate competency in laser treatment of stones, treatment of ureteral strictures, and treatment of ureteral and renal pelvic neoplasms. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examination, and in-house written examinations.
2. **Medical Knowledge**: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs advanced Endourology/minimally invasive surgery. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. **Practice-Based Learning & Improvement**: Residents are expected to demonstrate continuous learning in Endourology/minimally invasive surgery through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation, and evaluation and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

PGY-4: Introduction to Urologic Oncology with Introduction to Robotics. Residents will gain knowledge in the pre- and postoperative care, intraoperative technical skills, with an emphasis on Urologic Oncology patients. Introductory skills in robotics are taught to the resident. By the end of this experience, residents will have basic knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate familiarity with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection.

Competencies & Evaluation of Outcomes

1. Patient Care: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Urologic Oncology with robotic skill teaching as indicated. Residents will have basic knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will demonstrate familiarity with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. Medical Knowledge: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for Urologic cancer. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. Practice-Based Learning & Improvement: Residents are expected to demonstrate continuous learning in Urologic Oncology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.

4. Interpersonal & Communication Skills: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. Professionalism: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation and verbal communication from support staff and colleagues.
6. Systems-Based Practice: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

Pediatric Urology. Residents in this third year of urology will again have exposure to common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. However, their proficiency with these basic skills is expected to be at a sufficiently high level. Residents will further demonstrate their previously acquired competency in the surgical management of common Pediatric Urologic surgical problems such as circumcision, cryptorchidism and vesicoureteral reflux. Residents will obtain more significant operative experience with increasing levels of participation in hypospadias, congenital anomalies, and major urinary tract reconstruction. Advanced cases in Pediatric Urology Robotics are taught in this academic year.

PGY-5 YEAR – 12 months

PGY-5: Advanced Urologic Oncology with additional instruction in Robotic Urology. Residents will gain knowledge in pre- and postoperative care, intraoperative technical skills with an emphasis on Urologic Oncology patients. Further knowledge and skills are taught in robotic urology. By the end of this experience, residents will have advanced knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase their knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate surgical competency with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph-node dissection.

Pediatric Urology. Residents in this fourth year of urology will supervise and teach junior residents in the evaluation and treatment of common problems in pediatric urology as seen in the clinic, emergency department and in-patient pediatric consults. However, their proficiency with these basic skills is expected to be at a sufficiently high level. Residents will generally participate in advanced pediatric urologic procedures including reconstruction, oncology, laparoscopy and robotics.

Competencies & Evaluation of Outcomes

1. **Patient Care**: Residents are expected to gather essential information from the patient with Urologic complaints using medical interviewing, physical examination, and diagnostic testing. They will learn to make informed diagnostic and therapeutic decisions in the area of Urologic Oncology. Residents will have advanced knowledge in the postoperative care after large Urologic Oncologic procedures such as radical nephrectomy with or without IVC thrombectomy, radical cystectomy with various types of urinary diversion, radical prostatectomy, and retroperitoneal lymph-node dissection for testis cancer. Robotic techniques are taught to residents for the abovementioned procedures as indicated. Residents will recognize the postoperative complications and initiate prompt and reasonable intervention. They will increase their knowledge of Urologic cancer therapies and decision-making process regarding relative treatments. Residents will demonstrate surgical competency with Oncologic procedures such as radical nephrectomy, radical cystectomy, radical prostatectomy, and retroperitoneal lymph- node dissection. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
2. **Medical Knowledge**: Residents are expected to learn to critically evaluate and use current medical information from Urologic texts and conferences to evaluate the patient who needs surgery for Urologic cancer. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
3. **Practice-Based Learning & Improvement**: Residents are expected to demonstrate continuous learning in Urologic Oncology through attendance at conferences, Journal Clubs, and regional meetings. They will use evaluations of their performance to improve their practice. This outcome is measured with clinical performance ratings, focused observation and evaluation, in-training examinations, and in-house written examinations.
4. **Interpersonal & Communication Skills**: Residents are expected to communicate effectively with patients, families, support staff, and other health professionals. They are to learn to maintain comprehensive and legible medical records. They are to work effectively as members of the health-care team. This outcome is measured with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
5. **Professionalism**: Residents are expected to demonstrate high standards of ethical behavior. They are to respect the dignity of patients. They are to accept responsibility for patient care, including continuity of care and demonstrate dependability and commitment. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.
6. **Systems-Based Practice**: Residents are expected to be an advocate for the best interest of their patients. They are to work effectively in various health-care delivery systems and settings. They are to promote quality Urologic care and optimal follow-up interventions. This outcome is assessed with clinical performance ratings, focused observation and evaluation, and verbal communication from support staff and colleagues.

Common GME Policies Link

medicine.hsc.wvu.edu/gme/

Supervision Policy

Supervision of Residents

Purpose

To establish a policy to ensure all residents are provided increasing amounts of supervision.
[WVU GME Policy on Supervision](#)

Responsibilities/Requirements

- A urology faculty is always assigned to supervise the residents. A printed and/or emailed call schedule is sent out monthly to residents, faculty, and the hospital paging office. Faculty are notified with change in condition of patients following evaluation by the resident. Faculty are notified of elective admissions as soon as possible. When the residents are called for emergency department admissions and consults, the attending faculty are notified immediately following the resident's evaluation.
- In the event of unforeseen circumstances, such as illness, the resident will be informed by the program director who the supervising urology faculty will be.
- All clinical work is done under the supervision of attending faculty. While the degree of supervision in any given examination will vary with the particulars of the examination as well as the level of training of the resident, the ultimate responsibility for the written report created is that of the attending surgeon.
- All faculty are available during the day and when on call via telephone and/or beeper.
- In all cases, the ultimate responsibility rests with the attending physician who supervises all resident activities.

Lines of Responsibility for Resident Supervision:

- Outpatients – All residents will see patients in the outpatient setting. Every patient seen as an outpatient has a designated staff member responsible for all care provided in their respective clinic. Direct communication with the attending staff occurs prior to any procedure undertaken in the outpatient setting. Faculty are present in the clinic procedure room when a procedure is performed. All residents will discuss cases with the supervising attending staff.
- Inpatients – All residents participate in the care of inpatients. The junior residents have the primary responsibility for taking calls from the wards and entering orders in the EMR for patients on the Urology service. Junior residents are expected to see consultations and inform senior residents and/or attending staff for any question that may arise, or when any significant change in patient's status occurs. Each inpatient has an attending staff member who is responsible for all care provided. Attending staff will round on all inpatients either in person or through communication with the resident staff at least once per day.

- Consultation/Emergency Department – All residents participate in the care of emergency department patients and consultations from other services. The junior resident will usually see the patients first and then discuss the findings and plans with the more senior resident team members. Usually, the resident on-call will see the patient first. Each patient seen in consultation will either be seen by, or discussed with, one of the attending staff, typically the urology faculty member on call.
- Operating Room – All residents participate in the care of patients in the operating room. A graded experience is provided to allow residents to assume a greater role as their operative skills develop. The chief resident will determine the assignment to residents to operative case based on staffing needs to match the complexity with level of training. Each operative procedure is covered by one of the attending staff, and that staff member is present for the key portions of the procedure.

Transition of Care

Purpose

To establish a transition of care policy for the Department of Urology. This will be based on effective communication between residents and urology faculty members. By definition, transition of care assumes that a physician transfers the care of a patient from one urology resident/physician on call to another urology resident/physician on call. [WVU GME Handoffs and Transitions of Care](#)

Responsibilities/Requirements

Effective communication is vital to safe and effective patient care. Many errors are related to ineffective communication at the time of transition of care. In order to provide consistent superior patient care, it is vitally important that we communicate with one another consistently and effectively when care of a patient is handed off from one physician to another. This policy is meant to define the expected process involved in transition of care and applies to all urology residents and faculty members.

I. The Daily Sign-in and Sign-out

- There must be a formal sign out daily by each resident on the inpatient service. Sign out must include direct communication between residents and should be face to face.
- Residents who are directly responsible for patients on the inpatient service who are on call receive access to the urology patient list on the EMR. The resident on call must know, at a minimum, the following information:
 1. Patient name, age, sex, room assignment
 2. Relevant diagnosis
 3. Active urologic problems
 4. Code status
 5. Follow up and/or required actions, e.g., check labs, urinary catheter, stoma, etc.

- Residents that are post-call must communicate the events of the preceding night to the residents coming on that day. All new admissions and consults must be listed on the EMR dashboard. In addition, any significant developments overnight must be shared with the oncoming resident providing care for the service.

II. Transfer to another level of care

- When a patient is transferred from one level of care to another, e.g., the wards to the ICU or vice versa, and a different resident or group assumes the care of that patient, there must be documented communication between the resident physicians that includes the information that summarizes relevant information and provides the information necessary to provide effective care.
- The resident physician that “sends” the patient to the service providing a different level of care must place a note in the EMR that summarizes the clinical events preceding the transfer and should also communicate verbally with the resident that “receives” the patient. That note in the EMR should include a brief history, relevant examination findings, relevant labs and/or imaging studies, advanced directives, current medications, and a brief assessment and plan.
- The physician that “receives” the patient must place a note in the EMR that summarizes the patient’s condition and includes an assessment and plan that is reviewed and approved by the urology attending responsible for the patient.
- Any decision to transfer a patient from one level of care to another must be made with the knowledge and consent of the attending faculty physician. In the event of an emergency, this may be obtained during or after the transfer.

Any questions regarding this policy should be directed to the Program Director or his designee.

How to Access and File a Patient Safety Report via CONNECT

- Go to CONNECT: <http://connect.wvuhealthcare.com/>
- In the left-hand menu, click on ***SAFETY REPORTS***
- Under Patient Safety Net (PSN), click on ***THIS WEB-BASED REPORTING TOOL***

For questions with the system, or to directly contact Risk Management, please email Melissa Polito at PolitoM@wvumedicine.org, or Jan Manilla at manillaja@wvumedicine.org. Or contact the Risk Management office by phone during regular hours: 304-598-4167.

Conference/Didactic Attendance Policy

Residents are expected to attend all conferences listed below unless involved with an emergent patient situation, attending an out-of-town meeting, on vacation, or on sick leave.

The Wednesday Morning Conference begins at – 6:30 am (or earlier per Program Director or Chief Resident.)

Topics will consist of the following: Campbell's Urology Review, Pediatrics Conference, and Complications in Urology Conference, and General Urology topic review. A brief indications conference is also included during this block conference time. Residents must be punctual to attend this Conference and sign the attendance sheet. Lectures also are given by Urology Department faculty members, as well as invited speakers from other departments in the School of Medicine.

Residents presenting material at these conferences must provide a handout of the material to serve as a teaching guide for their peers and faculty. Residents will be evaluated periodically by faculty on their presentations throughout the academic year. Results of these evaluations will be shared with residents during their semi-annual progress meetings.

Additional conferences may be scheduled as well such as radiology, pathology and robotic simulation sessions. Informal Friday Morning Conferences may be used to catch up on material not covered completely in the Wednesday Conference.

Residents will be assigned topics in each of the urologic disciplines to present at these Conferences, which will be led by faculty and guest lecturers from the respective departments. Residents will be evaluated periodically by faculty on their presentations throughout the academic year. Results of these evaluations will be shared with residents during their semi-annual progress meetings.

Journal Club is held monthly, and announcements are sent by e-mail. Residents must attend this Conference. The Chief Resident or designee will be responsible for selecting articles from the Urologic literature for presentation and discussion. Each resident will review all articles and be asked to present information in an informal fashion from a particular article(s).

Call Responsibilities and Backup Call Systems

The call schedule will be made by the chief resident with oversight by the Residency Program Director. Each resident will have at least 2 weeks off each month from primary (first) call responsibility. The majority of primary call responsibility will be shared equally by the PGY-2 and PGY-3 residents when averaged over the course of the year, and the remainder of primary call duties will be taken by the PGY-4 resident. A PGY-1 resident will be allowed to take call but will require additional supervision by senior residents as per ACGME guidelines. All call is considered to be "at-home" call.

The following is an estimation of the expected call responsibilities:

1. PGY 2 and 3 will be equally weighted on call throughout the entire year with a maximum of (9) primary calls.
2. Power weekends will be eliminated for the PGY 2 and 3 but will still be in effect for the PGY 4
3. PGY 4 will take 3-4 calls monthly as primary (depending on 30 or 31 days) and will be limited to no more than 3 backup calls for first 6 months.
4. PGY 2 and 3 will split major and minor holidays, taking (1) each. PGY 4 will backup for (1) of each
5. Rounding for the weekend will only be required by the Intern on the weekend PGY4 is on call (i.e., 1 per month)
6. Interns will take primary day call during M-F 6a-6p.

This gives every member of the team 5-6 days off per month except for the Chief (who has 2-3 but can be mitigated by the PGY4 backup) and more appropriately distributes the call responsibilities

compared to prior years. With vacations/meetings, etc... this may not be exactly true each month but will represent a rough average for the call for the year.

The chief resident is expected to be physically present (i.e., in the local area) to provide “back-up” or second call responsibility to the primary resident on call. PGY4 must have backup. If there are greater than 10 patients, backup resident must help round. If on call resident is up over 24 hours, backup will be called in. Two schedules will be made to accommodate for backup to have Monday off.

Any questions about call schedule arrangements/assignments must be addressed with the responsible faculty on call. In the event that an agreement cannot be reached regarding the call schedule, the issue should be presented to the residency program director.

Evaluation Policy

Purpose

To establish a policy for the evaluation and structural feedback that will enhance the residency training programs and institute quality improvement mechanisms. To ensure timeliness, all evaluations will be due by the date designated by the program manager.

Responsibilities/Requirements

A. Evaluation of Residents

Formal evaluation will be based on the following criteria:

- Evaluation forms
- Monthly formative narrative comments by faculty
- Input from faculty
- In-service and end year examinations
- Professionalism
- Attendance and participation in conference
- Milestones evaluations will be completed for each resident semi-annually. Mid-Cycle evaluations will be completed by assigned faculty mentors.
- Any negative evaluations will be brought to the resident’s attention and measures to correct the problem will be addressed.
- The program director will evaluate each resident a minimum of twice a year for a formal evaluation of his/her progress.
- All formal evaluations are kept as part of the resident’s personnel file.

- The program director is always available for discussion and the residents are strongly encouraged to seek guidance for any perceived difficulty or problem.
- Residents may have access to their academic files at any time. The file can be requested from the residency program coordinator.
- At the conclusion of each resident's training, a formal written final evaluation summarizing their years of training will be completed by the program director and maintained in the resident's permanent file.
- Faculty evaluations of the resident will be kept in the resident's permanent file.
- Evaluations will be one of the tools utilized in determining promotion to the next level of training.

B. Evaluation of Faculty by Residents

- Faculty evaluations will be completed by each resident at least annually through the E- Value program.
- These evaluations will be anonymous and confidential which will assure each resident is free to comment frankly and openly without fear or intimidation or retaliation.
- A final report, of the Urology faculty will be compiled together of the resident's faculty evaluations and will be submitted to the Department Chair for review. If any derogatory comments or complaints are noted, the Department Chair and Program Director will consult with the DIO.

C. Program Evaluation

- Program evaluations will be completed by each resident annually through the E-Value program.
- The program evaluation will be anonymous and confidential which will assure each resident is free to comment frankly and openly without fear of intimidation or retaliation.
- A final report will be compiled together of the Urology resident's program evaluation by the ACGME ADS program. It will be submitted to the GME Office for the DIO review. If any derogatory comments or complaints are noted, the DIO will consult with the Department Chair and Program Director.

Feedback Buttons

If you are a resident who has experienced mistreatment; if you have been demeaned for requesting, or been denied, adequate supervision; or if you have witnessed any of these things happening to a resident, please complete the information online and make a report. Help us stop mistreatment and create and promote a safe learning environment.

[Mistreatment Form \(https://medicine.hsc.wvu.edu/gme/mistreatment-form/\)](https://medicine.hsc.wvu.edu/gme/mistreatment-form/)

Physicians in training must be held to a high standard of professionalism in all areas of their lives. These standards are not intuitive and must be taught and reinforced both by formal education and by constructive formative feedback. If you have witnessed a resident or fellow displaying either a lapse in professionalism or exemplary professionalism, please complete the information online and provide us with the details. Help us to improve our working and learning environment [Professionalism Form](#)

Case Logs/Procedural Logs

It is the responsibility of the resident to keep his/her case logs up-to-date weekly. Case logs will be monitored quarterly for log entries. If cases are not logged weekly, the resident will have his/her meal card suspended and/or a suspension from the clinic and any Operating Room cases until in compliance. All cases are logged into the ACGME website at <https://apps.acgme.org/connect/login>. Please see the Program Manager if you have forgotten your password or have questions regarding the site. Residents must log all cases that they participate in. If two residents are participating in a major urologic case where both residents perform a significant portion of the case, the chief/senior resident may code the case as teaching resident and the second resident can code the case as surgeon.

Clinical and Educational Work Hours & Wellness Policy

Containing the ACGME's work hour regulations, plus instruction for proper and timely logging of work hours in E-Value; protocol if they think they are going to need to violate a work hour rule; call rooms in case they are too tired to drive home; taxi vouchers at the Emergency Room check-in desk for a taxi ride home if they are too fatigued to drive home; Concern regarding the importance of maintaining physical and mental wellness – contact info for FSAP <http://www.hsc.wvu.edu/fsap/>, 304-293-5590, fsap@hsc.wvu.edu; how to page the chaplain on call, pager #0590; The Wellness Center, <http://wvumedicine.org/thewellnesscenter/>

Compliance with the Clinical & Educational (C&E) Work Hours Standards as outlined in the ACGME Common Program Requirements are expected for all programs.

The primary responsibility for the development of a call schedule that follows the ACGME's C&E Work Hour Standards resides with the program director, the program manager, and the core faculty of each program. In addition to the call schedule, the program manager for each program will regularly monitor their trainees logging of C&E Work Hours in order to: 1) Ensure timely logging; and 2) Monitor hours logged to allow for early intervention in unsafe work hour situations.

The GME Office will also provide monthly central oversight to ensure institutional compliance across all programs with current standards as outlined in the ACGME Common Program Requirements.

Each program must have a written policy that: 1) follows the ACGME's C&E Work Hour Standards; 2) is program and department specific; 3) and is provided to all trainees and faculty on an annual basis. This policy must define an effective program structure that is configured to provide residents with excellent educational and clinical experience opportunities, while also allowing for reasonable opportunities for rest and personal well-being. [VI.F.2.a)]

Factors that must be addressed include, but are not limited to: maximum hours per week, and per shift; mandatory time free; frequency of in-house call; frequency of at-home call; night float; guaranteed time off for medical, dental, and mental health appointments; vacation & sick time procedures, as well as other types of leave; rules for inclement weather and/or disaster situations; and the expectation of honest, and timely logging of work hours.

Honest and Timely Logging of Work Hours:

- **Honesty is a cornerstone** of our ethical and professional code here at WVU SOM. Without honesty, there is no trust. **Log your work hours honestly.** [VI.B.4.f)]
- Our **institutional standard** for logging of work hours is to **log them daily.**
- **However**, understanding that life is rarely standard – **if necessary, fall back on this one rule – at bare minimum, log every four days.** Beyond that, you will not remember what you actually worked.

Maximum Hours:

- C&E 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, clinical work done from home, and all moonlighting. [VI.F.1.]
- C&E Work **periods for residents and fellows must not exceed 24 hours of continuous scheduled assignment. Up to 4 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 trainee during this time.* [VI.F.3.a). (1) & (a)]

In Sum...

Averaged over a 4-week period.

- Max of 80hrs/week
- At least 1 day in 7 free of work
 - In each month NOT containing a vacation, you MUST HAVE **5 DAYS OFF**.
 - In each month containing a vacation, you MUST HAVE **4 DAYS OFF**.
- In-house call no more than every 3rd night

Breaks between shifts.

- Should have 8hrs off between shifts.
- Must have 14hrs after 24hrs in-house call.

Continuous Scheduled Shift Length

- Must not exceed 24 consecutive hours (+4hrs for transition of care/didactics)

****All clinical work done from home, including charting, must be logged as work hours.**

Vacation/Holiday/Sick/Family Leave/Medical Leave/Bereavement Policy

The resident/fellow leave guidelines of the West Virginia University School of Medicine exist to ensure the safety and general welfare of the residents/fellows and the effectiveness of the training programs. The

guidelines are in accordance with the guidelines of West Virginia University, West Virginia University School of Medicine, ACGME, the regulatory and/or accrediting agencies, and the Residency Committee and are approved by the Resident/Fellowship Program Director, the Chair, and the Graduate Medical Education Committee.

The Program Director and the Competency Committee will review resident/fellow leave time to assure that Residency Review Committee requirements are met. Due to the potential for stress and fatigue during residency training, it is expected that residents/fellows will take advantage of whatever amount of annual leave you are able to take each year in accordance with this policy without consequence to your studies. If not requested, annual leave may be assigned at the discretion of the Program Director.

However, use of leave may impact on a resident's/fellow's ability to complete program requirements. Therefore, a resident/fellow who takes all the allowable annual and sick leave may not be able to complete the program requirements in the allotted training time and/or may not be eligible to take the required and/or applicable board examinations at the conclusion of the training period without additional training time. The Department is not responsible for providing additional training time and, in fact, may not be able to do so without requesting permission from ACGME, which permission may or may not be granted. The grant of permission by ACGME is beyond the control of WVUSOM.

In addition to WVU leave policies, the ACGME and the applicable board may 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 Urology Board has the following requirements with regard to required training time: A minimum of 48 months of clinical urology education is required. Within the final 24 months of urology education, residents must serve at least 12 months as a chief resident. The clinical and academic experience as a chief resident should prepare the resident for an independent practice of urology. As such, this Chief Resident experience should include management of patients with complex urologic disease, advanced procedures, and, with appropriate supervision, a high level of responsibility and independence.

Inclement Weather Protocols

Resident to alert Chief Resident and Program Director should weather prohibit safe travel to the hospital.

Parking Policy

The following are some helpful hints and information that address many of the more common questions we receive regarding parking:

- Parking for residents is in lots of E and B1 Only.
- Do not use patient/visitor parking lots. This practice does not reflect the patient priority values of our organization.
- Do not park illegally anywhere on WVUH property. Permit parking spaces are always available. If you cannot find a space, approach one of the Parking 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 go to the Parking Office on the 4th floor of Ruby.

- If you lose your parking permit, please see the Parking Office for replacement. A nominal fee is charged to replace a lost permit.
- Please be aware that warning tickets stay on record for 3 months. After a vehicle is issued a minimum of 3 warnings, the next notice given will be an orange final notice sticker in effect for 6 months. If the vehicle is parked illegally after receiving an orange sticker within the 6-month period, it will be towed at the owner's expense. A tow authorization being issued extends the period a vehicle can be towed again to 6 months from the date of the tow. The same vehicle could potentially be towed multiple times.
- Please be aware that it does not matter in which WVUH lot or lots you receive the warnings and final notice. The effect is cumulative. If you park illegally anywhere on WVUH property within 6 months of an orange sticker, your vehicle will be towed, even if it is an area in which you had never before parked illegally.
- If you have been towed, your vehicle will be taken to a secured area on campus.
- Please note that the D off-shift parking was intended to provide spaces for afternoon shift parking. There should always be space available, and you have the same degree of safety at night without risking violation if your times run over into day shift. (Remember to use your security escort at night any time you are not comfortable walking to or from your vehicle- call 74444)
- Remember that F-2 (gravel lot next to paved F-1) is now an employee permit parking lot and spaces are always available in that lot. F-2 is newly graveled, has parking curbs, and is monitored by our Parking Officers.
- If you do not understand where you should park, or if you have any other questions about lot designations, ticketing, or anything related to parking, please call the parking office at 304-598- 4029 any time between 7:00 am and 3:30 pm.

Link to Daily, and On-Call Schedule

Coverage, and Consults, daily schedules for residents/fellows, and faculty - [On Call](#)

Phone Numbers

- Program Director (Dr. Hajiran): 304-293-2706
- Program Manager (Morgan):
 - Mobile (preferred): 304-906-0531
 - Office: 304-293-7385
- GME Office contact number: 304-293-0672

QI Policy

Program specific requirements

Resident Quality Improvement Program

Per the Institute of Medicine's 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century*, in order to "continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States", all health care constituencies (health professionals, federal and state policy makers, public and private purchasers of care, regulators,

organization managers and governing boards, and consumers) must adopt a shared vision of six specific aims for quality improvement:

- Patient-centered – care that is responsive to patient preferences, needs, values.
- Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing to those not likely to benefit.
- Equitable – providing care that does not vary in quality because of personal characteristics.
- Timely – reducing waits and delays for care.
- Efficient – avoiding wastes.
- Safe – avoiding injuries to patients from care.

The Urology Residency Quality Improvement (QI) Program has been designed to meet two primary goals:

- Fulfill the Residency Review Committee (RRC) requirements that residents learn QI methods and participate in a QI project during their residency.
- Provide training that enables residents to address quality of care issues during both their training and in their future careers.

Objectives of the QI program is to ensure that all residents:

- Participate in at least one QI project during their residency.
- Complete the QI project under the guidance and supervision of a knowledgeable faculty mentor.
- Understand and can perform the basic steps of a QI project:
- Identify area, problem, or opportunity for improvement.
- Assemble an appropriate QI project team.
- Develop an AIM statement.
- Identify measurable goals.

Test and implement system changes using plan-do-study-act (PDSA) cycles.

Scholarly Activity Policy

Program specific presentations/projects required.

Moonlighting Policy

Urology residents are not permitted to moonlight.

Supervision Policy

A. Programs must provide a professional, respectful, and supportive environment that is free from mistreatment, abuse, and coercion of residents, fellows, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory, supportive, and respectful manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of

residents/fellows and faculty regarding episodes of inappropriate and unprofessional behavior, especially when exhibited toward a trainee who is requesting supervision and guidance in the patient care setting.

B. The safe and appropriate care of each patient underlies all guidelines for supervision in medical education. Although the attending physician is ultimately responsible for the care of the patient, every physician involved in a patient's care shares in the responsibility and accountability for their individual actions. Each resident/fellow and faculty member must inform each patient of their respective role in that patient's care. [ACGME CPR, VI.A.2.a). (2)] Effective programs, in partnership with their Sponsoring Institution, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care. The degree of supervision for a resident/fellow is expected to evolve progressively as the resident/fellow gains more experience. The level of supervision for each resident/fellow must be commensurate with that resident's/fellow's level of independence in practice, and will be influenced by the complexity, acuity, and urgency of the patient's condition. [ACGME CPR, VI.A.2.b). (1)]

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

D. Levels of Supervision

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

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

VI. A.2.c). (1)] Additional information on Direct Supervision may be found here. (CTRL-click)

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

iii. Oversight – The supervising physician is available to provide review of procedures/enc

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

1. Clinical responsibilities must be conducted in carefully supervised and graduated manner, tempered by progressive levels of independence to enhance clinical judgment and skills.
2. This supervision must supply timely and appropriate feedback about performance, including constructive criticism about deficiencies, recognition of success, and specific suggestions for improvement.
3. Resident supervision must support each program's written educational curriculum.
4. Resident supervision should foster humanistic values by demonstrating a concern for each resident's well-being and professional development.
6. Residents are supervised by faculty physicians in accordance with these established guidelines.
7. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.
8. The quality of resident supervision and adherence to the above guidelines are monitored through annual review of the residents' evaluations of their faculty and rotations, and via the GME Supervision Survey.
9. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval. Monthly progress reports will continue to be submitted until the situation or issue is resolved.

F. For a list of resident/fellow and attending physician patient care activities and supervision responsibilities, please CTRL-click on the following link: [Appendix L: Resident and Attending Physician Patient Care Activities and Supervision Responsibilities for Non-Operating Room Procedures](#)

Revision Approved by GMEC Taskforce: November 2, 2017; February 2, 2023, Revision Approved by the GMEC: November 10, 2017; February 10, 2023

Clinical Competency Committee (CCC)

With the implementation of the Next Accreditation System (NAS) by the ACGME, all residency programs must establish a Clinical Competency Committee (CCC). For this reason, this Statement of Purpose is created to assist the CCC with their mission.

The WVU Department of Urology Residency Program's CCC officially commenced functioning in July, 1, 2013. The committee is chaired by Dr. Chad Morley, Associate Professor of Urology. Additional members of the committee include all full-time urology faculty. Residents are not formally considered to be part of the committee. However, the chief resident or senior resident may be asked to provide insight to the committee as requested. The goal of the committee is to make recommendations to the Program Director based on data available. Decisions will be linked to the competencies and milestones.

Members of the WVU Department of Urology Clinical Competency Committee

- **Chad Morley, MD**, Director of CCC
- **Daniel McClelland, MD**
- **John Barnard, MD**

- **Ahmed Ali, MD**
- **Ali Hajiran, MD**, Program Director
- **Morgan Myers**, Residency Program Manager

The committee will meet semiannually in December and June of each academic year to review evaluations and provide information regarding successful completion of the milestones. Additional meetings may be scheduled at the discretion of the CCC Chairman Dr. Chad Morley or Dr. Ali Hajiran, Program Director. All decisions will be made by consensus. The committee will use (but not be limited to) the following evaluation tools to assist in the decision-making process for competency assessment:

WVU Department of Urology Resident Assessment Tools

1. Annual AUA ISE Performance Report – November
2. Annual AUA SASP Performance Report - June
3. ACGME Case Log Completion – monthly
4. Duty Hours Logging – monthly
5. Attendance at weekly Urology Resident Conference
6. Self-Evaluation of Milestone Performance
7. Mock Oral Examination Score Sheet
8. Completion of Robotics Simulation Training – semiannually
9. Case Presentation at M & M conference
10. Resident Presentation at Teaching Conference
11. General Competencies Evaluation of Resident by Faculty
12. Patient Care Evaluation

The Clinical Competency Committee meets biannually to review each resident and assign milestones levels. The milestones are then reported to the ACGME through the ADS (Accreditation Data System). Residents are presented with their milestone's metric at the end of each 6-month rotation and discussed with the Program Director. The Program Director and the resident sign off on the official Milestones Narrative Report which is then uploaded to the resident's E-Value resident portfolio.

Program Evaluation Committee (PEC)

- Will consist of members of the CCC as well as a resident representative.
- Program evaluations will be completed by each resident annually through the E-Value program.
- The program evaluation will be anonymous and confidential which will assure each resident is free to comment frankly and openly without fear of intimidation or retaliation.
- A final report will be compiled together of the Urology resident's program evaluation by the ACGME ADS program. It will be submitted to the GME Office for the DIO review. If any derogatory comments or complaints are noted, the DIO will consult with the Department Chair and Program Director.

Work Environment Policy

Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, and coercion of residents, faculty, and staff. All GME-related supervision will be provided in a non-retaliatory and supportive manner. Programs, in partnership with their Sponsoring Institution, must have a process for education of residents and faculty regarding inappropriate and unprofessional behavior, *especially* when exhibited toward a trainee who is requesting supervision and guidance. [VI.B.6. – with slight edits]

AMA GME Competency Curriculum

See above.

Electronic Educational Resources

Available through Ruby and HSC at [HSC Library](#)

Program Closure/Reduction Policy

[WVU Program and Institution Closure/Reduction](#)

Fit for Duty Policy

Fitness for Duty refers to the ability of a resident physician to perform the essential functions of his or her job without an impairment that may pose a potential risk to patients, a direct threat to the safety of others in the workplace, and/or interfere with the performance of his or her necessary duties, with or without a reasonable accommodation.

There are at least four categories of impairment associated with Fitness for Duty:

- (1) Impairment associated with the misuse or the suspicion of misuse of prescription medications, alcohol or illegal drugs.
- (2) Impairment associated with behavior that may pose a direct threat to the employee, patients or to others in the workplace.
- (3) Impairment caused by a medical condition, including mental health, and/or the use of medication for that condition; and
- (4) Impairment associated with fatigue/sleep deprivation.

The supervisor who receives reliable information that an individual may be unfit for duty, or through personal observation believes an individual to be unfit for duty, will validate and document the information or observations as soon as is practicable. Actions that may trigger the need to evaluate an employee's fitness for duty include, but are not limited to, problems with dexterity, coordination, concentration, memory, alertness, vision, speech, inappropriate interactions with coworkers or supervisors, inappropriate reactions to criticism, or suicidal or threatening statements.

A resident physician who is suspected of being impaired for any reason is immediately subject to drug screening. Refusal of drug screening is grounds for immediate suspension and/or termination with referral to the Faculty and Staff Assistance Program (FSAP) and/or the West Virginia Medical Professional Health Assistance Program.

In the spirit of a just culture of safety and wellbeing, any person may report suspicion of impairment to the employee's supervisor or to the compliance hotline. There shall be no retaliation or repercussions towards individuals who have reported such concerns.

Residents and any others are urged to report any concern regarding duty hours, fatigue and other issues to the compliance hotline of the WVUH, the primary teaching hospital at 1-877-298-4376. These concerns will be reported to the GME office.

As a result of impairment, the employee may be suspended until fitness for duty is established. Involvement of the Human Resources department, the FSAP Program, and the hospital Practitioner Health Committee is expected.

Patient Safety Policy

Link to ORAGAMI Patient Safety Reporting: <https://connect.wvumedicine.org/safety-reports/>

I. Rationale

In accordance with the ACGME Clinical Learning Environment Review (CLER), the West Virginia University Office of Graduate Medical Education must ensure that residents are educated and engaged in patient safety activities or programs.

II. Scope

This policy applies to all graduate medical education programs sponsored by the West Virginia University School of Medicine.

III. Policy

- A. Programs should encourage and support residents to work in Inter-professional teams to enhance patient safety and improve patient care quality. Common Program Requirements VI.A.5.f). (5).
- B. Programs should encourage and support residents to participate in identifying system errors and implementing potential systems solutions. This can be achieved through the following activities or program:
 - 1) Reporting of adverse events and near misses/close calls to improve system of care.
 - 2) Participation in in inter-professional, interdisciplinary, systems-based improvement efforts such as patient safety event reviews and analyses (i.e., department level Morbidity and Mortality Conferences, institution or department level Root Cause Analysis of adverse events)

Adapted from: Common Program Requirements VI.A.5.f). (6).

- C. Program directors should provide feedback to residents when they are involved in patient safety events.
- D. Programs must develop policies to ensure all residents and fellows are instructed in patient safety.
 - 1) Programs must incorporate patient safety instruction into its curriculum.
 - 2) All residents and fellows must complete the WVU Office of Graduate Medical Education assigned self-directed modules from the Institute for Healthcare Improvement (IHI) Open School.
 - 3) Any alternate format of instruction must be submitted for review by the WVU Office of Graduate Medical Education Patient Safety Subcommittee.
 - 4) It is recommended that residents and fellows receive additional instruction in the form of small or large group discussions or workshops.
- E. Programs must develop competency-based goals and objectives that pertain to instruction in patient safety and participation of resident or fellows in patient safety activities.
- F. Programs, through the Program Evaluation Committee (PEC), must evaluate instruction in patient safety and participation of resident or fellows in patient safety activities at least annually.

Adapted from: Program Director Guide to the Common Program Requirements, 2012. Each assignment in which the resident is expected to participate must have a set of competency-based goals and objectives. Assignment refers to each rotation, scheduled recurring sessions such as M&M conferences, journal club, grand rounds, simulated learning experience, lecture series, and required resident projects such as a quality improvement project that are not explicitly part of a recurring session or rotation.

IV. Evaluation

- A. Monitor resident and fellow completion of mandatory IHI Learning Modules.
- B. Monitor resident and fellow scores and passing and failing rate in the IHI Learning Modules post-test.

Institutional Vendor Policy

The purpose of this policy is to establish guidelines for interactions with industry representatives for residents in graduate medical education programs sponsored by the West Virginia University School of Medicine. Interactions with industry occur in a variety of contexts, including marketing of new pharmaceutical products, medical devices, and research equipment as well as on-site training of newly purchased devices. Many aspects of these interactions are positive and important for promoting the educational, clinical and research missions of the institution. However, these interactions must be ethical and cannot create conflicts of interest that could endanger patient safety, data integrity, and the integrity of our education and training programs.

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

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

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

Appointments may be made on a per visit basis or as a standing appointment for a specified period of time, with the approval of the program director or department chair, or designated hospital or clinic personnel issuing the invitation.

Vendor support of educational conferences involving resident physicians may be used provided that the funds are provided to the institution not directly to the resident. The program director should determine if the funded conference or program has educational merit. The institution must not be subject to any implicit or explicit expectation of providing something in return for the support. Financial support by industry should be fully disclosed by the meeting sponsor. The meeting or lecture content must be determined by the speaker and not the industrial sponsor. The lecturer is expected to provide a fair and balanced assessment of therapeutic options and to promote objective scientific and educational activities and discourse.

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

Well-Being Policy

The West Virginia University School of Medicine (WVU SOM) is committed to preparing our residents and fellows for a lifetime of caring for others and themselves. Therefore, one of the most important lessons we must teach them is the crucial importance of the physicians' own physical and mental well-being to their ongoing practice of medicine. Initiating learning in well-being and self-care, and normalizing these pursuits, is crucial for residents and fellows at this stage of training because.

GME is the time when they begin to establish the practice habits they will have for the rest of their lives.

The WVU SOM's GME Well-being Program requires each training program to provide instruction in well-being as an integral part of their ongoing curriculum. This instruction must take place at least annually, although best

practice would be more frequently and on a regular basis with different sessions provided for each. An ideal set up would be to provide a well-being session for Grand Rounds in order to educate supervising teaching faculty in addition to residents and fellows, as this is an ACGME mandate.

In addition, although residents and fellows are no longer required by WVU SOM to complete an annual well-being screening, we are asking training programs to continue the call to wellness initiated in the 2017 guidelines by encouraging and supporting their residents and fellows to schedule a well-being screening on their own should they feel a need to do so.

The Faculty and Staff Assistance Program (FSAP) and Spiritual Care remain the two available free options for screening at this time. Spiritual Care offers group training didactics and experiences.

(Appendix A) should individual programs wish to use this as a part of their wellness curriculum.

FSAP, though their staffing is more limited, is also able to provide group training didactics, as their schedules permit. To contact FSAP, please refer to their flyer (Appendix B) at the end of this policy.

As each program sets their individual well-being policy, they will use the “fill-in-the-blank” program-specific well-being policy (Appendix C), to define how well-being will be integrated into their program, and to clarify the expectations for residents, fellows, and supervising faculty.

The GME Office will be assessing the overall well-being of our residents, fellows, and supervising teaching faculty on a regular basis utilizing the annual ACGME Well-being Survey, and other instruments including, but not limited to, the Mini Z 2.0, and the PHQ-9. This required GME oversight will be done in collaboration with our training programs as we strive to make continual improvements to our clinical learning environment.

Diversity Policy

The WVU School of Medicine is the flagship institution of medical education, healthcare, and research for the state of West Virginia. As a land grant institution, our goal is to improve the health and wellness of West Virginia residents. The school endeavors to select a gender-balanced, diverse, and tolerant graduate student body, faculty, and staff. Our priority is to recruit key, value-added, underrepresented in medicine groups that include African Americans, Hispanics, LGBTQ, and Native Americans/Pacific Islanders. The WVU School of Medicine also aims to recruit residents/fellows who are included in the socioeconomically and educationally disadvantaged rural Appalachian population.

The school’s endeavors are congruent with the strategic plan of the School, the Health Sciences Center, and the University. The school believes the recruitment and accommodation of key value-added groups greatly enriches our educational and research missions; the environment for our students, residents/fellows, faculty, and staff; and our goals in improving the healthcare of the citizens of West Virginia.

This policy is implemented to ensure there are no quotas or set asides. Regardless of an applicant's characteristics, they are considered in the same competitive pool using the same application of university policies and procedures. Each graduate medical education program is required to have their own program specific Diversity Policy as well as monitor their diversity against goals and national statistics for their specific program. Furthermore, GME will evaluate recruitment efforts centrally by monitoring the number of offers made to our defined value-added groups, the number of individuals who decline offers, and the number of individuals who choose to be employed by or be a resident/fellow at West Virginia University’s School of Medicine.

Academic and Learning Environments Graduate Medical Education (GME) ensures its educational program occurs in a professional, respectful, and intellectually stimulating academic and clinical environments; GME recognizes the benefits of diversity; and promotes resident’s/fellow’s attainment of competencies required of future physicians.

Diversity/Pipeline Programs and Partnerships GME has effective policies and practices in place and engages in ongoing, systematic, and focused recruitment and retention activities to achieve mission-appropriate diversity outcomes among its residents/fellows, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

Additional Policies

- Disaster Response
- Interactions with vendor reps
- ADA (Americans with Disabilities)
- Appropriate use of the internet
- Other institutional policies

[WVU GME Policies](#)

Accessing the Event Management System (EMS)

Reporting safety events and near misses:

1. Access **CONNECT** <https://connect.wvumedicine.org/>
2. On the left-hand menu, choose **Safety Reports**
3. Choose **J.W. Ruby Memorial Hospital**
4. To file a patient safety even report, choose **Event Management System (EMS)** in blue
5. You can also choose the **EMS Playground** if you want to practice using the system first – but do not use the playground to file a real report.

Reporting mistreatment, lack of professionalism, lapse in professionalism, or exemplary professionalism:

1. Access the Office of GME website <https://medicine.hsc.wvu.edu/gme/>
2. Scroll down to the bottom of the page under **ADDITIONAL RESOURCES**.
3. Click on whichever button pertains to the issue you need to report, and complete & submit the form. The report is delivered directly to the GME Office.
4. **PLEASE NOTE:** The more information you are able to include in your report, the better.
(However, please do not include identifiable patient health information.) Each report is addressed.

Fundamentals of Fatigue Prevention and Management

Access fundamentals of fatigue prevention and management:

<https://sole.hsc.wvu.edu/Site/741/File?InstanceId=502657>

Discretionary / Resident Stipend Policy

Can be used for:

- Conference Travel

- Textbooks
- Study Material
- Board Review
- Stethoscopes
- Lead Vests
- *Electronics will be approved or disapproved on a case-by-case basis.*

Allotment per year:

- PGY 1: \$150
- PGY 2: \$300
- PGY 3: \$300
- PGY 4 & 5 Combined: \$650

Reimbursement Policy

Reimbursements will be considered and approved or denied on a case-by-case basis. This must be submitted to the program manager/program director, and ultimately approved/denied by the chairman and department administrator.

A list of Resident/Fellow Dos and Don'ts/Re-Cap

- Vacation Policy
 - a. 4-week advance notice
 - b. 5-day blocks
 - c. Must know last (2) weeks of vacation by Mid-December or holiday break counts as vacation.
 - d. Chief cannot leave greater than 10 workdays in June.
 - e. Mid Atlantic Main AUA
 - f. Everyone takes 1 vacation in first 6 months.
 - g. Minimize 2 residents off at a time.
- Minimal Clinic Duties
 - a. Minimum – 2 days per month
 - b. Done on the Honor System with random audits.
 - c. If not done, 1 month warning will be given, if not, will be assigned 1 week of clinic.
 - d. Must be with different faculty.
 - e. If unable to make it on time to a scheduled clinic, the resident must personally contact the staff and report reason why.
- Call Schedule
 - a. Back-up call is mandatory to the PGY – 4
 - b. Back up resident MUST be called if.
 - a. Residents are over their hours.
 - b. Feeling fatigued

- Conference schedule
 - a. Faculty and Staff will give 1 Grand Rounds presentation at least per year.
- Journal Club
 - a. Will be once per month.
- SASP requirements
 - a. Listed on conference email send outs.
- Print out case logs, CV.
 - a. Residents must keep case logs up to date no greater than a month.
 - b. If not, residents will be given a 2-week warning.
 - c. > 2 warning will cause a formal professionalism review by the CCC.
 - d. Must print out and submit- due dates listed on conference schedule.

- Research

*Not required, but **HIGHLY** encouraged.*

- a. Research where the resident has contributed SIGNIFICANTLY to medical students will count.
 - b. Paper is either “accepted”, “published”, submitted and rejected with a “new” submission sent it correcting the critiques.
 - c. Resident should have research topic prior to August 1 that they will be working on
 - d. Residents may tell faculty if asked to do additional research that they already have their project and are encouraged to direct the faculty to a medical student.
 - e. If a resident presents at a meeting, they MUST submit that research idea for publication prior to going to an additional meeting.
 - f. If a resident presents or publishes, they must send out an email to all staff involved within 72 hours.
- Medical Student involvement (third and fourth year)
 - a. Chief resident and Dr. Hajiran will be making evaluations for all rotating students at the request of the Department of Surgery
 - b. Third year medical student participation ideas formulated by residents and staff.
- Resident Fatigue
 - a. Should a resident feel fatigued, concerned about wellbeing, over hours, or not meeting 5 days per month off. It is up to the resident to notify the chief resident and program director prior to the end of the month so accommodations can be made.
 - b. Contingency schedule is to be made weekly to allow for weekend resident to have the opportunity to have Monday off.
- Weekly meetings with chief resident
 - a. TBD – Likely after teaching rounds on Friday

- Attendance of Meetings
- In-Service Exam Score
 - a. Goals per PGY level
 - a. PGY1 - 40% total answers correct.
 - b. PGY2 - 50% total answers correct.
 - c. PGY3 - 70% total answers correct.
 - d. PGY4 - 70% total answers correct.
 - e. PGY5 - 70% total answers correct.
 - b. If goal is not met, a remediation program will be initiated until the next In-Service Exam
 - c. Non-compliance with the remediation plan will result in disciplinary action including written warnings, probation, and/or dismissal/non-reappointment.
- Resident Administrative Requirements
 - a. Residents MUST respond to emails and text pertaining to Education and Patient care within 24 hours to acknowledge receipt. Specifically, for patient care, return of text within 1 hour is considered professional.
 - b. Pagers: During work hours and when on call, residents' pagers must be ON and with you at all times.
 - c. Duty must be logged correctly every week.
 - d. Case logs must be logged correctly every month.
 - e. WVU Medicine requirements must be performed on time (CBLs, vaccinations, clinical notes, etc.)
- Orientation – To include.
 - a. Case Logs – Tips and Tricks
 - b. Handbook Discussion with Dr. Hajiran and Morgan
 - c. Resident Wellness
 - d. Get to know your presentations.

New in 2025:

***All meetings will need to be approved by Dr. Hajiran via the travel request form (and turned in to Morgan) or won't be reimbursed.**

*** You get 5 business days away for fellowship interviews, beyond that you need to use vacation. This must be pre-approved.**

*** There will be a limit on the amount of funding we have moving forward for meetings.**

*** Single Days off must be notified 6 weeks in advance. We need to have a list of who is off on what days.**

*** Updated Urology Blocks**

- PGY1 - 6M URO, SICU, PLASTICS, COLORECTAL, NIGHTS, SURG ONC
- PGY2 - 3M PEDIATRICS / 3M ROBOTICS
- PGY3 - 3M ENDO / 3M GENERAL
- PGY4 - ADVANCED ENDO / RECON / CONSULT SERVICE
- PGY5 - 2M ONCOLOGY / 2M ADVANCED RECON

*** In-Service Exam Score Goals per PGY level**

- PGY1 - 40% total answers correct**
- PGY2 - 50% total answers correct**
- PGY3 - 70% total answers correct**
- PGY4 - 70% total answers correct**
- PGY5 - 70% total answers correct**

If goal is not met, a remediation program will be initiated until the next In-Service Exam

Non-compliance with the remediation plan will result in disciplinary action including written warnings, probation, and/or dismissal/non-reappointment.