

**TRANSITIONAL YEAR
POLICY MANUAL
2011-2012**

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Overview of the Transitional Program

The objective of the transitional year is to provide a well-balanced program of graduate medical education in multiple clinical disciplines designed to facilitate the choice of and preparation for a specific specialty.

The transitional year must be designed to fulfill the educational needs of medical school graduates who:

1. have chosen a career specialty for which the categorical program in graduate medical education has, as a prerequisite, one year of fundamental clinical education (this education may also contain certain specific experiences for development of desired skills); or
2. desire a broad-based year to assist them in making a career choice or specialty selection decision; or
3. are planning to serve in public health organizations or on active duty in the military as general medicine officers or primary flight/undersea medicine physicians; or
4. desire or need to acquire at least one year of fundamental clinical education before entering administrative medicine or nonclinical research.

Program Requirements

3 months – Internal Medicine wards

2 months – Primary care specialty (family medicine wards, general surgery wards, internal medicine wards, pediatric wards, labor & delivery)

1 month – ICU (MICU, SICU, or Pediatric Step Down)

1 month – Selective (Cardiology wards, Neuro Consults, or Hem Onc wards, Plastic Surgery, Pediatric Surgery, Trauma Surgery, Oncology Surgery)

1 month – Emergency medicine

1 month – VA Internal Medicine Ambulatory Clinics

3 months – Electives

Electives

Anesthesiology

Behavioral Medicine: Psych consults

ENT

Internal Medicine: Ambulatory Medicine Clinic, Cardiology, Endocrinology, Hem/Onc Consults, Infectious Diseases, Medical Ethics/Palliative Care, Medical Intensive Care Unit, Medicine Wards, Nephrology, Psychiatric Consultation/Liaison, Pulmonary

Neurology: Neurology Consults

Neurosurgery: Pain Clinic

Ob/Gyn: Ultrasound

Occupational Medicine

Orthopedic Clinic

Pediatrics: Adolescent Medicine, General Pediatrics Clinic

Radiology

Research

Sponsoring Programs

The sponsoring programs for the transitional year program are Internal Medicine and Pediatrics. Both of these departments provide rotations in the fundamental clinic skills.

Transitional Year Education Committee

The Transitional Year Education Committee (TYEC) is the committee that is responsible for monitoring the activities of the transitional year program. The TYEC convenes at least four times a year.

The membership of this committee is composed of but not limited to the transitional year program director, the program directors (or designees) of disciplines regularly included in the curriculum, the program directors (or designees) of the sponsoring programs, a resident member nominated by his or her peers, and the chief executive officer (CEO) (or designee in hospital administration) of the parent institution.

The responsibilities of the committee include:

- a. To ensure adequate resources for the didactic and clinical curriculum prescribed. This includes monitoring the adequacy of the number of patients, variety of illnesses, educational materials, teaching/attending physicians, and financial support.
- b. To ensure that residents are educated in high-quality medical care based on scientific knowledge, evidence-based medicine, and sound teaching by qualified educators.
- c. To ensure educational opportunities and equivalent to those provided first-year residents in the categorical program in which transitional year residents participate.
- d. To review at least twice a year the evaluations of transitional-year residents' performance and the residents' assessment of each rotation and the participating faculty.
- e. To review the curriculum each academic year to ensure that the educational program is current and relevant.
- f. To maintain a record of those in attendance and actions taken. Responsibilities (a-e) should be reviewed at least annually.
- g. To review ACGME letters of accreditation for sponsoring programs and to monitor areas of noncompliance.



Transitional Year Objectives

The transitional year is the key year for development of common patient care skills. Specific objectives are characterized with the ACGME competency framework.

Patient Care

ACGME defines patient care as providing compassionate, appropriate, and effective care for the treatment of health problems. Residents in the WVU transitional year are expected to:

- Communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
- Gather essential and accurate information about their patients
- Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- Develop and carry out patient management plans
- Counsel and educate patients and their families
- Use information technology to support patient care decisions and patient education
- Perform competently all medical and invasive procedures considered essential for the area of practice
- Provide health care services aimed at preventing health problems or maintaining health
- Work with health care professionals, including those from other disciplines, to provide patient-focused care

Medical Knowledge

ACGME defines medical knowledge as demonstrating knowledge about established and evolving biomedical, clinical, and cognate (e.g., epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents in the WVU transitional year are expected to:

- Demonstrate an investigatory and analytic thinking approach to clinical situations
- Know and apply the basic and clinically supportive sciences which are appropriate to their discipline

Practice-Based Learning and Improvement

ACGME defines practice-based learning and improvement as the ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents in the WVU transitional year are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology
- Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
- Use information technology to manage information, access on-line medical information; and support their own education
- Facilitate the learning of students and other health care professional

Interpersonal and Communications Skills

ACGME defines interpersonal and communication skills as the ability to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents in the WVU transitional year are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- Collaborate effectively with others as a member or leader of a health care team or other professional group

Professionalism

ACGME defines professionalism as demonstrating a commitment to carrying out professional responsibilities, adhering to ethical principles, and exhibiting sensitivity to a diverse patient population. Residents in the WVU transitional year are expected to:

- Demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
- Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
- Demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

Systems-Based Practice

ACGME defines systems-based practice as demonstrating 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 that is of optimal value. Residents in the WVU transitional year 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 and how these elements of the system affect their own practice
- Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- Practice cost-effective health care and resource allocation that does not compromise quality of care
- Advocate for quality patient care and assist patients in dealing with system complexities
- Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

Policy on Resident Selection/Recruitment

Applicants must be:

- a. graduates of an LCME accredited medical school
 - b. international medical graduates with current ECFMG certification or 5th pathway program
 - c. Must have a current J-1 Visa
- All applications are accepted through ERAS. Applicants who request information by mail, telephone or e-mail will be sent a letter briefly describing the program.
 - All applications must contain the following:
 - Common Application Form (CAF)
 - Three letters of reference
 - Personal Statement
 - USMLE Scores
 - MSPE/Dean's letter
 - Transcripts
 - CV
 - ECFMG for international graduates
 - 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 to be invited for an interview for the positions available within the training program.

Interview

Applicants are selected for interview based on medical school performance, letters of recommendation, and USMLE scores.

The program director 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 a packet including the following:

- Salary information
- Benefits information (leave information, health, disability, professional liability, life insurance information)
- Information about the area
- Lodging information
- Morgantown pamphlets

Candidates will be evaluated on:

- Contents of the application materials (Dean's Letter, Personal Statement, Transcripts, USMLE scores, Letters of Reference)
- Overall interview

Interviews are conducted in November, December, and January

A selection committee comprised of the program director and other individuals involved in the interview process will determine the list of candidates for the match.

All applicants are selected through the National Residency Matching Program (NRMP)

A candidate will not be ranked on the match list unless he/she has had a formal interview.

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.

Policy on Resident Supervision

I. Purpose:

To establish guidelines which outline standards regarding the appropriate level of supervision needed for resident physicians who care for patients in both the inpatient and outpatient settings at WVU Healthcare.

This policy describes the general guidelines for the supervision of residents within West Virginia University Healthcare. The policy will define the role, responsibilities and patient care activities of resident physician as well as define the process for supervision of resident physicians by a licensed independent practitioner who is a member of the WVUH medical staff.

II. Definitions per the ACGME Requirements:

Direct Supervision: the supervising physician is physically present with the resident and patient.

Indirect Supervision:

-with direct supervision immediately available:

the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision

-with direct supervision available: the supervising physician is not physically present within the site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision

III. Scope:

This policy applies to all patient care, which is provided by the resident and attending physicians at West Virginia University Hospitals.

Inpatient Care: On all services, for Transitional Year residents, direct supervision or indirect supervision with direct supervision immediately available will be provided at all times by an attending, fellow, or more senior resident. All attendings must co-sign history and

physicals and daily notes, which are written by the residents for each patient on his or her service.

Outpatient Care: In all outpatient clinics an attending (or multiple attendings) is assigned to supervise patient care delivered by the residents as well as to teach the residents. In the outpatient setting there is either direct supervision or indirect supervision with direct supervision immediately available by an attending at all times.

IV. Resident Responsibilities:

Definition of a resident: An individual who is participating in an approved West Virginia University School of Medicine Graduate Medical Education (GME) program. The term “resident” includes interns, residents and fellows. All residents actively participate in patient care at WVUH and carry out clinical responsibilities under the supervision of a licensed attending physician with the appropriate clinical privileges.

1. It is the resident’s responsibility to participate in patient care at levels appropriate to his or her level of training under general supervision of appropriately licensed attending physicians and to provide these duties in accordance with the established practices and policies of the institution or clinical department to which he or she is assigned.

Inpatient resident responsibilities

- Initiate direct communication with the attending physician regarding patient management and care.
- Be aware of his or her level of training, technical skill, personal knowledge and clinical experience. The resident must not perform any procedures, treatments or plans of management that he or she lacks the ability and training to perform.
- Participate in patient care at levels appropriate to his or her level of training and under general supervision of appropriately privileged attending physicians.
- Inform the patient and/or the patient’s family of their role in caring for the patient.
- Notify the attending (regardless of the time of day) of any significant changes in the patient’s status or significant difficulty in developing a plan of care due to conflicts with the patient, their representatives or consultants. This includes but is not necessarily limited to:
 1. Admission
 2. All discharges, including discharges from the ED or discharges Against Medical Advice
 3. Decline in prior status
 4. Transfer in level of care (step-down or ICU transfer)
 5. End of life decisions (change from prior status)
 6. Death (may be delayed when patient previously designated Comfort Measures Only)
 7. Significant conflict with patient and/or family
 8. Significant conflict with consulting service

Outpatient Resident Responsibilities:

- Present patient findings and an appropriate plan of care to the attending physician assigned to clinic.
- Complete all paperwork and progress notes for patient's seen in clinic and route their work to the designated responsible attending.

V. Attending Responsibilities:

Definition: A licensed independent practitioner who had completed the credentialing process that is consistent with the requirements determined by the West Virginia University Hospitals.

1. The attending has the ultimate responsibility for all medical decisions and plans of treatment regarding patient care. He or she will document their degree of participation in regards to care of each specific patient.
2. The attending is responsible for providing at least indirect supervision with direct supervision available.
3. The attending is responsible for providing reviews of procedures and/or encounters with feedback provided in a timely manner after patient care is delivered.
4. The attending is responsible for participating in educational activities of the residency training program through (but not limited to) providing resident lectures, participating in the appropriate institutional orientation programs.

Inpatient Attending Responsibilities

- Review the patient's history, labs and other tests and make appropriate reviews of the patient's progress
- Examine the patient within 24 hours of admission and record their findings, examine the patient when there is a significant change in condition, or as required to provide quality patient care.
- Confirm or revise the patient diagnosis and problem list as defined by the resident, and determine necessary changes needed in the course of treatment.
- Assist residents when needed to perform any service that would be performed by an attending physician in a non-teaching setting.
- Authorize or deny any new admission, discharge from in-patient status or release from observation status.
- Review resident documentation and assure that appropriate documentation is made immediately in the patient's record when changes are made or a procedure is completed on a patient.
- An attending physician must authorize the supervision of a junior resident by a more senior level resident based on the attending physician's assessment of the senior level resident's experience and performance.

- Review daily progress notes as well as discharge summaries and make necessary addendums within 24 hours.
- Understand that a resident who calls for help and/or supervision is not to be viewed as weak or a failure, but rather to be viewed that he or she is attempting to optimize patient care as well as resident education and to minimize medical error.

Outpatient Attending Responsibilities:

- The attending must provide Direct Supervision or Indirect Supervision with direct supervision immediately available (when the Primary Care Exception is appropriate.)
- Be clearly designated and available to the residents who are assigned to clinic.
- Determine the amount of independence given to residents based on the resident's level of training, knowledge, manual skills and experience, as judged by the responsible attending physician.

VI. Procedures

It is the policy of West Virginia University Hospitals that residents must be supervised while performing procedures and must be deemed competent to perform each given procedure by an attending physician.

1. If the resident does not have sufficient opportunity to perform the procedures in the clinical setting, a simulation laboratory session may be scheduled. This simulation session will be exercised under the supervision of an attending physician who can then determine whether or not the resident is competent to perform the given procedure.
2. Once a resident has demonstrated competency in a specific procedure, he or she will then be qualified to supervise medical students and less experienced residents performing the said procedure.
3. Once a resident has been evaluated as competent to perform a procedure, this competency carries over for the other services.
4. Procedures, which each transitional year resident could perform (under supervision either by an attending physician or a more senior resident who is qualified as a supervisor) include but are not limited to:
 1. Advanced Cardiac Life Support (ACLS)
 2. Arterial Line Placement
 3. Central Intravenous Line Placement
 4. Endotracheal Intubation
 5. Gynecological Evaluation
 6. Rectal Exam
 7. Lumbar Puncture
 8. Paracentesis

Resident responsibility regarding procedures:

- Obtain informed consent for the procedure from the patient.
- Know and communicate to the attending the following information regarding procedures: indications and contraindications for each procedure, how to prep the patient for the procedure, the steps of the procedure, possible complications of the procedure and how to administer post-procedure care.
- Complete a procedure note in the electronic medical records.
- Log all procedures into the E-value online system in order to keep track of performed procedures

Attending responsibilities regarding procedures:

It is the responsibility of the attending physician to:

- Supervise residents performing procedures and to provide assistance if and when necessary.

VII. The Supervisory Role

It is the policy of West Virginia University Hospitals that the residents are to be supervised by an attending physician in order to allow the resident to increase his or her responsibility according to the level of education, ability and experience.

Senior residents on all rotations can also act in the role of a supervisor after they have been determined to be competent to do so by an attending physician, and will be responsible for supervising the interns, sub-interns and medical students.

Policy on Transition of Care

DEFINITIONS:

Transition of care:

Transition of care is defined as when a physician transfers the care of a patient to another physician. This includes sign-out as well as sign-in. It also includes the transfer of a patient from one level of care to another, e.g. transfer of a patient from the wards to the ICU or vice versa. By definition, transition of care also occurs when a physician transfers the care of a patient at the end of a rotation and a new physician assumes the care of the patients on that service.

Proper Hand-over of Patients:

The proper hand-over of patients should include at least the following. The exiting physician must notify the attending and co-resident(s) who will be responsible for patient care that they will be leaving. The exiting physician must give a proper verbal checkout which includes the patient's active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan. The exiting physician should also attempt to anticipate any events that may occur with his or her patient in their absence and give the best course of action. The exiting physician should also make aware any orders that have been or need to be placed. This should all be done face-to-face to ensure accuracy and proper evaluation of the exiting physician's checkout to ensure patient care and safety as well as improving resident education.

RATIONALE:

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 consistently excellent care, it is vitally important that we communicate with one another consistently and effectively when the 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 each of our teaching sites where we provide inpatient and outpatient care.

All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. It is also essential for residents and faculty members to do so by abiding by current duty hour policy.

SPECIFICATIONS:

I. Service Schedules:

- a. The call schedules for the Transitional Year residents are created by the department in which the resident will be rotating for that month.

II. Inpatient Services:

- a. General
 - i. Patient handoffs should include both a written summary and a verbal check-out to ensure effective transmission of information
 - ii. Mandatory information for check-out includes, but is not limited to, the following:

1. Attending responsible for the patient
 2. Code status
 3. Contact information for MPOA if patient lacks competence
 4. Active problem list
 5. Medications
 6. Allergies
 7. Expected problems, and when possible a potential treatment plan
 8. Pending tests and consults
- b. ICU Rotations:
- i. Transitions of care will occur primarily during rounds
 1. The “on-call” resident will be present for afternoon rounds
 2. Each patient will be discussed with a review of the above information with contingency plans for expected problems
 - ii. New patients will be discussed during morning rounds
 - iii. Prior to leaving after rounds, the post call resident will check out with the on call resident to review the above information again with an update on what is still pending
- c. Wards Service:
- i. Time of handovers will vary depending on the rotation you are on and the teams involved.
 1. Handovers will include a verbal review of written check out sheets containing the appropriate information as outlined above
 2. All cross cover calls will be documented in the medical record and passed along during the check out to night float team or check in to daytime ward teams.
 3. New admissions will be presented to the assigned ward team, with the attending present

III. Outpatient Services:

- a. If a resident and/or attending, for any reason, must leave clinic while he or she has outpatient patient duties, he or she must inform the other clinic resident(s) and attending(s) of their patients’ condition, orders placed, and any unfinished business prior to being excused. This should be done face-to-face when possible to ensure the best possible patient care and for proper evaluation of resident checkout by attending(s) and co-resident(s).

IV. Admitting a Patient from Outpatient Service:

- a. The admitting service physician must contact the admission resident of the admitting inpatient service for acceptance and proper hand-over of the patient.
- b. They will also document the appropriate information in their clinic note immediately so it will be available for review for the inpatient service

V. Transfer to Another Level of Care:

- a. When a patient is transferred from one level of care to another (e.g. the wards to the ICU) and a different resident physician or group of physicians assumes the care of that patient, there must be documented communication between resident

physicians that includes the information that summarizes relevant information and provides the information necessary to provide effective care.

- b. The resident physician that “sends” the patient to the service providing a different level of care must write a transfer note that summarizes the clinical events preceding the transfer, and should also communicate verbally with the resident that “receives” the patient. That note should include a brief history, relevant exam findings, relevant labs and/or imaging studies, advanced directives, current medications, and a brief assessment and plan.
- c. The resident physician that “receives” the patient must write a note that summarizes the patient’s condition and includes an assessment and plan that is reviewed and approved by the faculty physician.
- d. 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.

VI. End of Rotation/Off Service:

- a. On completion of an inpatient rotation, the resident physician must communicate with the resident physician that is coming on service to assume the care of his or her patients. This will ensure that each patient on the service continues to receive continuous, high quality care without interruption.
- b. Communication must include an off-service note written by the resident rotating off service. The off-service note must briefly summarize the patient’s course to date, and include any active problems, advanced directives, diagnostic tests pending, current medications, and the diagnostic and therapeutic plan.
- c. Communication should also include a face-to-face hand off that provides an opportunity to discuss each patient and allow questions and clarification of any issues. If for some compelling reason this is not possible, then the residents should at least review the list of patients over the telephone and a patient list must be left by the resident rotating off service for the incoming resident in a prearranged location.

VII. Resident Evaluation:

- a. Residents will be evaluated on their transfer of care performance at the end of each month by their supervising faculty and senior residents.

Policy on Evaluations

1. Each Transitional Year resident will be evaluated by faculty & peer members after each monthly rotation. These evaluations will assess the resident's competence in patient care, medical knowledge, practice-based learning and improvement, interpersonal and communications skills, professionalism and systems-based practice. Residents will be formally evaluated by nurses when rotating on the Internal Medicine Wards and VA clinic. Residents will also be evaluated by patients on various rotations throughout the year. The program director and education committee will review all resident evaluations including the narrative comments. Less than average scores and/or negative narrative comments can result in remediation or probation.
2. The resident will complete an evaluation of each faculty member for each rotation. The transitional year resident will utilize the E*value system. The evaluation should be completed as soon as possible. Confidentiality will be maintained and assured, in order to make the faculty evaluations worthwhile and useful for recognizing praiseworthy teaching and identifying potential for improvement. The information contained in these evaluations is seen by the Program Director and shared with the faculty in annual evaluations.
3. The Transitional Year resident will complete an evaluation of each rotation monthly. These evaluations will be performed through the E*value system and confidentiality will be maintained.
4. Each resident will meet with the program director a minimum of three times a year for a formal evaluation of their progress. The first of these evaluations will occur by the end of October of the academic year, the second evaluation will be by the end of February of the academic year and the third in June. At each of these meetings the evaluations by the faculty, peers, nurses, self, and patients will be reviewed. A discussion of the resident's general progress will occur.
5. The program director will be available for additional discussions and evaluations of a resident's progress. The residents are strongly encouraged to seek guidance from the program director for any perceived difficulties or problems.
6. All residents will be required to complete an annual evaluation of the program. This evaluation will be performed through the E*value system in May or June.
7. At the conclusion of each resident's training a formal written final evaluation will be completed by the program director and maintained in the resident's permanent file. This evaluation will summarize the resident's year of training and verify that the resident has demonstrated sufficient competence for completion of the transitional year residency. The resident's didactic conference attendance will be noted in the formal written final evaluation.
8. The resident will have access to his academic file and evaluations at any time. These evaluations can be obtained through contacting the program coordinator or program director.

Policy on Duty Hours and On-call Requirements

Duty hours are monitored through E*value for each of the rotations. No resident is expected to work more than an 80 hour work week averaged over a four-week period. Residents must not exceed 16 hours in duration. Each resident's schedule reflects 1 day off in seven averaged over a four week period. Adequate time is provided for rest and personal activities which consist of at least a 10 hour time period between all daily duty periods and after in-house call.

Call schedules for each of the major disciplines are described below.

Internal Medicine: All the General Medicine Ward Teams (no in-house) take call daily following a set algorithm to ensure equal distribution of patients across all general medical services. Each intern would be expected to admit from 1-5 patients per day. Therefore, no resident is expected to work more than 80 hours per week. Every 5th night one of the General Medical teams takes Long Call and covers admissions from 4:30 - 7 pm daily. The ICU Float resident begins work at 7 pm and will cover admissions between 7-8 pm daily. The interns are expected to finish up work no later than 9 pm and return the following day no earlier than 7 am to ensure at least 10 hours between shifts.

The Night Float team works 12 -hour shifts (8 pm - 8 am) six days per week starting on Sunday 8:00 p.m. and ending on Saturday 8:00 a.m. On Saturday and Sunday, the ward team that is up for call will take admissions from 8am-8pm. All team members are given a day off per week averaged over the four week rotation. These days are assigned by the Chief Resident to assure each member of the ward team has four days off.

When residents are rotating in the Cardiac Care Unit each resident will do 6 straight night shifts from 8pm-7am the following morning. The remaining residents will take long call until 8pm every fourth day. During MICU, interns will not take overnight call. This also ensures they will work less than 80 hours per week averaged over the one month rotation.

Pediatric Wards: Transitional Year residents take a week of night shift (7p to 9a). There are two interns during the day for day shift; 7a to 7p. Morning checkout is at 7am. All days off for the intern will usually be on the weekends unless the schedule cannot accommodate these days off.

Pediatric Step Down: The Transitional Year resident works from 7am to 7pm. The resident will have every Saturday off.

Surgery: There is a Surgery Night Float team composed of four residents: a PGY 4 or 5, PGY 3 and two PGY1 residents. The Night Float team covers call from 5:30 pm to 6:00 am Sunday through Friday for General Surgery, Oncology Surgery, Plastic Surgery, Trauma and Pediatric Surgery. Transitional Year residents are not scheduled for the Surgery Night Float rotation.

There are now two general surgery teams, the Gold service and the Silver service. The Oncology service consists of a chief resident (PGY-5), and an intern. The Plastic Surgery service consists of a PGY-3 resident and 1-2, PGY-1 residents. The interns on these services will be responsible for calls during the daytime hours on weekdays however this responsibility will fall to the night float team at 6:00 pm. The daytime intern is required to attend the intern "sign-out" conference at 5:30pm, for a smooth transition of care to the night coverage team. This allows for a half hour of overlap for the residents.

Weekend coverage (Saturday 5:30am-Sunday 6:30pm) for the surgery services is a shared responsibility. Each intern on the surgery services is assigned 2-4, 13 hour shifts/month. These shifts will be assigned prior to the start of the month. The number of shifts will vary with the number of weekend days in the month as well as the number of interns rotating

on the surgery services that particular month. The interns will be on call with a team of residents and as a team will be responsible for more than one service.

Transitional Year residents rotating in the Surgical Intensive Care Unit will work 12 hour shifts from 5:30 am to 5:30 pm or 5:30 pm to 5:30 am.

Family Medicine: The Transitional Year residents will be assigned variable shifts throughout the week – working either 7 am – 5 pm or 7 am to 8 pm. There is no overnight call for the Transitional Year residents. They are expected to participate in every admission prior to 8 pm. Weekends will be staffed by the Transitional Year residents with an assigned senior 8 am – 8 pm. If patient care demands allow, the resident may leave the hospital and return for admissions. The resident is expected to be in the hospital to round on assigned patients by 7 am. Mornings check in/sit down rounds is at 9 am in an 8th floor classroom. The team then rounds on patients together. Check out rounds are held at 3:30 – 4 pm in the family medicine department resident work room.

Policy on Stress and Fatigue

Education will be provided throughout the year on signs and symptoms of fatigue. If a resident perceives that they are too fatigued or stressed to work, they should notify their supervising attending and the program director. A suitable arrangement will be made based on the individual situation.

Policy on Planned Educational Activities

Conferences Schedules: Residents are required to attend the planned educational activities on each of their scheduled rotations. The resident should sign the attendance sheets at all educational activities. The program coordinator will obtain these attendance sheets from the various disciplines and compile a record of attendance for all of the Transitional Year residents. The attendance records will be monitored on a regular basis by the Program Director and reviewed with each resident during the tri-annual meetings. Residents must attend 70% of the didactic sessions. See attachment A.

Internal Medicine: Morning Report is Monday thru Thursday at 8:00 – 9:00 AM in the Dr. DiBartolomeo room 4th floor HSC; Grand Rounds are held every Friday 8:00 - 9:00 AM in the HSC Fukushima Auditorium. Noon conferences are held daily Monday thru Friday in room 4080, HSC.

Emergency Medicine: Every Thursday there are four hours of conference, (8:00 AM to 12:00 noon, 7th Floor HSC) On a daily basis bedside teaching is performed with the residents. TY residents are expected to attend a minimum of 70% of the scheduled Thursday conferences unless there is a conflict with the duty hour rules.

Pediatrics: Every Tuesday 12:00-5:00pm 4th floor HSC; Grand Rounds is every Wednesday at 8:00 AM in room 1901 HSC.

Surgery: Trauma conference is every Thursday @ 6:45 AM; General Surgery Conferences are Wednesdays 7:00AM to 12:00 in room 4080, HSC. (M&M, Grand Rounds, Surgical Case Conference, ABSite Review, Basic Science).

Family Medicine Wards: Noon conference is every Monday, Wednesday, and Friday in the Family Medicine lecture room. Optional medical student presentations are on Tuesdays.

Transitional Year: At least once a month a three hour didactic session will be held for the transitional year residents. The location will vary. These didactic sessions will cover a broad range of topics and they are mandatory for the TY residents.

Policy on Scholarly Activity

Each resident must participate in research or other scholarly activity. In the second half of the academic year each resident will be assigned a date and time he/she will be expected to give a formal presentation to their colleagues. The presentations should be a researched topic of interest. If a resident completes a research rotation they will be expected to submit an abstract for GME Week.

Policy on Extracurricular Professional Activity

Per the ACGME requirements PGY 1 residents are not permitted to moonlight.

Policy on Vacation and Leave

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.

ANNUAL LEAVE

Full time residents/fellows will accrue two (2) days of annual leave per month. A day in the leave system is equal to 7.5 hours. **While, as a resident/fellow, you are entitled to use, and may request the use of, the entirety of your annual leave, the Transitional Year program recommends that its residents/fellows request no more than 16 days of annual leave per year to ensure that program requirements are met.**

Annual leave must be accrued prior to using it. Annual leave time caps at 24 accrued days which will appear in the leave system as 180 hours. Once you accrue 24 days, you will stop accruing annual leave. Unused accrued annual leave time carries over from year to year, and at the end of your residency or fellowship, beginning from the day following your last day worked, any unused time, up to the maximum allowable accumulation of 24 days (180 hours), will either be paid to you in a lump sum or you may choose to remain on the payroll until your leave is exhausted if you are leaving the institution, or, if you are staying on for fellowship training or as faculty, unused accrued leave will transfer over to your new position or to another qualifying state agency.

Annual leave will be granted on a “first come, first served” basis and is determined by the total number of Department providers present during the time period requested. All annual leave must be approved, in advance, by your Program Director and reported to the Residency Coordinator, as well as the Chief Resident/Fellow and Service Chief. Program Directors have the right to deny annual leave at the requested time. The amount of time that can be missed on any one rotation is limited by the educational goals of the rotation. Only 1 week of annual leave may be taken on single month rotations, and only 2 weeks of annual leave may be taken on 2-month rotations. No more than 2 days of annual leave time may be taken during a 2 week rotation. Additional weeks may be taken on multi-month rotations, however no block of time greater than 2 weeks may be granted, and only one week of annual leave time may be used in any one calendar month. Extended annual leave or combining annual leave with meetings is discouraged due to prolonged absence from the program. Such requests require special approval from the Program Director and must fall within the requirements of the ACGME and the applicable Board.

A resident does not have the option of reducing the time required for the residency by forgoing annual leave.

In the Transitional Year program, annual leave time may not be used during the following rotations or dates which are considered “blackout” periods:

Transitional Year residents may only take annual leave during their elective months.

SICK LEAVE

Full time residents/fellows will accrue 1.5 sick days per month. Sick leave must be accrued prior to using it. Sick leave may be used by an employee who is ill or injured, when a member of the immediate family is seriously ill, or when a death occurs in the immediate family. Immediate family is defined as: father, mother, son, daughter, brother, sister, husband or wife, mother-in-law, father-in-law, son-in-law, daughter-in-law, grandmother, grandfather, granddaughter,

grandson, stepmother, stepfather, stepchildren, or others considered to be members of the household and living under the same roof.

If you have any question regarding whether sick leave can be used, please contact the Residency Coordinator. **Excessive/unexplained absences may affect your competency evaluation and/or your promotion to the next level of training.** Sick leave for more than five (5) consecutive work days cannot be granted to an employee without satisfactory proof of illness or injury as evidenced by a statement of the attending physician or by other proof. An employee who has been absent from work for an extended period because of illness or injury must obtain medical clearance before returning to work. The University may require verification of an illness or other causes for which leave may be granted under this policy regardless of the duration of the leave. A copy of all medical documentation must be sent to the medical management unit.

HOLIDAYS

While the University provides scheduled holidays to its employees as state employees, the requirements of medical coverage do not allow for all these holidays to be taken as scheduled. The Program Director and Residency Coordinator will assist in scheduling and coordination of available holiday time.

If you are on a service where physicians observe a state holiday, you will not be required to work on that holiday. As professionals, you are exempt from overtime or compensatory time, therefore, if a service requires you to work on a state holiday, you will not be compensated additional amounts for that worked holiday.

However, residents/fellows who work on State-defined Holidays (for example, Thanksgiving Day or a service where physicians do not observe a state holiday) may be granted an equivalent number of alternate days to be taken at a time mutually agreed upon by the resident/fellow, the Residency Coordinator, and the Program Director. No grant of an equivalent number of days is required of or owed by WVUSOM.

CONTINUING MEDICAL EDUCATION LEAVE

All CME conferences a resident/fellow wishes to attend must be approved, in advance, by the Program Director and reported to the Residency Coordinator, as well as the Chief Resident and Service Chief. Attendance at CME conferences counts toward duty hours during the actual conference time. As a result, annual leave does not need to be used for CME attendance. One day of travel time, if necessary, will be granted before and after the conference without the use of annual leave.

LEAVES OF ABSENCE

A Leave of Absence (LOA), including Family Medical or Military leave, may be requested by a resident/fellow after all applicable leave time has been exhausted. The University policies regarding LOA, WVU BOG 24 regarding leave and the University Human Resources Department provide guidance regarding the procedures and forms that must be completed.

Generally, LOA will be granted based on the need to attend to personal matters such as perinatal care or serious illness. No academic credit may be provided for non-annual leave. Additional

months will be added to the training duration if possible, but residents/fellows are advised that LOA may impact a resident's/fellow's ability to complete program requirements. Therefore, a resident/fellow who takes a LOA 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. A maximum of 6 months of LOA may be honored before a resident/fellow may be required to reapply to and be reaccepted into the program.

University policy and applicable laws control compensation and duration of leaves for pregnancy, illness, military, or injury. Educational requirements of the residency must be met irrespective of leave. Such leaves may result in the extension of time necessary to complete the residency/fellowship. The Program will make every attempt to meet individual needs created by pregnancy or illness, and LOA will be considered and provided in accordance with University policy and applicable law, but the Program cannot control the potential inability of a resident/fellow to complete the required training if a LOA is taken.

PROCEDURE FOR REQUESTING LEAVE

The Transitional Year Program requires that annual leave requests be submitted in writing for approval 15 days in advance of the requested time off. *AN ANNUAL LEAVE REQUEST FORM MUST BE COMPLETED AND SUBMITTED FOR APPROVAL.* After all required signatures are obtained, the leave request form must be provided to your designated leave coordinator for entry into the www.MyAccess.wvu.edu system. If prior written approval is not sought for annual leave, disciplinary action may result, and a letter will be placed in your personnel file. Annual leave requests without the required advance notice may not be approved. Coverage for call schedules, patient care, and other obligations must be adequately arranged for by the resident *and* communicated.

GRIEVANCE, WITNESS, AND JURY LEAVE

Employees who are subpoenaed, commanded to serve as jurors, or required to appear as witnesses or representatives for review proceedings of the Federal Government, the State of West Virginia, or a political subdivision thereof, or in defense of the University shall be entitled to work release time for such duty and for such period of required absence which overlaps regularly scheduled work time. Employees are entitled to leave with pay for the required period of absence during the regularly scheduled work time including reasonable travel time. For additional information, refer to the WVU Department of Human Resources Policies and Procedures.

When attendance in court is in connection with official duties, time required, including reasonable travel time, shall not be considered as absence from duty.

INCLEMENT WEATHER

If a resident/fellow is absent due to inclement weather, an annual leave day must be taken unless the institution is closed.

Additional information regarding leave can be found in WVU BOG 24 or at www.hr.wvu.edu.

Policy on Reporting Absences/ Sick Leave

If, for any reason, you are unable to report to work as scheduled you must notify the Program Coordinator at 293-2463. If there is no answer at that number you should leave a message prior to your scheduled start time with the reason and expected duration of the absence. Also, if there is no answer please page Mary Warden, MD at 1029. You must also notify the senior resident or faculty member for your scheduled rotation. When rotating on a Medicine rotation notify the chief resident. If you are absent for greater than 5 days due to illness you must be evaluated by a physician and provide the program with a documented excuse. Failure to comply with this policy will result in disciplinary action.

Policy Access to Personnel Files

A confidential file containing pertinent employment information is maintained for each resident. If the resident wishes to inspect this personnel file, they should contact the coordinator. Personnel files can only be reviewed in the program coordinator's office. Outside requests for employment verification are restricted to the release of the employee's name, employment dates and job title. Additional information, including salary data may only be released with written authorization from the employee.

Malpractice Insurance

“All faculty and resident physicians employed by the State of West Virginia are provided professional liability coverage by the West Virginia State Board of Risk Management. This self-insurance coverage is provided as a benefit of employment on an occurrence basis with limits of one million dollars per incident. Dates of coverage are the same as the physician's dates of employment with the State.” (as per Sandra Price, Risk Manager, Robert C Byrd Health Sciences Center)

The coverage applies to all acts within the assigned duties and responsibilities of the residency training program. It does not cover outside activities such as moonlighting for which residents are required to provide their own professional liability coverage.

Questionable incidents concerning patient care must be reported to the program director and to risk management at the Health Sciences Center at 293-3584.

Policy on USMLE/COMLEX step 3

GME bylaws: 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 PG-2 year to be eligible to advance to the PG-3 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 PG-2 year. These residents will not be advanced to the PG-3 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 PG-2 year. They will not be advanced to the PG-3 year unless they have done so.

Effective July 1, 2009 all transitional year residents must sit for the USMLE step 3 or COMLEX step 3 examination as a requirement for completion of the transitional year. All requests for exceptions to this policy must be provided in writing to the program director and will be taken to the TY Education Committee.

Policy on Promotion

In order to obtain a certificate of completion for the transitional year and be promoted to an advanced program the resident must:

- Complete twelve months of rotations which include:
 - 3 months – Internal Medicine wards
 - 2 months – Primary care specialty (general surgery wards, internal medicine wards, family medicine wards, labor & deliver, or pediatrics wards)
 - 1 month – ICU (MICU, SICU, or Pediatric Step Down)
 - 1 month – Selective (Cardiology wards, Neuro Consults, or Hem Onc wards, Plastic Surgery, Pediatric Surgery, Trauma Surgery, Oncology Surgery)
 - 1 month – Emergency medicine
 - 1 month – VA Internal Medicine Ambulatory clinics
 - 3 months – Electives
- Demonstrate an average of satisfactory scores or higher in the six core competencies
- Satisfactorily meet the goals & objectives for each rotation
- Complete all rotation, faculty, self, and program evaluations
- Demonstrate conference participation
- Complete all duty hours in e-value
- Sit for the USMLE Step 3 examination

Policy on Resident Dismissal and/or Corrective Action

A resident may be dismissed or corrective action may be taken for cause including but not limited to:

- Has made any misrepresentation on his or her application for admission to Residency Program
- Has engaged in dishonest, unethical, unlawful or immoral conduct
- Has neglected the tasks, duties or responsibilities assigned by the Program Director or other authorized persons including but not limited to the proper and timely completion of medical records
- Has failed to fulfill his or her obligations as set forth by West Virginia University Hospitals agreement including violating any policy of West Virginia University
- Has committed any act or failure to act which, under applicable state laws, could lead to disciplinary proceeding or the revocation, suspension or termination of a physician license to practice medicine in West Virginia
- Has committed any act or failure to act which, under the Bylaws of the Medical Staff of West Virginia University Hospitals could lead to disciplinary action or the revocation, suspension, or termination of the clinical privileges or appointment of a member of the Medical Staff of West Virginia University Hospitals

If an action is initiated during the term of the resident's contract, the routine process shall be as follows:

- The resident will be notified that the Program is considering action
- Upon notification, the resident will have an opportunity to meet with the Program Director and present verbal and written evidence in support of his/her position in response to the reasons for the action set forth by the Program Director.
- After the above referenced meeting, if the Program Director believes that action is warranted, action may be taken. Such actions include but are not limited to dismissal, letters of warning or reprimand, suspension with or without pay, and extension of the term of the resident's program. All are the options that may be instituted by the Program Director.

Disciplinary Action

- Residents are expected to meet and adhere to academic, clinical and professional standards set forth by the Institutional Requirements, Common Program Requirements, and Transitional Year Program Requirements as well as the West Virginia University Hospitals and the West Virginia University School of Medicine.
- If at any time a resident exhibits unsatisfactory performance, remediation is necessary. In most circumstances, the resident will continue to perform his/her daily duties during the remediation process.
- Inadequate performance will be clearly communicated, in writing, to the resident as early as possible, and at minimum, at the four-month formal evaluation.
- If the program director feels that disciplinary action must be taken against a resident, the institutional process will be initiated. This includes:
 - Departmental remediation

- Departmental probation

Policy and Procedure on Academic Grievance

I. 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.

II. 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.

III. 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.

IV. Procedure

A. Level I Resolution

A good faith effort will be made by an aggrieved resident/fellow and the Program Director to resolve a grievance, which will begin with the aggrieved resident/fellow notifying the Program Director, in writing, of the grievance within 10 working days of the date of receipt of the dispute or complaint. This notification should include all pertinent information and evidence 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. If the aggrieved resident is a Transitional Year resident, then the DIO will appoint a Department Chairman to handle the Level 2 grievance. This resident's notification should include all pertinent information, including a copy of the Program Director's final written decision, and evidence 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 day time frame will result in the resident/fellow waiving his or her right to proceed further with this procedure. In this situation, the decision at Level II will be final.

Upon timely receipt of the written grievance, the DIO will appoint a Grievance Committee and will contact the aggrieved resident/fellow to set a mutually convenient time to meet with them. The Grievance Committee will review and carefully consider all material presented by the resident/fellow and his or her Program Director or the grievable party at the scheduled meeting, following the protocol outlined in Section E.

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

Policy on Assistance for Impaired Residents

The West Virginia University Hospitals, Inc. (WVUH) Practitioner Health Committee serves as the primary resource in the management of impaired Practitioners. Impairment may be due, but not limited to physical, and/or mental/behavioral problems, including drug and alcohol use, misuse and/or abuse. Impairment includes any physical, mental, behavioral or emotional illness that may interfere with the Practitioners ability to function appropriately and provide safe patient care. The purpose of impaired Practitioner assistance is to maximize support for Practitioners through appropriate interventions. This process relates specifically to mental, physical or behavioral impairment and does not include performance management or disciplinary actions.

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

All Practitioners are required to self refer to his/her program director, DIO, or the Vice President of Medical Affairs in the event that he/she experiences any substance abuse/health problem that could impact on professional/clinical performance in the Hospital. If reported to the department chair, the chair shall report to the Vice President of Medical Affairs. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

A Practitioner who seeks assistance with WVU FSAP regarding substance abuse / health problems is required to inform the Vice President of Medical Affairs of this evaluation. The Vice President of Medical Affairs will then refer the Practitioner to the Practitioner Health Committee.

Policy of Program Closure/Reduction:

Should the Transitional Year Residency Review Committee (RRC) reduce the size of the transitional year program or close the residency program, the program director will inform the residents as soon as possible of the reduction or closure. In the event of such reduction or closure, the GME office will make reasonable efforts to allow the residents already in the program to complete their education or to assist the residents in enrolling in an ACGME accredited program in which they can continue their education.

Policy for Appropriate Use of the Internet, Electronic Networking and Other Media

These guidelines apply to all resident physicians and resident dentists enrolled in a program administered by the West Virginia University School of Medicine. Use of the Internet includes but may not be limited to posting on blogs, instant messaging [IM], social networking sites, e-mail, posting to public media sites, mailing lists and video-sites. These guidelines apply whether using public or private devices and computers.

Background: Social and business networking Web sites or on-line communities are being used increasingly by faculty, students, residents and staff to communicate with each other, and to post events and profiles to reach external audiences. As part of the sponsoring institution's commitment to building a community in which all persons can work together in an atmosphere free of all forms of harassment, exploitation, or intimidation, resident physicians and resident dentists are expected to act with honesty, integrity, and respect for the rights, privileges, privacy, sensibilities, and property of others.

The capacity to record, store and transmit information in electronic format brings responsibilities to those working in healthcare with respect to privacy of patient information and ensuring public trust in our participating hospitals, institutions and practice sites. Significant educational benefits can be derived from this technology but physicians need to be aware that there are also potential problems and liabilities associated with its use. Material that identifies patients, institutions or colleagues and is intentionally or unintentionally placed in the public domain may constitute a breach of standards of professionalism and confidentiality that damages the profession and our institution. Guidance for resident physicians and resident dentists in the appropriate use of the

Internet and electronic publication is necessary to avoid problems while maintaining freedom of expression. The sponsoring institution is committed to maintaining respect for patient privacy. Compliance with these guidelines help our residents obtain skills with the ACGME competencies of Interpersonal Communication Skills (ICS), Professionalism (P), and Systems Based Practice (SBP).

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

General Guidelines for Safe Internet Use:

These Guidelines are based on several foundational principles:

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

a) Posting Information about Patients

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

These guidelines apply even if the individual patient is the only person who may be able to identify him or herself on the basis of the posted description or image. Residents should ensure that anonymous descriptions do not contain information that will enable *any* person, including people who have access to other sources of information about a patient, to identify the individuals described. Photographs of patients should not be posted on the internet. Even completely de-identified information about patients should not be posted on any public site. There is a legitimate public perception that open listings on any private health information, no matter how disguised, lacks professionalism.

b) Posting Information About Colleagues and Co-Workers

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

c) Professional Communication with Colleagues and Co-Workers

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

d) Posting Information Concerning Hospitals or other Institutions

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

e) Offering Medical Advice

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

f) Use of social networking sites and blogs

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

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

Penalties for inappropriate use of the Internet

The penalties for inappropriate use of the Internet include but may not be limited to:

- Remediation, probation, suspension, dismissal or failure to promote or renew by the sponsoring institution
- Prosecution by law enforcement under the requirements of HIPAA.

Enforcement

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

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

For a complete listing of all HSC ITS Policies and procedures and /or to view our “Checklist to Protect Your Information Resources”, please visit:

<http://www.hsc.wvu.edu/its/Administration/PoliciesProcedures/>

PLANNED EDUCATIONAL ACTIVITIES FOR SPECIFIC ROTATIONS

Department	Day	Time	Type	Place
Anesthesia	Tuesday	1:30-4:30	Teaching Didactics	Anesthesia conference room
	Wednesday	7:00-8:00	Grand Rounds	3A&3B 4th Floor Ruby
Internal Medicine	Mon-Thu	8:00-9:00	Morning Report	Dr. DiBartolomeo conference room 4th floor HSC
	Mon-Fri	12:00-1:00	Noon Conference	4080 HSC
	Friday	8:00-9:00	Ground Rounds	Fukushima auditorium
Emergency Medicine	Thursday	8:00-9:00	Grand Rounds	ED conference room 7th Floor HSC
		9:00-1:00	Core Content	
Family Medicine	M, W, F	12:00-1:00	Teaching Didactics	Family Medicine lecture room
Neurology				See separate sheet
OB/Gyn	Thursday	1:00-2:00	Lecture	4080 HSC
		2:00-3:00	Lecture	
		3:00-4:00	Teaching Rounds	
		4:00-5:00	Grand Rounds	
Ophthalmology	Mon-Fri	7:00-8:00	Teaching Didactics	Ophthalmology auditorium
Pathology	M, Th, Fri	8:00-9:00	Teaching Didactics	Room 2165 HSC
	Tuesday	12:00-1:00	Clinical Path	Clinical Labs conference room, 3rd floor Ruby
	Wed, Thur	12:00-1:00	Neuro Path	Room 2165 HSC
Pediatrics	Tuesday	12-5:00	Teaching Didactics	Peds conference room 4th floor HSC (4411)
	Wednesday	8:00-9:00	Grand Rounds	1901 HSC
Psychiatry	Wednesday	1:00-2:00	Grand Rounds	1st Floor conference room, Chestnut Ridge
		2:00-4:00	Teaching Didactics	Faculty Staff Dining room, Chestnut Ridge
Radiology	Mon-Fri	12:00-1:00	Noon Conference	Rad Onc conference room, basement HSC
Surgery	Wednesday	7:00-12:00	Teaching Didactics	4080 HSC