



**RADIATION ONCOLOGY RESIDENCY PROGRAM
REQUIREMENTS AND GUIDELINES
2019 - 2020**

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ABR information came from <http://www.theabr.org>

Please refer to the Graduate Medical Education website for the most recent policies and procedures concerning resident employment: <https://med.virginia.edu/gme/>

Note: The term “resident” in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms “resident” and “fellow” will be used respectively.

UVA Radiation Oncology Residency Program Introduction

A. Overview

Graduate medical education is the crucial step of professional development between medical school and autonomous clinical practice. It is in this vital phase of the continuum of medical education that residents learn to provide optimal patient care under the supervision of faculty members who not only instruct, but serve as role models of excellence, compassion, professionalism, and scholarship.

Graduate medical education transforms medical students into physician scholars who care for the patient, family, and a diverse community; create and integrate new knowledge into practice; and educate future generations of physicians to serve the public. Practice patterns established during graduate medical education persist many years later.

Graduate medical education has as a core tenet the graded authority and responsibility for patient care. The care of patients is undertaken with appropriate faculty supervision and conditional independence, allowing residents to attain the knowledge, skills, attitudes, and empathy required for autonomous practice. Graduate medical education develops physicians who focus on excellence in delivery of safe, equitable, affordable, quality care; and the health of the populations they serve. Graduate medical education values the strength that a diverse group of physicians brings to medical care.

Graduate medical education occurs in clinical settings that establish the foundation for practice-based and lifelong learning. The professional development of the physician, begun in medical school, continues through faculty modeling of the effacement of self-interest in a humanistic environment that emphasizes joy in curiosity, problem-solving, academic rigor, and discovery. This transformation is often physically, emotionally, and intellectually demanding and occurs in a variety of clinical learning environments committed to graduate medical education and the well-being of patients, residents, fellows, faculty members, students, and all members of the health care team.

B. Definition of Specialty

1. Radiation oncology is that branch of clinical medicine concerned with the causes, prevention, and the treatment of cancer and certain non-neoplastic conditions utilizing ionizing radiation. Radiation oncologists are an integral part of the multi-disciplinary management of the cancer patient, and must collaborate closely with physicians and health care professionals in the management of the patient.
2. The objective of the residency program is to educate and train physicians to be skillful in the practice of radiation oncology and to be caring and compassionate in the treatment of patients.

C. Length of Educational Program

1. The length of the education program in radiation oncology must be 48 months, preceded by 12 months of post-graduate clinical education.
2. **PGY 1** - The first year of post-graduate clinical education must be accredited by the ACGME, AOA, or RDPSC and spent in internal medicine, family medicine, obstetrics and gynecology, surgery or surgical specialties, pediatrics, or a transitional year program, and must include at least nine months of direct patient care in medical and/or surgical specialties other than radiation oncology. Resident applicants must apply for their PGY1 year in a separate match process from the UVA Radiation Oncology residency application process.
3. **PGY 2 – PGY 5: UVA Radiation Oncology Residency Program** - No fewer than 36 months must be spent in clinical radiation oncology.

UVA has four clinical areas where external beam radiation therapy occurs; Emily Couric Clinical Cancer Center (ECCCC) Radiation Oncology Clinic, the Moser Outpatient Radiation Oncology Center on 250 West, the Gamma Knife Center in the Primary Care building, and an integrated rotation at Culpeper Medical Center (CMC) in Culpeper, Virginia. The 36 months do not include clinical elective rotations outside the Department of Radiation Oncology, nor does it include time spent within our department on non-clinical rotations, such as physics and research. Residents are expected to remain in the UVA Radiation Oncology Residency Training program for the duration of the training. If a resident desires to/has to transfer to another training program, he/she must follow the ACGME requirements for transfer as described in [Section III C](#).

The rotations will involve the care of oncology patients with gynecologic, genitourinary, gastrointestinal, breast, lymphoma/leukemia, head and neck, lung, pediatric, central nervous system, soft tissue and bone, and skin malignancies. In addition, the program provides eight (8) months of off-service rotations. The following 3 months of required electives (off-service rotations) are considered mandatory program requirements: Physics/Dosimetry (1 month); Gamma (1 month); and Nuclear Medicine (1 month). To complete his/her training, the resident will select additional electives, which may include options such as Pediatric Hematology (UVA); Proton Training (Switzerland); VCU; research; or rotating to another facility. Additional research rotation time and rotations at outside academic institutions may be arranged to meet specific resident educational objectives. Scholarly activity during residency is considered essential to training. It is expected that each resident will submit at least one manuscript for peer review publication and present research at one or more national meetings.

The ACGME requirements state that “The program must educate resident physicians in adult medical oncology, pediatric medical oncology, oncologic pathology, and diagnostic imaging in a way that is applicable to the practice of radiation oncology.” In order to satisfy those requirements through tumor board attendance, the residents will track their participation in multidisciplinary, interactive tumor conferences that are attended by adult and/or pediatric oncologists. This is consistent with the ACGME core program requirements in radiation oncology as a method to satisfy program requirements for adult and pediatric medical oncology, oncologic pathology, and diagnostic imaging.

In addition, the residency program offers a structured educational program in basic radionuclide handling techniques applicable to the use of manual brachytherapy sources and the use of remote after loader units, teletherapy units, and Gamma Stereotactic Radiosurgery units that includes a minimum of:

200 hours of classroom and laboratory training in:

- a. radiation physics and instrumentation,
- b. radiation protection,
- c. mathematics pertaining to the use and measurement of radioactivity,
- d. radiation biology;

500 hours of work experience under the supervision of an Authorized User including training in:

- a. ordering, receiving, and unpacking radioactive materials safely and performing the related radiation surveys,
- b. checking and using survey meters for proper operation,
- c. preparing, implanting, and removing brachytherapy sources,
- d. maintaining running inventories of radioactive material on hand,
- e. using administrative controls to prevent a misadministration involving the use of radioactive material,
- f. using emergency procedures to control radioactive material,
- g. reviewing full calibration measurements and periodic spot-checks,
- h. preparing treatment plans and calculating treatment doses and times,
- i. implementing emergency procedures to be followed in the event of the abnormal operation of the medical unit or console,
- j. selecting the proper prescribed dose and how it is to be administered.

D. Resident Complement

A total of 6 residents have been approved for this training. This total is based on the number of faculty, new patient consultations, and simulations performed annually at the University of Virginia Health System's ECCC Radiation Oncology Clinic, Moser, Gamma Knife, and CMC. Also, a complement of 6 residents has been approved by the Radiation Oncology Residency Review Committee (RRC), the Accreditation Council for Graduate Medical Education (ACGME), and the UVA Graduate Medical Education (GME) Office.

The Program Director will not appoint more residents than approved by the RRC. Any increase will be based on educational considerations, not the fulfillment of service requirements.

1. The program's educational resources are adequate to support these six residents and allow for:
 - a. A meaningful peer interaction throughout the training period among the residents themselves
 - b. A minimum of 1 ABR certified faculty member for every 1.5 residents
2. The institution provides the residents with appropriate financial support and benefits to ensure that they are able to fulfill the responsibilities of this educational program.
3. The RRC guidelines will be followed for any changes in the residency complement.

E. Duration and Scope of Graduate Medical Education Training and USMLE Requirements

The UVA Department of Radiation Oncology is accredited for training in radiation oncology by the Radiation Oncology Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME). This department adheres to the UVA GME policies concerning graduate medical education requirements for passing "USMLE, Steps 2 and 3" ([#7](#)) and "Recruitment and Selection of Graduate Medical Trainees" ([#2](#)). Each resident must adhere to the Departmental "[Policy on Board Eligibility](#)".

I. Oversight

A. Sponsoring Institution

The Sponsoring Institution is the organization or entity that assumes the ultimate financial and academic responsibility for a program of graduate medical education, consistent with the ACGME Institutional Requirements.

When the Sponsoring Institution is not a rotation site for the program, the most commonly utilized site of clinical activity for the program is the primary clinical site.

1. The program must be sponsored by one ACGME-accredited Sponsoring Institution.
2. The University of Virginia (UVA) is the Sponsoring Institution.
3. UVA assists the program director in:
 - a. Teaching
 - b. Selecting, evaluating, and dismissing residents whose performance is unsatisfactory
4. The UVA GME will ensure that residents:
 - a. can participate on committees and councils whose actions affect their education and/or patient care; and
 - b. will participate in an educational program regarding physician impairment, including substance abuse and sleep deprivation.

B. Participating Sites

A participating site is an organization providing educational experiences or educational assignments/rotations for residents.

1. The program, with approval of its Sponsoring Institution, must designate a primary clinical site.
 - a. The Sponsoring Institution must also sponsor at least one oncology-related fellowship program accredited by the ACGME in a surgical, medical, or pediatric subspecialty.
2. There must be a program letter of agreement (PLA) between the program and each participating site that governs the relationship between the program and the participating site providing a required assignment.
 - a. The PLA must:
 - i. be renewed at least every 10 years; and
 - ii. be approved by the designated institutional official (DIO).

3. The program must monitor the clinical learning and working environment at all participating sites.
 - a. At each participating site there must be one faculty member, designated by the program director as the site director, who is accountable for resident education at that site, in collaboration with the program director.
4. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one month full time equivalent (FTE) or more through the ACGME's Accreditation Data System (ADS).
5. At least 50 percent of the residents' education experiences should take place at the primary clinical site.
6. Assignment to a participating site must be based on a clear educational rationale, integral to the program curriculum, with clearly-stated activities and objectives; and provide resources not otherwise available to the program.
7. When multiple participating sites are used, there must be assurance of the continuity of the educational experience.
8. Participating Sites
 - a. The program director must determine all rotations and assignments of residents, and is responsible for the overall conduct of the educational program and faculty members at each participating site.
 - b. Clinical faculty members at each participating site should have faculty appointments from the Sponsoring Institution or the primary clinical site.
 - c. Participating sites must provide a means for direct participation in joint conferences, either in person when institutions are in geographic proximity to the primary clinical site, or by electronic means when not.
 - d. Prior approval must be obtained from the Review Committee for the addition of a participating site, regardless of the duration of rotation(s).
9. **Culpeper Medical Center (CMC)** is a participating site in Culpeper, Virginia
 - a. Under the direction of Shiv Khandelwal, M.D., UVA Radiation Oncology faculty member
 - b. Dr. Khandelwal will:
 - i. be responsible for providing teaching and mentorship on this rotation as specified in the faculty responsibility section of the UVA residency guidelines.
 - ii. determine when a resident is capable of independently functioning at CMC
 - iii. notify the CMC staff when the resident has been granted privileges to operate independently in the use of image guided technologies.
 - iv. evaluate the residents following this rotation based on their PGY level specific achievement of the ACGME core competency milestones as specified in the residency guidelines.
 - c. The CMC Rotation Global Educational/Learning Objectives and Goals are:
 - i. to provide the residents with a community oncology practice experience
 - ii. to broaden their understanding of how a broad range of oncology patients receive oncology care outside an academic medical system
 - d. Rotation Specifics:
 - i. Residents on this rotation will:
 - a) complete the "Checklist for the Incoming Radiation Oncology Resident to complete prior to starting the Novant Health UVA Health System Culpeper Medical Center Rotation" (two months before the rotation)
 - b) rotate at CMC Monday and Tuesday from 8:00 am to 5:30 pm
 - c) rotate Wednesday, Thursday and Friday per the Clinic Coverage Schedule
 - d) have the same responsibilities and PGY level specific core competency milestones as outlined in the residency guidelines
 - e) have their salary, benefits, and medical liability premiums provided by the University of Virginia Health System
 - f) call 540-829-4271 (the clinic @ CMC) if they are going to be late or unable to work

- g) create an email distribution list for:
 - 1) Shiv Khandelwal, MD (srk6v@virginia.edu), Physician/Medical Dir. at CMC
 - 2) Einsley Janowski, MD, PhD (ej8t@virginia.edu), Program Director
 - 3) Rebekah McComb (rm5dg@virginia.edu), Program Coordinator
 - 4) Caitlin Connelly (ct9nw@virginia.edu), Senior Administrative Coordinator
 - to let them know when the resident will be late or absent and
 - the reason for the absence
 - h) keep logins up-to-date so they aren't expired upon arrival at CMC
 - i) participate in Treatment Simulation & Planning for Culpeper patients
 - j) participate in the care of UVA Radiation Oncology patients
 - k) have access to videoconferencing to view scheduled conferences, lectures, and seminars
 - ii. Residents will not:
 - a) rotate at CMC as a PGY2
 - b) be on call for CMC patients for after hour phone calls
 - c) cover emergency patients at CMC while on call at UVA
 - iii. The UVA Department of Radiation Oncology will reimburse residents for mileage at the standard institutional reimbursement rate (58 cents/mile) x 90 miles round trip for travel expenses incurred while on this rotation
10. **Virginia Commonwealth University (VCU)** is a participating site in Richmond, Virginia
- a. UVA residents can elect to perform a one month rotation under the direction of Dr. Emma Fields, a VCU Radiation Oncology faculty member and Residency Program Director.
 - b. VCU residents can elect to perform a one month rotation at UVA.
 - c. This affiliation will provide residents with an academic rotation outside the parent institution to expose residents to a wider array of academic experts, and to treatment techniques and technologies not available or routinely performed at the parent institution.
 - d. Residents on these rotations will be evaluated based on PGY-specific competency-based milestone expectations.
 - e. The UVA Department of Radiation Oncology will reimburse residents performing a one month VCU rotation:
 - i. up to \$1,600 to help defray the cost of mileage or lodging
 - a) mileage will be reimbursed at 58 cents/mile
 - ii. the resident will:
 - a) decide how to apply this reimbursement (lodging and/or gas) and
 - b) provide documentation of expenses
11. The UVA Department of Radiation Oncology will reimburse residents performing a one month elective away rotation to a participating site:
- a. for travel to and from the participating site (flight or gas)
 - b. a per diem for lodging and/or local transportation based on location of the participating site
 - i. maximum of \$2,500 for domestic rotations
 - ii. maximum of \$3,500 for international rotations
 - iii. considerations will be made for special circumstances; and can be approved by either the Program Director or the Department Chair
 - c. only if they provide documentation of expenses to Rebekah McComb and/or Caitlin Connelly.
- C. The program, in partnership with its Sponsoring Institution, must engage in practices that focus on mission-driven, ongoing, systematic recruitment and retention of a diverse and inclusive workforce of residents, fellows (if present), faculty members, senior administrative staff members, and other relevant members of its academic community.
- D. Resources**
- 1. The program, in partnership with its Sponsoring Institution, must ensure the availability of adequate resources for resident education.
 - a. Facilities

- i. At the primary clinical site there must be two or more megavoltage machines, a machine with a broad range of electron beam capabilities, computed tomography (CT)-simulation capability, and three-dimensional conformal computerized treatment planning, including intensity modulated radiation therapy (IMRT).
 - a) Varian TRUEBEAM (at ECCCC-primary site)
 - b) Varisource iX HDR unit (at ECCCC)
 - c) Varian TRILOGY (at Moser)
 - d) TomoTherapy unit (at ECCCC & Culpeper)
 - ii. There must be adequate conference room and audiovisual facilities.
 - b. Other Services
 - i. Adequate medical services available in the specialties of medical oncology, surgical oncology, and pediatric oncology.
 - ii. There must be access to current imaging techniques, PACS systems, nuclear medicine, pathology, a clinical laboratory, and a tumor registry.
 2. The program, in partnership with its Sponsoring Institution, must ensure healthy and safe learning and working environments that promote resident well-being and provide for:
 - a. access to food while on duty;
 - b. safe, quiet, clean, and private sleep/rest facilities available and accessible for residents with proximity appropriate for safe patient care;
 - c. clean and private facilities for lactation that have refrigeration capabilities, with proximity appropriate for safe patient care;
 - d. security and safety measures appropriate to the participating site; and,
 - e. accommodations for residents with disabilities consistent with the Sponsoring Institution's policy.
 3. Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. This must include access to electronic medical literature databases with full text capabilities.
 - a. The sponsoring institution provides residents with:
 - i. ready access to a computerized search system
 - ii. rapid access to national databases in medicine to permit timely literature review.
 - b. The Department provides:
 - i. textbooks for each resident (a radiobiology textbook, physics textbook, and a clinical oncology textbook, among others).
 - ii. several up-to-date textbooks for onsite reference and study.
 4. The program's educational and clinical resources must be adequate to support the number of residents appointed to the program.
 - a. There must be a minimum of 600 patients receiving external beam radiation therapy per year cumulatively at the primary clinical site and any participating sites.
- E. The presence of other learners and other care providers, including, but not limited to, residents from other programs, subspecialty fellows, and advanced practice providers, must enrich the appointed residents' education.
1. The program must report circumstances when the presence of other learners has interfered with the residents' education to the DIO and Graduate Medical Education Committee (GMEC) in accordance with sponsoring institution guidelines (GME Policy [#13](#))

II. **Personnel**

A. **Program Director**

1. There must be one faculty member appointed as Program Director (Einsley Janowski, M.D., Ph.D.) with authority and accountability for the overall program, including compliance with all applicable program requirements.
 - a. The UVA GMEC must approve a change in Program Director.
 - b. Final approval of the Program Director resides with the Review Committee.

- c. The program must demonstrate retention of the program director for a length of time adequate to maintain continuity of leadership and program stability.
 - i. The program director should have an appointment of at least three years.
2. At a minimum, the program director must be provided with the salary support required to devote 20 percent FTE (at least eight hours per week) of non-clinical time to the administration of the program.
3. Qualifications of the Program Director:
 - a. must include specialty expertise and at least three years of documented educational and/or administrative experience, or qualifications acceptable to the Review Committee;
 - b. must include current certification in the specialty for which they are the program director by the American Board of Radiology or by the American Osteopathic Board of Radiology, or specialty qualifications that are acceptable to the Review Committee;
 - i. The program director must actively participate in Maintenance of Certification in radiation oncology through the American Board of Radiology or the American Osteopathic Board of Radiology.
 - c. must include current medical licensure and appropriate medical staff appointment; and,
 - d. must include ongoing clinical activity.
 - e. should be a full-time faculty member at the primary or a participating clinical site.
 - i. If at a participating site, the program director should be readily available to residents as needed.
4. Program Director Responsibilities

The program director must have responsibility, authority, and accountability for: administration and operations; teaching and scholarly activity; resident recruitment and selection, evaluation, and promotion of residents, and disciplinary action; supervision of residents; and resident education in the context of patient care.

 - a. The program director must:
 - i. be a role model of professionalism;
 - ii. design and conduct the program in a fashion consistent with the needs of the community, the mission(s) of the Sponsoring Institution, and the mission(s) of the program;
 - iii. administer and maintain a learning environment conducive to educating the residents in each of the ACGME competency domains;
 - iv. develop and oversee a process to evaluate candidates prior to approval as program faculty members for participation in the residency program education and at least annually thereafter, as outlined in [Section V.B.](#);
 - v. have the authority to approve program faculty members for participation in the residency program education at all sites;
 - vi. have the authority to remove program faculty members from participation in the residency program education at all sites;
 - vii. have the authority to remove residents from supervising interactions and/or learning environments that do not meet the standards of the program;
 - viii. submit accurate and complete information required and requested by the DIO, GMEC, and ACGME;
 - ix. provide applicants who are offered an interview with information related to the applicant's eligibility for the relevant specialty board examination(s);
 - x. provide a learning and working environment in which residents have the opportunity to raise concerns and provide feedback in a confidential manner as appropriate, without fear of intimidation or retaliation;
 - xi. ensure the program's compliance with the Sponsoring Institution's policies and procedures related to grievances and due process ([GME Policy #6](#))
 - xii. ensure the program's compliance with the Sponsoring Institution's policies and procedures for due process when action is taken to suspend or dismiss, not to promote, or not to renew the appointment of a resident;

- xiii. ensure the program's compliance with the Sponsoring Institution's policies and procedures on employment and non-discrimination;
 - a) Residents must not be required to sign a non-competition guarantee or restrictive covenant.
 - xiv. document verification of program completion for all graduating residents within 30 days;
 - xv. provide verification of an individual resident's completion upon the resident's request, within 30 days; and,
 - xvi. obtain review and approval of the Sponsoring Institution's DIO before submitting information or requests to the ACGME, as required in the Institutional Requirements and outlined in the ACGME Program Director's Guide to the Common Program Requirements.
- b. Associate Program Director (Kara Romano, M.D.): if there is an APD, he/she will assist in these administrative responsibilities but the Program Director is ultimately responsible for all aspects of the residency.

B. Faculty

Faculty members are a foundational element of graduate medical education – faculty members teach residents how to care for patients. Faculty members provide an important bridge allowing residents to grow and become practice-ready, ensuring that patients receive the highest quality of care. They are role models for future generations of physicians by demonstrating compassion, commitment to excellence in teaching and patient care, professionalism, and a dedication to lifelong learning. Faculty members experience the pride and joy of fostering the growth and development of future colleagues. The care they provide is enhanced by the opportunity to teach. By employing a scholarly approach to patient care, faculty members, through the graduate medical education system, improve the health of the individual and the population.

Faculty members ensure that patients receive the level of care expected from a specialist in the field. They recognize and respond to the needs of the patients, residents, community, and institution. Faculty members provide appropriate levels of supervision to promote patient safety. Faculty members create an effective learning environment by acting in a professional manner and attending to the well-being of the residents and themselves.

1. At each participating site, there must be a sufficient number of faculty members with competence to instruct and supervise all residents at that location.
 - a. The faculty must include a minimum of four (4) full-time-equivalent (FTE) radiation oncologists, located at the primary clinical site, who devote the majority of their professional time to the education of the residents.
 - i. *James Larner, M.D.*
 - ii. *Paul Read, M.D., Ph.D.*
 - iii. *Tim Showalter, M.D., M.P.H.*
 - iv. *Einsley Janowski, M.D. Ph.D.*
 - v. *Kara Romano, M.D. (.75 FTE)*
 - b. To provide a scholarly environment of research and to participate in the teaching of radiation and cancer biology, the faculty must include at least one full-time radiation biologist (*Tarek Abbas, PhD*) or cancer biologist (PhD level or equivalent) who devotes the majority of his or her professional time to laboratory-based cancer research.
 - i. The individual must be based at the primary clinical site or at a participating site.
 - c. To provide a scholarly environment of research and to participate in the teaching of radiation physics, the faculty must include at least one full-time medical physicist (PhD level or equivalent).
 - i. The individual must be based at the primary clinical site or at a participating site.
 - ii. The department currently has seven physicists who serve at the various sites. Several participate in the teaching of radiation physics to radiation oncology residents, such as:
 - a) *David Schlesinger, Ph.D.*
 - b) *Bruce Libby, Ph.D.*
 - c) *Sarah Scarboro, Ph.D.*

2. Faculty members must:

- a. be role models of professionalism;
 - b. demonstrate commitment to the delivery of safe, quality, cost-effective, patient-centered care;
 - c. demonstrate a strong interest in the education of residents;
 - d. devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities;
 - e. administer and maintain an educational environment conducive to educating residents;
 - f. regularly participate in organized clinical discussions, rounds, journal clubs, conferences, and Multi-Disciplinary Tumor Boards; and,
 - g. pursue faculty development designed to enhance their skills at least annually:
 - i. as educators;
 - ii. in quality improvement and patient safety;
 - iii. in fostering their own and their residents' well-being; and,
 - iv. in patient care based on their practice-based learning and improvement efforts.
3. Faculty Qualifications
- a. Faculty members must have appropriate qualifications in their field and hold appropriate institutional appointments.
 - b. Physics faculty members must:
 - i. have current certification in the specialty by the American Board of Radiology or the American Osteopathic Board of Radiology, or possess qualifications judged acceptable to the Review Committee.
 - c. Any non-physician faculty members who participate in residency program education must be approved by the program director.
4. Core Faculty
- Core faculty members must have a significant role in the education and supervision of residents and must devote a significant portion of their entire effort to resident education and/or administration, and must, as a component of their activities, teach, evaluate, and provide formative feedback to residents.
- a. Core faculty members must be designated by the program director.
 - b. Core faculty members must complete the annual ACGME Faculty Survey.
 - i. The core faculty-to-resident ratio must be at least 0.67 core faculty members for every resident in the program.
5. The UVA [GME Policy 12](#) details the delineation of the responsibilities of the attending physician, the trainee and the program.
6. Attendance will be kept at the above departmental conferences for assessment purposes.
7. The faculty will evaluate the residents
- a. based on the resident's achievement of milestone expectations
 - b. through the institution's electronic New Innovations system
 - c. during mock oral examination held monthly.

C. Program Coordinator

- 1. There must be a program coordinator, *Mrs. Rebekah McComb*
 - a. provides administrative support to the Program Director and the Associate Program Director,
 - b. maintains the records of the residents and visiting medical students.
- 2. At a minimum, the program coordinator must be supported at 50 percent FTE (at least 20 hours per week) for administrative time.

D. Other Program Personnel

The program, in partnership with its Sponsoring Institution, must jointly ensure the availability of necessary personnel for the effective administration of the program.

- 1. The departmental staff includes: dosimetrists, therapists, nurses, and clerical staff

III. Resident Appointments

A. Eligibility Requirements

- 1. An applicant must meet one of the following qualifications to be eligible for appointment to an ACGME-accredited program:

- a. graduation from a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education (LCME) or graduation from a college of osteopathic medicine in the United States, accredited by the American Osteopathic Association Commission on Osteopathic College Accreditation (AOACOCA); or,
 - b. graduation from a medical school outside of the United States or Canada, and meeting one of the following additional qualifications:
 - i. holding a currently valid certificate from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to appointment; or,
 - ii. holding a full and unrestricted license to practice medicine in the United States licensing jurisdiction in which the ACGME-accredited program is located.
2. All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, AOA-approved residency programs, Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada, or in residency programs with ACGME International (ACGME-I) Advanced Specialty Accreditation.
- a. Residency programs must receive verification of each resident's level of competency in the required clinical field using ACGME, CanMEDS, or ACGME-I Milestones evaluations from the prior training program upon matriculation.
 - i. Prior to entering the program, residents must have completed 12 months of post-graduate clinical education as indicated in III.A.2 above, which must include:
 - ii. a minimum of nine months of direct patient care in family medicine, internal medicine, obstetrics and gynecology, pediatrics, or surgery or surgical specialties, or in a transitional year program; and,
 - iii. a maximum of three months in radiation oncology.
3. A physician who has completed a residency program that was not accredited by ACGME, AOA, RCPSC, CFPC, or ACGME-I (with Advanced Specialty Accreditation) may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director of the ACGME-accredited program and with approval by the GMEC, may be advanced to the PGY-2 level based on ACGME Milestones evaluations at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry.
4. Resident Eligibility Exception – does not apply to Radiation Oncology
- B. The program director must not appoint more residents than approved by the Review Committee**
1. All complement increases must be approved by the Review Committee
 2. The program must offer at least four resident positions.
- C. Resident Transfers**
- The program must obtain verification of previous educational experiences and a summative competency-based performance evaluation prior to acceptance of a transferring resident, and Milestones evaluations upon Matriculation.

IV. Educational Program Curriculum

The ACGME accreditation system is designed to encourage excellence and innovation in graduate medical education regardless of the organizational affiliation, size, or location of the program.

The educational program must support the development of knowledgeable, skillful physicians who provide compassionate care.

In addition, the program is expected to define its specific program aims consistent with the overall mission of its Sponsoring Institution, the needs of the community it serves and that its graduates will serve, and the distinctive capabilities of physicians it intends to graduate. While programs must demonstrate substantial compliance with the Common and specialty-specific Program Requirements, it is recognized that within this framework, programs may place different emphasis on research, leadership, public health, etc. It is expected that the program aims will reflect the nuanced program-specific goals for

it and its graduates; for example, it is expected that a program aiming to prepare physician-scientists will have a different curriculum from one focusing on community health.

A. The curriculum must contain the following educational components:

1. a set of program aims consistent with the Sponsoring Institution's mission, the needs of the community it serves, and the desired distinctive capabilities of its graduates;
 - a. The program's aims (guidelines) must be made available to program applicants, residents, and faculty members.
2. competency-based goals and objectives for each educational experience designed to promote progress on a trajectory to autonomous practice. These must be distributed, reviewed, and available to residents and faculty members.
3. delineation of resident responsibilities for patient care, progressive responsibility for patient management, and graded supervision;
4. a broad range of structured didactic activities;
 - a. residents must be provided with protected time to participate in core didactic activities.
 - b. The current [Lecture and Tumor Board Schedule](#) can be found here.
5. advancement of residents' knowledge of ethical principles foundational to medical professionalism; and,
6. advancement in the residents' knowledge of the basic principles of scientific inquiry, including how research is designed, conducted, evaluated, explained to patients, and applied to patient care.

B. ACGME Competencies

1. The program must integrate the following ACGME competencies into the curriculum:
 - a. Professionalism

Residents must demonstrate a commitment to professionalism and an adherence to ethical principles.

 - i. Residents must demonstrate competence in:
 - a) compassion, integrity, and respect for others;
 - b) responsiveness to patient needs that supersedes self-interest;
 - c) respect for patient privacy and autonomy;
 - d) accountability to patients, society and the profession;
 - e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation;
 - f) ability to recognize and develop a plan for one's own personal and professional well-being; and,
 - g) appropriately disclosing and addressing conflict or duality of interest. (Core)
 - b. Patient Care and Procedural Skills

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

 - i. Residents must demonstrate competence in:
 - a) follow-up care of irradiated patients, including pediatric patients;
 - b) performing interstitial and intracavitary brachytherapy procedures;
 - c) the use of unsealed radioactive sources;
 - d) treating adult patients with conventionally fractionated external beam radiation therapy;
 - e) treating adult patients with stereotactic radiosurgery and stereotactic body radiation therapy; and,
 - f) treating pediatric patients, including patients with solid tumors
 - ii. Residents must be able to perform all medical, diagnostic, and surgical procedures considered essential for the area of practice.
 - c. Medical Knowledge

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

- i. Residents must demonstrate competence in their knowledge of:
 - a) clinical radiation oncology, including late effects on normal tissue;
 - b) clinical radiation physics;
 - c) medical statistics;
 - d) radiation and cancer biology; and,
 - e) radiation safety procedures.
- d. Practice-based Learning and Improvement
 Residents must demonstrate the ability to investigate and evaluate their care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and life-long learning.
 - i. Residents must demonstrate competence in:
 - a) identifying strengths, deficiencies, and limits in one's knowledge and expertise;
 - b) setting learning and improvement goals;
 - c) identifying and performing appropriate learning activities;
 - d) systematically analyzing practice using quality improvement methods, and implementing changes with the goal of practice improvement;
 - e) incorporating feedback and formative evaluation into daily practice;
 - f) locating, appraising, and assimilating evidence from scientific studies related to their patients' health problems; and,
 - g) using information technology to optimize learning.
- e. Interpersonal and Communication Skills
 Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals.
 - i. Residents must demonstrate competence in:
 - a) communicating effectively with patients, families, and the public, as appropriate across a broad range of socioeconomic and cultural backgrounds;
 - b) communicating effectively with physicians, other health professionals, and health related agencies;
 - c) working effectively as a member or leader of a health care team or other professional group;
 - d) educating patients, families, students, residents, and other health professionals;
 - e) acting in a consultative role to other physicians and health professionals; and
 - f) maintaining comprehensive and timely medical records, if applicable.
 - ii. Residents must learn to communicate with patients and families to partner with them to assess their care goals, including, when appropriate, end-of-life goals.
- f. Systems-based Practice
 Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care.
 - i. Residents must demonstrate competence in:
 - a) working effectively in various health care delivery settings and systems relevant to their clinical specialty;
 - b) coordinating patient care across the health care continuum and beyond as relevant to their clinical specialty;
 - c) advocating for quality patient care and optimal patient care systems;
 - d) working in interprofessional teams to enhance patient safety and improve patient care quality;
 - e) participating in identifying system errors and implementing potential systems solutions;
 - f) incorporating considerations of value, cost awareness, delivery and payment, and risk-benefit analysis in patient and/or population-based care as appropriate; and

- g) understanding health care finances and its impact on individual patients' health decisions.
- ii. Residents must learn to advocate for patients within the health care system to achieve the patient's and family's care goals, including, when appropriate, end-of-life goals.

C. Curriculum Organization and Resident Experiences

1. The curriculum must be structured to optimize resident educational experiences, the length of these experiences, and supervisory continuity.
2. The program must provide instruction and experience in pain management if applicable for the specialty, including recognition of the signs of addiction.
3. The curriculum must include forty-eight (48) months of education in radiation oncology.
 - a. This must include a minimum of 36 months in clinical radiation oncology.
 - b. The remaining 12 months may be spent performing such activities as taking elective rotations, performing research, pursuing an advanced degree, or taking other clinical rotations.
 - i. This time must not be used to pursue a fellowship.
 - ii. Previous time spent in another ACGME-accredited program must not be applied to reduce the required length of the residency in radiation oncology.
 - c. The American Board of Radiology's Holman Pathway residents must complete no fewer than 27 months of clinical radiation oncology.
4. Residents must have experience with lymphomas and leukemias; breast, central nervous system, gastrointestinal, genitourinary, gynecologic, head and neck, lung, pediatric, skin, and soft tissue and bone tumors; and treatment of benign diseases for which radiation is utilized.
5. Each resident must treat at least 450 patients with external beam radiation therapy.
 - a. Holman Pathway residents must treat 350 patients.
 - b. A resident should treat no more than 250 patients with external beam radiation therapy in any one year.
6. Each resident must perform at least 5 interstitial and 15 intracavitary brachytherapy procedures.
7. Each resident must treat at least 12 pediatric patients, including at least 9 patients with solid tumors.
8. Each resident must demonstrate the requisite skills in successfully treating at least 20 patients with intracranial stereotactic radiosurgery and at least 20 patients with stereotactic body radiation therapy to the liver, lung, spine, or other extracranial sites.
9. Each resident must demonstrate the requisite knowledge and skills in the administration of at least six procedures using radioimmunotherapy, other targeted therapeutic radiopharmaceuticals or unsealed sources.

Of the six procedures:

 - a. Oral I-131 ≥ 33 mCi: A minimum of three procedures must include the oral administration of I-131 with administered activity equal to or in excess of 1.22 Gigabecquerels (33 mCi). Patient conditions may be either benign or malignant but the counted administration must be for therapeutic intent.
 - b. Parenteral unsealed source: A minimum of three procedures must include a parenteral administration with therapeutic intent for a diagnosis of malignancy.
 - c. The residents will keep a separate log of the 6 cases ([Oral I-131 & Parenteral Administration Log](#)), signed by the authorized user, which will be part of the resident's permanent record as a hard copy of the log will be required to take the oral exam, for future licensure, and if any questions arise to document that current training qualifies graduating residents as authorized users, but the training does not provide the license.
10. The program must include education in adult medical oncology, pediatric medical oncology, oncologic pathology, oncologic diagnostic imaging, and palliative care in a way that is applicable to the practice of radiation oncology.
 - a. In order to meet this requirement programs should:
 - i. Document resident attendance at regularly-scheduled multidisciplinary patient disposition conferences (at least four hours per month during the clinical rotations); or,

- ii. provide a two-month rotation in medical oncology, to include adult and pediatric patients, as well as a one-month rotation in both oncologic pathology and diagnostic imaging.
 - b. Each conference must include the documented participation of a physician board-certified in the applicable specialty or subspecialty.
11. Didactic sessions should be attended by residents, radiation oncologists, and other staff members.
 12. The program must provide instruction in the following areas:
 - a. three-dimensional conformal radiation therapy;
 - b. intensity-modulated radiation therapy;
 - c. image-guided radiation therapy;
 - d. stereotactic radiosurgery;
 - e. stereotactic body radiotherapy;
 - f. concurrent chemo-radiotherapy;
 - g. intra-operative radiation therapy;
 - h. radioimmunotherapy;
 - i. unsealed sources;
 - j. total body irradiation therapy as used in stem-cell transplantation;
 - k. total skin radiation therapy;
 - l. high- and low-dose rate brachytherapy; and,
 - m. particle therapy.
 13. The program must provide instruction in medical physics that includes practical demonstrations of radiation safety procedures, calibration of radiation therapy machines, the use of state-of-the-art treatment planning systems, the application of treatment aids, and the safe handling of sealed and unsealed radionuclides.
 14. The program must provide instruction in radiation and cancer biology that includes the molecular effects of ionizing radiation and radiation effects on normal and neoplastic tissues, as well as the fundamental biology of the causes, prevention, and treatment of cancer.
 15. The program must ensure that there are intradepartmental clinical oncology conferences that address the following topics: new patient management, patient safety, and continuous quality improvement.
 16. Residents must keep a detailed, well-organized, and accurate ACGME electronic procedure log for the cases listed in sections IV.C.4 – IV.C.8. Those listed in section IV.C.9 are kept in a separate log, as described above (IV.C.9.c.).
 - a. Patients should be counted as simulated by a resident if the resident was present and participated throughout the initial simulation and treatment planning process; the resident simulates and plans treatment of a new area on an established patient (for example a new metastasis, new primary, or recurrence).
 - b. Patients should not be counted as simulated by a resident if:
 - i. the case was taken over from another resident, even if subsequent care involves a second simulation; unless, this involves treatment of another area, or a substantial change in fields with a new isocenter.
 - ii. the simulation and planning were performed by staff members and the resident only saw the patient after he or she was on treatment;
 - iii. another resident has counted the case on their log, unless (i) applies;
 - iv. the patient was seen in consult only.
 - c. The resident must follow-up on the irradiated patients, including pediatric patients, on an inpatient or outpatient basis.
 - d. Residents are expected to check the Master Mosaiq schedule to arrive in clinic at the start of his/her patients' treatment each morning and stay in clinic until all of his/her patients have been treated.
 - e. Residents are expected to gather essential and accurate information about their patients; make informed decisions about diagnostic and therapeutic intervention based on patient information and preferences, up to date scientific evidence, and clinical judgment; develop and carry out patient management plans; perform competently all medical and invasive

procedures considered essential for the practice of radiation oncology; and, counsel and educate patients and their family.

D. Scholarship

Medicine is both an art and a science. The physician is a humanistic scientist who cares for patients. This requires the ability to think critically, evaluate the literature, appropriately assimilate new knowledge, and practice lifelong learning. The program and faculty must create an environment that fosters the acquisition of such skills through resident participation in scholarly activities. Scholarly activities may include discovery, integration, application, and teaching.

The ACGME recognizes the diversity of residencies and anticipates that programs prepare physicians for a variety of roles, including clinicians, scientists, and educators. It is expected that the program's scholarship will reflect its mission(s) and aims, and the needs of the community it serves. For example, some programs may concentrate their scholarly activity on quality improvement, population health, and/or teaching, while other programs might choose to utilize more classic forms of biomedical research as the focus for scholarship.

1. Program Responsibilities

- a. The program must demonstrate evidence of scholarly activities consistent with its mission(s) and aims.
- b. The program, in partnership with its Sponsoring Institution, must allocate adequate resources to facilitate resident and faculty involvement in scholarly activities.
- c. The program must advance residents' knowledge and practice of the scholarly approach to evidence-based patient care.

2. Faculty Scholarly Activity

- a. Among their scholarly activity, programs must demonstrate accomplishments in at least three of the following domains:
 - Research in basic science, education, translational science, patient care, or population health
 - Peer-reviewed grants
 - Quality improvement and/or patient safety initiatives
 - Systematic reviews, meta-analyses, review articles, chapters in medical textbooks, or case reports
 - Creation of curricula, evaluation tools, didactic educational activities, or electronic educational materials
 - Contribution to professional committees, educational organizations, or editorial boards
 - Innovations in education
- b. The program must demonstrate dissemination of scholarly activity within and external to the program by the following methods:
 - i. faculty participation in grand rounds, posters, workshops, quality improvement presentations, podium presentations, grant leadership, non-peer-reviewed print/electronic resources, articles or publications, book chapters, textbooks, webinars, service on professional committees, or serving as a journal reviewer, journal editorial board member, or editor;
 - ii. peer-reviewed publication.

3. Resident Scholarly Activity

- a. Residents must participate in scholarship.
- b. Residents must complete an investigative project under faculty member supervision.
 - i. Projects should take the form of biological laboratory research, clinical research, translational research, medical physics research, or other research approved by the program director.
 - ii. The results of such projects should be suitable for publication in a peer-reviewed scholarly journals or presentation at scientific meetings.
- c. There will be an annual research award – Roentgen Resident/Fellow Research Award.

4. Innovative Projects

- a. Requests for innovative projects that may deviate from the institutional, common and/or specialty specific program requirements must be approved in advance by the Review Committee.
- b. In preparing requests, the program director must follow Procedures for Approving Proposals for Innovative Projects located in the [ACGME Manual on Policies and Procedures](#).
 - i. Section: 26.80 Submission of Proposal
- c. Once a Review Committee approves a project, the sponsoring institution and program are jointly responsible for the quality of education offered to residents for the duration of such a project.

V. Residency Evaluation Process

A. Resident Evaluation

1. Feedback and Evaluation

- a. Faculty members must directly observe, evaluate, and frequently provide feedback on resident performance during each rotation or similar educational assignment.
- b. Evaluation must be documented at the completion of the assignment. This will be done anonymously in the New Innovations (NI) system.
 - i. For block rotations of greater than three months in duration, evaluation must be documented at least every three months.
 - ii. Longitudinal experiences, such as continuity clinic in the context of other clinical responsibilities, must be evaluated at least every three months and at completion.
- c. The program must provide an objective performance evaluation based on the Competencies and the specialty specific Milestones, and must:
 - i. use multiple evaluators (e.g. faculty members, peers, patients, self, and other professional staff members); and,
 - ii. provide that information to the Clinical Competency Committee for its synthesis of progressive resident performance and improvement toward unsupervised practice.
- d. The program director or their designee, with input from the Clinical Competency Committee, must:
 - i. meet with and review with each resident their documented semi-annual evaluation of performance, including progress along the specialty-specific Milestones;
 - ii. assist residents in developing individualized learning plans to capitalize on their strengths and identify areas for growth; and,
 - iii. develop plans for residents failing to progress, following institutional policies and procedures.
 - iv. ensure that each resident keeps a detailed, well-organized, and accurate electronic log of the procedures specified in Program Requirement IV.C.16.; and
 - a) The log should include patients simulated, procedures performed, and modalities used.
 - v. review the logs with each resident at least semiannually to ensure accuracy and to verify that the case distribution meets the standards specified.
 - a) The program director must provide documentation of these discussions for the resident's record maintained by the program.
- e. At least annually, there must be a summative evaluation of each resident that includes their readiness to progress to the next year of the program, if applicable.
- f. The evaluations of a resident's performance must be accessible for review by the resident.
- g. Once a month after Sim Conference the attending and resident will spend fifteen minutes of uninterrupted time discussing the weaknesses and strengths of the resident within the rotation, what needs to improve before the end of the rotation, setting goals to be reviewed at the end of the rotation; except during the elective rotations.
- h. Faculty will evaluate residents via monthly [mock oral examinations](#) based on their expected milestone achievements in the areas of patient care and medical knowledge, by scoring the cases on a 1 to 5 scale (correlating with the NAS way of scoring).

- i. Faculty will be responsible for the following mock oral examination topics:
 - a) Showalter: GU, Peds
 - b) Read: Head & Neck, Lymphoma
 - c) Larner: CNS, Lung
 - d) Janowski: GI, Breast
 - e) Khandelwal: Sarcoma
 - f) Romano: GYN
- 2. Final Evaluation
 - a. The program director must provide a final evaluation for each resident upon completion of the program.
 - i. The specialty-specific Milestones, and when applicable the specialty-specific Case Logs, must be used as tools to ensure residents are able to engage in autonomous practice upon completion of the program.
 - ii. This evaluation must:
 - a) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy;
 - b) verify that the resident has demonstrated the knowledge, skills, and behaviors necessary to enter autonomous practice;
 - c) consider recommendations from the Clinical Competency Committee; and,
 - d) document the resident's performance during the final period of education; and,
 - e) be shared with the resident upon completion of the program.
- 3. A Clinical Competency Committee must be appointed by the program director.
 - a. At a minimum, the Clinical Competency Committee must include three members of the program faculty, at least one of whom is a core faculty member.
 - i. Additional members must be faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents.
 - b. The Clinical Competency Committee must:
 - i. review all resident evaluations at least semi-annually;
 - ii. determine each resident's progress on achievement of the specialty-specific Milestones; and,
 - iii. meet prior to the residents' semi-annual evaluations and advise the program director regarding each resident's progress.
- 4. Staff 360 Degree Evaluation of the Resident
 - a. Representatives from Dosimetry, Therapy, Physics, and the nursing staff will evaluate the residents during the semi-annual CCC meetings.
 - b. Residents will complete peer evaluations through New Innovations annually.

B. Faculty Evaluation

- 1. The program must have a process to evaluate each faculty member's performance as it relates to the educational program at least annually. (This will be satisfied by the PEC).
 - a. This evaluation must include a review of the faculty member's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities.
 - b. This evaluation must include written anonymous and confidential evaluations by the residents.
- 2. Faculty members must receive feedback on their evaluations at least annually.
- 3. Results of the faculty educational evaluations should be incorporated into program-wide faculty development plans.
- 4. The PEC will define any faculty deficiencies and report them to the department chair, who will address issues during the annual faculty evaluations.
- 5. The residents are required to anonymously evaluate the Faculty annually in NI. The residency coordinator will print an annual summary report for the end-of-year PEC meeting. The summary

reports of the evaluations will provide feedback on how well the Faculty are meeting the needs of the resident in his/her achievement of the competency milestones and be reviewed by the PEC.

C. Program Evaluation and Improvement

1. The program director must appoint the Program Evaluation Committee (PEC) to conduct and document the Annual Program Evaluation as part of the program's continuous improvement process.
 - a. The Program Evaluation Committee must be composed of at least two program faculty members, at least one of whom is a core faculty member, and at least one resident.
 - b. Program Evaluation Committee responsibilities must include:
 - i. acting as an advisor to the program director, through program oversight
 - ii. review of the program's self-determined goals and progress toward meeting them;
 - iii. guiding ongoing program improvement, including development of new goals, based upon outcomes; and,
 - iv. review of the current operating environment to identify strengths, challenges, opportunities, and threats as related to the program's mission and aims.
 - c. The Program Evaluation Committee should consider the following elements in its assessment of the program:
 - i. curriculum;
 - ii. outcomes from prior Annual Program Evaluations
 - iii. ACGME letters of notification, including citations, Areas for Improvement, and comments;
 - iv. quality and safety of patient care;
 - v. aggregate resident and faculty:
 - a) well-being;
 - b) recruitment and retention;
 - c) workforce diversity;
 - d) engagement in quality improvement and patient safety;
 - e) ACGME Resident and Faculty Surveys; and,
 - f) written evaluations of the program.
 - vi. aggregate resident:
 - a) achievement of the Milestones;
 - b) in-training examinations (where applicable)
 - c) board pass and certification rates; and,
 - d) graduate performance.
 - vii. aggregate faculty:
 - a) evaluation; and,
 - b) professional development.
 - d. The Program Evaluation Committee must evaluate the program's mission and aims, strengths, areas for improvement, and threats.
 - e. The annual review, including the action plan, must:
 - i. be distributed to and discussed with the members of the teaching faculty and the residents; and,
 - ii. be submitted to the DIO.
2. The program must complete a Self-Study prior to its 10-Year Accreditation Site Visit.
 - a. A summary of the Self-Study must be submitted to the DIO.
3. One goal of ACGME-accredited education is to educate physicians who seek and achieve board certification. One measure of the effectiveness of the educational program is the ultimate pass rate.

The program director should encourage all eligible program graduates to take the certifying examination offered by the applicable American Board of Medical Specialties (ABMS) member board or American Osteopathic Association (AOA) certifying board.

- a. For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual written exam, in the preceding three years, the program's aggregate pass rate of those

- taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
- b. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial written exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
 - c. For specialties in which the ABMS member board and/or AOA certifying board offer(s) an annual oral exam, in the preceding three years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
 - d. For specialties in which the ABMS member board and/or AOA certifying board offer(s) a biennial oral exam, in the preceding six years, the program's aggregate pass rate of those taking the examination for the first time must be higher than the bottom fifth percentile of programs in that specialty.
 - e. For each of the exams referenced in V.C.3.a)-d), any program whose graduates over the time period specified in the requirement have achieved an 80 percent pass rate will have met this requirement, no matter the percentile rank of the program for pass rate in that specialty.
 - f. Programs must report, in ADS, board certification status annually for the cohort of board-eligible residents that graduated seven years earlier.
4. Faculty and Resident Evaluation of the Program
 - a. The faculty and residents are required to anonymously evaluate the Program annually.
 - b. The residents are encouraged to provide positive or negative feedback of the Program to the Program Director at any time and this information is solicited during the semi-annual meeting of the Program Director with the resident.
 5. UVA GME Evaluation of the Program
 - a. The UVA GME has in place an Annual Oversight Committee that implements, and oversees an internal review process.

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

- Excellence in the safety and quality of care rendered to patients by residents today
- Excellence in the safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling of:
 - the effacement of self-interest in a humanistic environment that supports the professional development of physicians
 - the joy of curiosity, problem-solving, intellectual rigor, and discovery
- Commitment to the well-being of the students, residents, faculty members, and all members of the health care team

A. Patient Safety, Quality Improvement, Supervision, and Accountability

1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

a. Patient Safety

i. Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

- a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety.
- b) The program must have a structure that promotes safe, interprofessional, team-based care.

ii. Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques.

The UVA GME Core Lecture Series addresses this topic every year. In addition, the residency curriculum includes the new 2 days devoted to patient safety in radiation oncology using the IAEA eLearning curriculum and small group format with Dr. Showalter. Residents will continue to be engaged in newsletter contributions for the American Brachytherapy Society Patient Safety corner, an educational forum.

iii. Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

- a) Residents, fellows, faculty members, and other clinical staff members must:
 - 1) know their responsibilities in reporting patient safety events at the clinical site;
 - 2) know how to report patient safety events, including near misses, at the clinical site; and,
 - 3) be provided with summary information of their institution's patient safety reports
- b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. This includes both Be Safe reporting and analyses and near-miss events discussed in Sim Conference.

iv. Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

- a) All residents must receive training in how to disclose adverse events to patients and families. (The UVA GME Core Lecture Series addresses this topic every year.)
- b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

b. Quality Improvement

i. Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

- a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.

ii. Quality Metrics

Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

- a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
 - iii. Engagement in Quality Improvement Activities

Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

 - a) Residents must have the opportunity to participate in interprofessional quality improvement activities.
 - 1) This should include activities aimed at reducing health care disparities. (The UVA GME Core Lecture Series addresses this topic every year.)
- 2. Supervision and Accountability
 - a. Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

 - i. Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is ultimately responsible and accountable for the patient's care.
 - a) This information must be available to residents, faculty members, other members of the health care team, and patients.
 - b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
 - b. Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site, or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.
 - i. The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation.
 - a) Residents will not be allowed to approve images for image guided radiation therapy without direct supervision of a resident with these privileges or a faculty member until they are deemed competent and granted this privilege by the Program Director. The faculty members are ultimately responsible for approval of all images obtained to guide radiation therapy.
 - b) Residents will not be allowed to insert or remove brachytherapy sources without direct supervision of a resident with these privileges or a faculty member until they are deemed competent and granted this privilege by the Director of Brachytherapy or Program Director.
 - c. Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

 - i. Direct Supervision – the supervising physician is physically present with the resident and patient.
 - ii. Indirect Supervision –

- a) 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.
- b) with direct supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
- iii. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
- d. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.
 - i. The program director must evaluate each resident’s abilities based on specific criteria, guided by the milestones.
 - ii. Faculty members functioning as supervising physicians must delegate portions of care to residents, based on the needs of the patient and the skills of each resident.
 - iii. Senior residents or fellows should serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
- e. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
 - i. Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence.
 - a) Initially, PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.]
 - f. Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

B. Professionalism

1. Programs, in partnership with their sponsoring institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients.
2. The learning objectives of the program must:
 - a. be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events;
 - b. be accomplished without excessive reliance on residents to fulfill non-physician obligations; and,
 - c. ensure manageable patient care responsibilities.
3. The program director, in partnership with the sponsoring institution, must provide a culture of professionalism that supports patient safety and personal responsibility.
4. Residents and faculty members must demonstrate an understanding of their personal role in the:
 - a. provision of patient- and family-centered care;
 - b. safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events;
 - c. assurance of their fitness for work, including:
 - i. management of their time before, during, and after clinical assignments; and,
 - ii. recognition of impairment, including illness, fatigue, and substance abuse, in themselves, their peers, and other members of the health care team.
 - d. commitment to lifelong learning;
 - e. the monitoring of their patient care performance improvement indicators; and,

- f. accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data.
- 5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition 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.
- 6. Programs, in partnership with their Sponsoring Institutions, must provide a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion of students, residents, faculty, and staff.
- 7. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns.
- 8. The GME will provide a healthy and safe educational and work environment in which residents may raise and resolve issues without fear of intimidation or retaliation. Mechanisms to ensure this environment must include:
 - a. An organization or other forum for residents to communicate and exchange information on their educational and work environment, their programs, and other resident issues.
 - b. A process by which individual residents can address concerns in a confidential and protected manner.

C. Well-Being

Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician and require proactive attention to life inside and outside of medicine. Well-being requires that physicians retain the joy in medicine while managing their own real-life stresses. Self-care and responsibility to support other members of the health care team are important components of professionalism; they are also skills that must be modeled, learned, and nurtured in the context of other aspects of residency training.

Residents and faculty members are at risk for burnout and depression. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as other aspects of resident competence. Physicians and all members of the health care team share responsibility for the well-being of each other. For example, a culture which encourages covering for colleagues after an illness without the expectation of reciprocity reflects the ideal of professionalism. A positive culture in a clinical learning environment models constructive behaviors, and prepares residents with the skills and attitudes needed to thrive throughout their careers.

1. The responsibility of the program, in partnership with the Sponsoring Institution, to address well-being must include:
 - a. efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships;
 - b. attention to scheduling, work intensity, and work compression that impacts resident well-being;
 - c. evaluating workplace safety data and addressing the safety of residents and faculty members;
 - d. policies and programs that encourage optimal resident and faculty member well-being; and,
 - i. Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
 - e. attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must:
 - i. encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow,

- or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence;
 - ii. provide access to appropriate tools for self-screening; and,
 - iii. provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.
2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, family emergencies, and parental leave. Each program must allow an appropriate length of absence for residents unable to perform their patient care responsibilities.
 - a. The program must have policies and procedures in place to ensure coverage of patient care.
 - b. These policies must be implemented without fear of negative consequences for the resident who is or was unable to provide the clinical work.

D. Fatigue Mitigation

1. Programs must:
 - a. educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;
 - b. educate all faculty members and residents in alertness management and fatigue mitigation processes; and,
 - c. encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.
 - d. The UVA GME Core Lecture Series addresses this topic every year.
2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.
3. The program, in partnership with its sponsoring institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

E. Clinical Responsibilities, Teamwork, and Transitions of Care

1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY-level, patient safety, resident ability, severity and complexity of patient illness/condition and available support services.
2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

 - a. Interprofessional teams within the department should include radiation oncologists, medical physicists, radiation therapists, dosimetrists, nurses, dieticians and social workers.
 - b. Interprofessional teams outside of the department should include surgical oncologists, medical oncologists, radiologists, pathologists and primary care physicians.
3. Transitions of Care
 - a. Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure.
 - b. Programs, in partnership with their sponsoring institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety.
 - c. Programs must ensure that residents are competent in communicating with team members in the hand-over process.
 - d. Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care.
 - e. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency.
 - f. [Radiation Oncology Policy on Transition of Care](#)

F. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

1. Maximum Hours of Clinical and Educational Work per Week
Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting.
2. Mandatory Time Free of Clinical Work and Education
 - a. The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being.
 - b. Residents should have eight hours off between scheduled clinical work and education periods.
 - i. There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
 - c. Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
 - d. Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days.
3. Maximum Clinical Work and Education Period Length
 - a. Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments.
 - i. Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education.
 - a) Additional patient care responsibilities must not be assigned to a resident during this time.
4. Clinical and Educational Work Hour Exceptions
 - a. In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:
 - i. to continue to provide care to a single severely ill or unstable patient;
 - ii. humanistic attention to the needs of a patient or family; or,
 - iii. to attend unique educational events.
 - b. These additional hours of care or education will be counted toward the 80-hour weekly limit.
 - c. A Review Committee may grant rotation-specific exceptions for up to 10% or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale. (The Review Committee for Radiation Oncology will not consider requests for exceptions to the 80-hour limit to the residents' work week).
 - i. In preparing a request for an exception the program director must follow the clinical and educational work hour exception policy from the [ACGME Manual on Policies and Procedures](#).
 - ii. Prior to submitting the request to the Review Committee, the program director must obtain approval from the sponsoring institution's GMEC and DIO.
5. Moonlighting
 - a. Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program and must not interfere with the resident's fitness for work nor compromise patient safety.
 - b. Time spent by residents in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
 - i. All moonlighting hours must be entered into New Innovations Duty Hour Module so the Program Director can review to determine the potential of fatigue. In addition, all duty hours must be logged during any month in which the resident is moonlighting.

- c. PGY-1 residents are not permitted to moonlight.
 - d. A resident may work a maximum of 3 shifts per month at Western State Hospital without having to use vacation time and as long as there is no detrimental impact on his/her residency training.
 - e. A resident cannot moonlight when on call for the UVA Department of Radiation Oncology.
 - f. Moonlighting will be allowed as defined by [GME Policy #10](#).
 - g. The [Radiation Oncology Moonlighting Agreement](#) and the [GME Application for Moonlighting](#) must be turned in and approved before any moonlighting can be done.
6. In-House Night Float
Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.
7. Maximum In-House On-Call Frequency
Residents must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four week period).
8. At-Home Call
- a. Time spent on patient care activities by residents on at-home call must count towards the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third night limitation, but must satisfy the requirement for one-day in-seven free of clinical work and education, when averaged over four weeks.
 - i. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
 - b. Residents are permitted to return to the hospital while on at home call to provide direct care for new or established patients. These hours of inpatient care must be included in the 80-hour maximum weekly limit.
9. Clinical and Educational Work Hours will be monitored in New Innovations for a four week period annually per the UVA GME guidelines. Our department chooses to log hours for October.
- G. Resident Leave Policies
- 1. Per the ABR policy: Leaves of absence and vacation may be granted to residents at the discretion of the program director in accordance with local rules. Depending on the length of absence granted by your program, the required period of graduate medical education may be extended accordingly. Residency program directors and their intuitional GME offices determine the need for extension of residency training. Therefore, it is not up to the ABR to determine graduation dates for individual residents.
 - 2. This can be found at: <https://www.theabr.org/radiation-oncology/certification-requirements>
 - 3. Additional Time for Completing Board Requirements as per [GME Policy #03](#)
In the event that additional training time is required to meet Board eligibility requirements (due to leave or other circumstances) the Trainee must be reappointed, with pay and benefits to continue for the extension.
 - 4. To request leave, the resident must complete a "Resident Leave Request" email with the information requested using the template available on the Z drive. This email should be completed for any time out of the clinic (vacation, conferences, etc.) at least two weeks before leave is to be taken.
 - a. The following people must be included on the Resident Leave Request email:
 - i. Supervising Attending for your current rotation
 - ii. Program Director
 - iii. Chief Resident(s)
 - iv. Residency Coordinator, Rebekah McComb
 - v. Administrative Coordinator, Caitlin Connelly
 - b. The same format should be followed when a sick day is needed.
 - c. If you know you will be out for an extended timeframe, please be sure to note that information in your email; so the department will be kept informed of your time away.
 - 5. Exceptional Leave will be allowed per [GME Policy #03](#).

VII. Resident Competency Milestones / Learning Objectives (described explicitly for Emily Couric Clinical Cancer Center, Moser, and Culpeper Medical Center Radiation Oncology Rotations)

Resident learning and progress will be evaluated through the perspective of the ACGME competencies, which are comprised of:

PC (Patient Care)	ICS (Interpersonal and Communication Skills)
MK (Medical Knowledge)	PBLI (Practice-Based Learning and Improvement)
P (Professionalism)	SBP (Systems-Based Practice)

In addition to competency-based objectives, the residents will be evaluated according to year of training with expectation of progressive learning, achievements and responsibility. At a semi-annual and annual Clinical Competency Committee meeting, the CCC will evaluate the resident/s on the accomplishment of his/her appropriate obtainment of the milestone.

The milestones for the residents are evaluated according to the ACGME Milestones, and summary scores are provided semi-annually by the CCC. Each rotation in the residency program also has specific goals and objectives, which are distributed to resident and faculty at the beginning of each rotation. The evaluations for each rotation are modeled after these objectives. The learning objectives for each rotation are listed below.

i. Rotations

1. Clinical Rotations

a. Radiation Oncology Rotations with Learning Objectives

i. Showalter

- a) **Genitourinary Cancer:** The resident will demonstrate an understanding of the proper performance of a Physical Examination of the GU patient including digital examination of the prostate; competency in interpreting Abd/Pelvic CT/MRI scans and Prostate U/S; an understanding of the proper technique of dosimetry of Prostate Brachytherapy; external beam techniques and dosimetry; IMRT and 3D DVH analysis. The resident will have an understanding of the role and integration of hormonal therapy, chemotherapy, and surgery.
- b) **Pediatric Cancer:** The resident will demonstrate competency in interpreting pediatric CT scans and MRI scans; and in how to review the films with a pediatric radiologist to determine gross disease. The resident will have an understanding of family dynamics. The resident will demonstrate an understanding of the need for anesthesia during external beam therapy; external beam techniques and dosimetry; the results of Major Pediatric Cooperative Trials; and role and integration of chemotherapy and surgery.
- c) **Soft Tissue and Bone Cancer:** The resident will demonstrate competency in interpreting CT scans and MRI scans of the soft tissues and bone; in external beam techniques and dosimetry; and in understanding of HDR interstitial brachytherapy implants. The resident will have an understanding of the role and integration of chemotherapy and surgery.
- d) **Prostate Brachytherapy:** The resident will learn the indications for prostate brachytherapy, appropriate patient selection for prostate brachytherapy including relative and absolute contraindications, how to perform prostate brachytherapy dosimetry, how to prescribe prostate brachytherapy +/- external beam radiotherapy, how to physically place the needles and sources with ultrasound guidance and perform real time planning, instructions for patients following prostate brachytherapy to minimize exposure to others, and how to describe acute and late toxicity, and potential local control rates of prostate cancer treated with prostate brachytherapy. The resident should have an understanding of physical half-lives of isotopes used for prostate brachytherapy and the rationale for choosing between them and choosing HDR, dose distributions of prostate brachytherapy, specifically doses to the prostate, bladder, and rectum, the integration of hormonal therapy and external beam radiation with prostate brachytherapy, limitations of prostate brachytherapy, acute and late toxicity of prostate brachytherapy, and local control of

prostate cancer treated with prostate brachytherapy. The resident demonstrates an understanding of the role of urologists, radiation oncologists, physicists, and dosimetrists in the safe delivery of prostate brachytherapy and the costs of prostate brachytherapy and how this compares to other forms of treatment for prostate cancer.

- e) **Lymphoma:** The resident will demonstrate the proper examination of the liver, spleen, and lymph nodes; competency in interpreting Head/Chest/Abd/Pelvic CT, PET scans, and Skeletal Surveys. The resident will demonstrate an understanding of the indications for Bone Marrow Biopsy; External beam techniques and dosimetry including DVH analysis and the rationale and techniques for Total Body Irradiation and Total Electron Skin Irradiation. The resident will have an understanding of the role and integration of chemotherapy and monoclonal antibody therapy.
 - f) **Gynecologic Cancer:** The resident will demonstrate the correct performance of a Physical Examination of the gynecology patient in the clinic; and competency in interpreting Abd/Pelvic CT/MRI scans and PET/CT imaging. The resident will be able to discuss HDR intracavitary and interstitial brachytherapy techniques, prescription, and rationale; external beam techniques and dosimetry including DVH analysis. The resident will demonstrate an understanding of the role and integration of chemotherapy and surgery.
- ii. Larner
- a) **Lung Cancer:** The resident will have demonstrate competency in interpreting chest x-rays, chest CT scans, and PET scans; CT PET simulations; external beam techniques; dosimetry; and Stereotactic Body Radiation Therapy (SBRT). The resident will have an understanding of the role of HDR Endobronchial Brachytherapy and the role and integration of chemotherapy and surgery.
 - b) **Central Nervous System Cancer:** The resident will demonstrate competency in performing a full neurological exam; in interpreting head CT scans and MRI scans; in 3D and IMRT External Beam techniques and dosimetry including DVH analysis; in Craniospinal Irradiation (CSI); and in Spinal and Intracranial Stereotactic Radiosurgery. The resident will have an understanding of the role and techniques of GammaKnife and the role and integration of chemotherapy and surgery.
- iii. Read
- a) **Head and Neck Cancer:** The resident will demonstrate the proper examination of the cervical lymph nodes, indirect laryngoscopy, machaidoscopic examination, and competency in interpreting Head and Neck CT scans, MRI scans and PET scans. The resident will demonstrate competency in External Beam techniques and dosimetry including DVH analysis; 3D and IMRT techniques, and Brachytherapy. The resident will have an understanding of the role and integration of chemotherapy, biologically targeted therapies, and surgery.
 - b) **Skin Cancer:** The resident will demonstrate competency in identifying early skin cancers; in external beam techniques and dosimetry including DVH analysis. The resident will have an understanding of the role and integration of surgery and radiation (particularly MOHS), and of different fractionation schedules for treating melanoma, and basal cell carcinomas/ squamous cell carcinomas.
- iv. Khandelwal at Culpeper Medical Center
- a) **Head and Neck Cancer:** The resident will demonstrate the proper examination of the cervical lymph nodes, indirect laryngoscopy, machaidoscopic examination, and competency in interpreting Head and Neck CT scans, MRI scans and PET scans. The resident will demonstrate competency in External Beam techniques and dosimetry including DVH analysis; 3D and IMRT techniques, and Brachytherapy. The resident will have an understanding of the role and integration of chemotherapy, biologically targeted therapies, and surgery.

- b) **Breast Cancer:** The resident will demonstrate the proper performance of a Breast Examination; competency in interpreting Mammograms, Breast MRI, Breast U/S; and an understanding of partial and whole breast external beam techniques, dosimetry including DVH analysis, and Breast brachytherapy techniques. The resident will understand the role and integration of hormonal therapy, chemotherapy, and surgery. The resident will have understanding of the role of genetic counseling.
 - c) **Genitourinary Cancer:** The resident will demonstrate an understanding of the proper performance of a Physical Examination of the GU patient including digital examination of the prostate; competency in interpreting Abd/Pelvic CT/MRI scans and Prostate U/S; an understanding of the proper technique of dosimetry of Prostate Brachytherapy; external beam techniques and dosimetry; IMRT and 3D DVH analysis. The resident will have an understanding of the role and integration of hormonal therapy, chemotherapy, and surgery.
 - d) **Soft Tissue and Bone Cancer:** The resident will demonstrate competency in interpreting CT scans and MRI scans of the soft tissues and bone; in external beam techniques and dosimetry; and in understanding of HDR interstitial brachytherapy implants. The resident will have an understanding of the role and integration of chemotherapy and surgery.
- v. Janowski
- a) **Gastrointestinal and Liver Cancer:** The resident will demonstrate competency in interpreting Chest/Abd/Pelvic CT and MRI and in External beam techniques and dosimetry including DVH analysis. The resident will have an understanding of the potential role and side effects of XRT; and the role and integration of chemotherapy and surgery.
 - b) **Breast Cancer:** The resident will demonstrate the proper performance of a Breast Examination; competency in interpreting Mammograms, Breast MRI, Breast U/S; and an understanding of partial and whole breast external beam techniques, dosimetry including DVH analysis, and Breast brachytherapy techniques. The resident will understand the role and integration of hormonal therapy, chemotherapy, and surgery. The resident will have understanding of the role of genetic counseling.
- vi. Romano
- a) **Gynecologic Cancer:** The resident will demonstrate the correct performance of a Physical Examination of the gynecology patient in the clinic; and competency in interpreting Abd/Pelvic CT/MRI scans and PET/CT imaging. The resident will be able to discuss HDR intracavitary and interstitial brachytherapy techniques, prescription, and rationale; external beam techniques and dosimetry including DVH analysis. The resident will demonstrate an understanding of the role and integration of chemotherapy and surgery.
 - b) **Skin Cancer:** The resident will demonstrate competency in identifying early skin cancers; in external beam techniques and dosimetry including DVH analysis. The resident will have an understanding of the role and integration of surgery and radiation (particularly MOHS), and of different fractionation schedules for treating melanoma, and basal cell carcinomas/ squamous cell carcinomas.
- b. Radiation Oncology Milestone Expectations per Specific Core Competency
- i. Lymphoma – Patient Care (Showalter Rotation)
 - a) Level 1
 - Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
 - b) Level 2

- Performs a detailed and directed history and physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designates prognostic factors.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/ symptoms seen in lymphoma patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Designs blocks, contours target(s), and contours normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/symptoms seen in lymphoma patients treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Designs blocks, contours target(s), and contours normal tissues accurately. Critically evaluates treatment plan options.
 - Independently manages toxicities/ symptoms seen in lymphoma patients treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Develops special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- ii. Head and Neck – Patient Care (Read Rotation and Khandelwal Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Appropriately identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2
- Performs a detailed directed history and physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designates prognostic factors.
 - Identifies treatment options.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/symptoms seen in head and neck cancer patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Outlines an appropriate comprehensive treatment plan regarding radiotherapy and other treatment modalities.
 - Contours target(s) and normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/symptoms seen in head and neck cancer patients treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports a comprehensive treatment plan.

- Contours normal tissue and target(s) accurately. Critically evaluates treatment plan options.
 - Independently manages patients with toxicities/symptoms seen in head and neck cancer patients treated with radiotherapy
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- iii. Genitourinary (GU) – Patient Care (Showalter Rotation and Khandelwal Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2
- Performs a detailed and directed history and physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designates prognostic factors.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/ symptoms seen in GU patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Designs blocks, contours target(s), and contours normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/ symptoms seen in GU patients treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Designs blocks, contours target(s), and contours normal tissues accurately. Critically evaluates treatment plan options.
 - Independently manages toxicities/ symptoms seen in GU patients treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- iv. Palliation – Patient Care (Read Rotation)
- a) Level 1
- Acquires an accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2

- Performs a detailed directed physical examination. Performs accurate pain assessment. Integrates pathology and imaging reports. Accurately stages a patient and designate prognostic factors.
 - Recognizes toxicities/symptoms seen in the practice of palliative radiation oncology. Aware of options for pain management and end of life issues.
- c) Level 3
- Explains the main treatment options.
 - With supervision, manages patients with toxicities/symptoms seen in patients treated with palliative radiotherapy, including pain issues.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Independently manages toxicities/symptoms seen in patients treated with palliative radiotherapy.
 - Develops appropriate and effective pain management strategy that requires no modification by attending.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- v. Breast – Patient Care (Khandelwal Rotation and Janowski Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life threatening conditions.
- b) Level 2
- Performs a detailed directed physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designate prognostic factors.
 - List organs at risk. Understands proper patient positioning and immobilization.
- c) Level 3
- Explains the main treatment options.
 - Contours target(s) and normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Contours normal tissue and target(s) accurately. Critically evaluates treatment plan options.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- vi. Gastrointestinal (GI) – Patient Care (Janowski Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.

- Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2
- Performs a detailed directed physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designates prognostic factors.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/symptoms seen in GI cancer patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Contours target(s)/normal tissues and delineates field borders with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/symptoms seen in GI cancer patients treated with radiotherapy while.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Contours target(s)/normal tissues and delineates field borders accurately. Critically evaluates treatment plan options.
 - Independently manages patients with toxicities/symptoms seen in GI cancer patients treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- vii. Gynecologic (GYN) – Patient Care (Romano Rotation and Showalter Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Appropriately identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2
- Performs a detailed directed physical examination. Integrates pathology and imaging reports. Accurately stage a patient and designates prognostic factors.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/symptoms seen in GYN cancer patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options which may include may include observation or radiation.
 - Contours target(s) and normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/symptoms seen in GYN cancer patients treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.

- Describes details of radiation therapy. Cites evidence based practice guidelines or institutional standards.
 - Contours normal tissue and target(s) accurately. Critically evaluates treatment plan options.
 - Independently manages patients with toxicities/symptoms seen in GYN cancer patients treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- viii. Lung – Patient Care (Larner Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2
- Performs a detailed directed physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designate prognostic factors.
 - Lists organs at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/ symptoms seen in lung cancer patients treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Contours target(s) and normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages patients with toxicities/symptoms seen in lung cancer patients treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Contours normal tissue and target(s) accurately. Critically evaluates treatment plan options.
 - Independently manages patients with toxicities/symptoms seen in lung cancer patients treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- ix. Adult Brain Tumor – Patient Care (Larner Rotation)
- a) Level 1
- Acquires accurate and relevant history and performs a general physical examination.
 - Identifies relevant anatomy.
 - Recognizes situations with a need for urgent or emergent medical care, including life-threatening conditions.
- b) Level 2

- Performs a detailed directed physical examination. Integrates pathology and imaging reports. Accurately stages a patient and designate prognostic factors.
 - Lists normal tissue at risk. Understands proper patient positioning and immobilization.
 - Recognizes toxicities/ symptoms seen in patients with brain tumors treated with radiotherapy.
- c) Level 3
- Explains the main treatment options.
 - Contours target(s) and normal tissue with minimal inaccuracies. States appropriate dose planning objectives for normal tissues and target(s).
 - With supervision, manages toxicities/symptoms seen in patients with brain tumors treated with radiotherapy.
- d) Level 4
- Makes a comprehensive treatment recommendation that is appropriate. Describes evidence that supports the treatment plan.
 - Contours normal tissue and target(s) accurately. Critically evaluates treatment plan options.
 - Independently manages patients with toxicities/symptoms seen in patients with brain tumors treated with radiotherapy.
- e) Level 5
- Conducts clinical research.
 - Special expertise to treat and manage the most complex cases.
 - Develops protocols to minimize toxicities/ symptoms *or* has an exceptional understanding of management of toxicities/symptoms.
- x. Brachytherapy – Patient Care (Showalter Rotation and Romano Rotation)
- a) Level 1
- Observes patients undergoing brachytherapy.
- b) Level 2
- Selects appropriate patients and understands relevant radiation safety protocols and procedures.
- c) Level 3
- Plans and performs brachytherapy with minimal faculty assistance.
- d) Level 4
- Able to independently plan and perform brachytherapy appropriately.
- e) Level 5
- Exceptional technical performance of brachytherapy.
- xi. Stereotactic Radiosurgery (SRS)/Stereotactic Body Radiotherapy (SBRT) – Patient Care (Larner Rotation)
- a) Level 1
- Observes patients undergoing SRS/SBRT.
- b) Level 2
- Selects appropriate patients and understands relevant radiation safety protocols and procedures.
- c) Level 3
- Plans and performs SRS/SBRT with minimal faculty member assistance.
- d) Level 4
- Is able to independently plan and perform SRS/SBRT appropriately.
- e) Level 5
- Conducts clinical research.
- xii. Medical Physics – Medical Knowledge (Physics/Dosimetry Rotation)
- a) Level 1

- Recognizes the importance of medical physics in radiation oncology.
- b) Level 2
 - Understands basic concepts of medical physics.
- c) Level 3
 - Applies concepts of medical physics to clinical situations.
- d) Level 4
 - Thoroughly understands medical physics concepts for safe delivery of radiation therapy.
- e) Level 5
 - Performs medical physics research.
- xiii. Radiation/Cancer Biology – Medical Knowledge (Larner Rotation)
 - a) Level 1
 - Recognizes the importance of radiation/cancer biology in radiation oncology.
 - b) Level 2
 - Understands basic concepts of radiation/cancer biology.
 - c) Level 3
 - Applies concepts of radiation/cancer biology to clinical situations.
 - d) Level 4
 - Thoroughly understands radiation/cancer biology concepts for safe delivery of radiation therapy.
 - e) Level 5
 - Performs radiation/cancer biology research.
- xiv. Professionalism 1 (All Rotations)

Compassion, integrity, and respect for others as well as sensitivity and responsiveness to diverse patient populations including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; Knowledge about, respect for and adherence to the ethical principles relevant to the practice of medicine, remembering in particular that responsiveness to patients that supersedes self-interest is an essential aspect of medical practice.

 - a) Level 1
 - Seeks out, learns from and models the attitudes and behaviors of physicians who exemplify appropriate professional attitudes, values and behaviors; includes caring, honest, genuine interest in patients and families and tolerance and acceptance of diverse individuals and groups.
 - Aware of basic bioethical principles; able to identify ethical issues in clinical situations.
 - b) Level 2
 - Exhibits appropriate attitudes, values and behaviors in straightforward situations; includes caring, honest, genuine interest in patients and families and tolerance and acceptance of diverse individuals and groups.
 - Consistently recognizes ethical issues in practice; able to discuss, analyze and manage in common clinical situations.
 - c) Level 3
 - Exhibits appropriate attitudes, values and behaviors in most situations; includes caring, honest, genuine interest in patients and families and tolerance and acceptance of diverse individuals and groups.
 - Effectively analyzes and manages ethical issues in most clinical situations.
 - d) Level 4
 - Exhibits appropriate attitudes, values and behaviors in all situations; includes caring, honest, genuine interest in patients and families and tolerance and acceptance of diverse individuals and groups.

- Consistently and effectively analyzes and manages ethical issues in all clinical situations.
- e) Level 5
- Develops a protocol to support the application of physician accountability or personal responsibility.
 - Publishes or presents research on physician accountability or personal responsibility.
- xv. Professionalism 2 (All Rotations)
 Accountability to patients, society and the profession; personal responsibility to maintain emotional, physical, and mental health
- a) Level 1
- Recognizes when in need of assistance and is able and willing to ask for help.
 - Understands the importance of physician accountability to patients, society and the profession.
 - Aware of the basic principles and aspects of the general maintenance of emotional, physical, and mental health, including issues of fatigue.
- b) Level 2
- Consistently recognizes limits of knowledge in common clinical situations and asks for assistance.
 - Demonstrates physician accountability to patients, society and profession in common clinical situations.
 - Identifies and manages common situations in which maintaining personal emotional, physical and mental health, including issues of fatigue, are challenged.
- c) Level 3
- Consistently recognizes limits of knowledge in most clinical situations.
 - Demonstrates physician accountability to patients, society, and profession in most clinical situations.
 - Identifies and manages most situations in which maintaining personal emotional, physical and mental health, including issues of fatigue, are challenged.
- d) Level 4
- Consistently demonstrates the ability to identify limits of own knowledge in all clinical situations.
 - Demonstrates physician accountability to patients, society, and profession in all clinical situations.
 - Identifies and manages all situations in which maintaining personal emotional, physical and mental health, including issues of fatigue, are challenged.
- e) Level 5
- Develops a protocol to support the application of physician accountability or personal responsibility.
 - Publishes or presents research on physician accountability or personal responsibility.
- xvi. Interpersonal and Communication Skills 1 (All Rotations)
 Effective communication with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; effective communication with physicians, other health care professionals and health related agencies.
- a) Level 1
- Recognizes the importance of effective communication with patients, families, and public.
 - Recognizes the importance of effective communication with the healthcare team.
- b) Level 2
- Demonstrates effective communication with patients, families, and public in common situations.

- Demonstrates effective communication with the healthcare team in common situations.
- c) Level 3
- Demonstrates effective communication with patients, families, and public in most situations.
 - Demonstrates effective communication with the healthcare team in most situations.
- d) Level 4
- Demonstrates effective communication with patients, families, and public in all situations.
- e) Level 5
- Publishes or presents research on interpersonal communication.
 - Develops a protocol for physician interpersonal communication.
- xvii. Interpersonal and Communication Skills 2 (All Rotations)
Effective member or leader of a healthcare team or other professional group; maintenance of comprehensive, timely and legible medical records.
- a) Level 1
- Recognizes the importance of working effectively as a member of a healthcare team.
 - Recognizes the importance of maintaining timely and legible records, including HER.
- b) Level 2
- Demonstrates the ability to effectively work as a member of a healthcare team, including the consultative role, in common clinical situations.
 - Maintains accurate, timely and legible records, including EHR, for some cases.
- c) Level 3
- Demonstrates the ability to effectively work as a member of a healthcare team, including the consultative role, in most clinical situations.
 - Maintains accurate, timely and legible records, including EHR, for most cases.
- d) Level 4
- Demonstrates the ability to effectively work as a member of a healthcare team, including the consultative role, in all clinical situations.
 - Maintains accurate, timely and legible records, including EHR, in all cases.
- e) Level 5
- Publishes or presents research on teamwork or record maintenance.
 - Develops a protocol for teamwork or record maintenance.
- xviii. Practice-Based Learning and Improvement 1 (All Rotations)
Identify strengths, deficiencies, and limits in one's knowledge and expertise; Set learning and improvement goals and identify and perform appropriate learning activities utilizing information technology, evidence from scientific studies and evaluation feedback. Systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement.
- a) Level 1
- Acknowledges gaps in personal knowledge and expertise and frequently asks for feedback.
 - Understands the importance of setting learning and improvement goals.
 - Can identify problems in health care delivery and see the quality gap in care.
- b) Level 2
- Begins to assess performance by evaluating feedback and assessments.
 - Begins to develop learning and improvement goals, based on feedback, with some external assistance.

- Uses information technology to locate scientific studies related to patient health problems.
 - Understands the essentials of quality improvement.
- c) Level 3
- Frequently assesses performance by evaluating feedback and assessments.
 - Develops learning and improvement goals based on feedback, with minimal external assistance.
 - Critically appraises scientific studies related to patient health problems.
 - Is able to define and construct process and outcomes measures of quality.
- d) Level 4
- Always assesses performance by evaluating feedback and assessments.
 - Performs self-directed learning independently.
 - Assimilates evidence from scientific studies into practice.
 - Designs and completes a quality improvement project.
- e) Level 5
- Publishes research on practice quality improvement.
- xix. Practice-Based Learning and Improvement 2 (All Rotations)
Participate in the education of patients, families, students, residents and other health professionals.
- a) Level 1
- Understands the importance of the education of patients, families, students, residents, and other health professionals.
- b) Level 2
- Participates in the education of patients and their families in common situations.
- c) Level 3
- Participates in the education of patients and their families, students, residents, and other health professionals in common situations.
- d) Level 4
- Participates in the education of patients and families, students, residents, and other health professionals in all situations.
- e) Level 5
- Publishes research on patient education.
 - Develops a protocol for educating patients.
- xx. Systems-Based Practice 1 (All Rotations)
Work and coordinate patient care effectively in various health care delivery settings and systems.
- a) Level 1
- Recognizes various health care delivery settings and systems.
- b) Level 2
- Works and coordinates patient care in various health care delivery settings and systems for common clinical situations.
- c) Level 3
- Works and coordinates patient care in various health care delivery settings and systems for most clinical situations.
- d) Level 4
- Works and coordinates patient care in various health care delivery settings and systems for all clinical situations.
- e) Level 5
- Publishes research on coordinating patient care in various health care delivery settings and systems.
- xxi. Systems-Based Practice 2 (All Rotations)

Incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population based care, as appropriate.

- a) Level 1
 - Recognizes the importance of cost awareness and risk-benefit analysis for patient and /or population based care.
- b) Level 2
 - Incorporates considerations of cost awareness and risk-benefit analysis for patient and /or population based care for common clinical situations.
- c) Level 3
 - Incorporates considerations of cost awareness and risk-benefit analysis in patient and /or population based care for most clinical situations.
- d) Level 4
 - Incorporates considerations of cost awareness and risk-benefit analysis for patient and /or population based care for all clinical situations.
- e) Level 5
 - Publishes research on cost awareness and risk-benefit analysis for patient and /or population based care.

xxii. Systems-Based Practice 3 (All Rotations)

Work in interprofessional teams to enhance patient safety and improve patient care quality; advocate for quality patient care and optimal patient care systems; participate in identifying system errors and implementing potential systems solutions.

- a) Level 1
 - Recognizes the importance of working in inter-professional teams to enhance patient safety and improve patient care quality.
 - Recognizes the importance of advocating for quality care and optimal patient care systems.
 - Recognizes the importance of participating in identifying system errors and implementing potential systems solutions.
- b) Level 2
 - Works in inter-professional teams to enhance patient safety and improve patient care quality in common clinical situations.
 - Advocates for quality care and optimal patient care systems in common clinical situations.
 - Participates in identifying system errors and implementing potential systems solutions in common clinical situations.
- c) Level 3
 - Works in inter-professional teams to enhance patient safety and improve patient care quality, in most clinical situations.
 - Advocates for quality care and optimal patient care systems in most clinical situations.
 - Participates in identifying system errors and implementing potential systems solutions in most clinical situations.
- d) Level 4
 - Works in inter-professional teams to enhance patient safety and improve patient care quality, in all clinical situations.
 - Advocates for quality care and optimal patient care systems in all clinical situations.
 - Participates in identifying system errors and implementing potential systems solutions in all clinical situations.
- e) Level 5
 - Publishes research on quality patient care or patient safety.

2. Required Elective Rotations

- a. Physics / Dosimetry Rotation (1 month required)
 - i. The curriculum in medical physics will include didactic lectures, laboratory demonstrations of radiation safety procedures, calibration of radiation therapy machines, the use of the computer for treatment planning, the construction of treatment aids, and the safe handling of sealed radionuclides. The safe handling of unsealed radionuclides will address quality control procedures for instruments used to determine the activity of dosages and procedures used to perform checks for proper operation of survey meters.
 - ii. Patient Care
 - a) Resident learns the basic physics QA to ensure safe treatment of patients, how to perform a hand calculation for emergency treatment, and the basic operation of dosimetry software for 3D and IMRT treatment planning.
 - iii. Medical Knowledge
 - a) Resident should learn a basic understanding of review of survey meters, types and uses, Physics chart checks, Physics QA for HDR and LDR, Physics QA for IMRT, LINAC maintenance and QA, and radiopharmaceutical QA, dosing, and administration.
 - iv. Practice Based Learning and Improvement
 - a) Resident recognizes and corrects personal errors. Resident can perform a literature search on specific physics topics.
 - v. Interpersonal Skills and Communication
 - a) Resident demonstrates ability to ask appropriate questions.
 - vi. Professionalism
 - a) Resident demonstrates a commitment to dress professionally at all times and to ethical business practice.
 - vii. Systems Based Practice
 - a) Resident demonstrates an understanding of the role of physicists and dosimetrists in the treatment of patients with radiation.
- b. Gamma Knife Rotation (1 month required)
 - i. Patient Care
 - a) Resident learns how the headframe placement, imaging, treatment planning, and treatment delivery are performed, emergency procedures for the GammaKnife™, acute and late toxicity of and intracranial radiosurgery.
 - ii. Medical Knowledge
 - a) Resident should learn a basic understanding of indications for Intracranial Radiosurgery, how the GammaKnife™ works to deliver conformal radiosurgery, dose distributions possible with a GammaKnife™ unit, and limitations of the GammaKnife™ treatment system.
 - iii. Practice Based Learning and Improvement
 - a) Resident recognizes and corrects personal errors. Resident can perform a literature search on specific radiosurgery topics.
 - iv. Interpersonal Skills and Communication
 - a) Resident demonstrates ability to ask appropriate questions.
 - v. Professionalism
 - a) Resident demonstrates a commitment to dress professionally at all times and to ethical business practice.
 - vi. Systems Based Practice
 - a) Resident demonstrates an understanding of the costs of GammaKnife™ radiosurgery and the role of physicists, neurosurgeons, and radiation oncologists in the treatment of patients with the GammaKnife™.
- c. Nuclear Medicine Rotation (1 month required)
 - i. Residents will need to request this rotation to the Program Coordinator who will request from the Radiology Program Coordinator available dates. Residents on this rotation will schedule a meeting with Dr. Patrice Rhem one month prior to their rotation to discuss the specifics of the rotation. Residents on this rotation will need Powerscribe training

(Radiology dictation system) 1-2 weeks before the Nuclear Medicine rotation. Resident must have the IT request form for EPIC Radiant training at least a week before the start date.

- ii. American Board of Radiology and NRC, regulations state: For ABR certification graduating residents must perform at least three (3) cases involving oral administration of >33 mCi of I-131 (i.e., therapeutic dose rather than a diagnostic procedure) and three (3) cases involving parenteral administration of any beta. Also, there must be classroom and laboratory instruction in the use of radiopharmaceuticals. (This regulation will be accomplished by a one month Nuclear Medicine rotation. Additional experience may be gained in radiation oncology specific rotations.)
- iii. This rotation may be waived by the Program Director in the event that all six (6) required cases are completed prior to the start of the PGY-5 year. The completed [Oral I-131 & Parenteral Administration Log](#) form must be turned in to the Program Coordinator in order for this to occur.
- iv. Patient Care
 - a) Resident learns the indications for various therapeutic nuclear medicine isotopes, the safe handling, dosing, and administration of therapeutic nuclear medicine isotopes, and doses which require inpatient hospitalization. Resident can verbalize the instructions to patients who leave the nuclear medicine department and explain the instructions to the patient on how to minimize radioactivity exposure and contamination to him/herself and others. Resident demonstrates an understanding of acute and late toxicity of therapeutic nuclear medicine isotopes.
- v. Medical Knowledge
 - a) Resident should demonstrate a basic understanding of Physical and Biologic half-lives of therapeutic nuclear medicine isotopes and mechanism of action of therapeutic nuclear medicine isotopes. Resident should learn dose distributions (if applicable) of therapeutic nuclear medicine isotopes. Resident should be able to verbalize the limitations of therapeutic nuclear medicine isotope.
- vi. Practice Based Learning and Improvement
 - a) Resident recognizes and corrects personal errors. Resident can perform a literature search on specific nuclear medicine topics.
- vii. Interpersonal Skills and Communication
 - a) Resident demonstrates the ability to ask appropriate questions.
- viii. Professionalism
 - a) Resident demonstrates a commitment to dress professionally at all times and to ethical business practice.
- ix. Systems Based Practice
 - a) Resident demonstrates an understanding of the role of nuclear medicine radiologists and radiation oncologists in the safe and appropriate administration of isotopes. Resident understands the medical costs of therapeutic nuclear medicine isotopes.

ii. Regularly Scheduled Didactic Teaching

1. Conferences and didactic teaching will be provided as described below:
 - a. Conferences will be attended by residents, radiation oncologists, physicists, dosimetrists, therapists, and other staff as deemed necessary.
 - b. Attendance will be kept at departmental conferences with a written attendance sheet, and by checking the appropriate competency(ies) being covered.
2. Simulation Conference/Journal Club which will:
 - a. be held bi-weekly
 - b. be a review of treatment simulation and planning of patients whose treatment plans have been completed the previous week, and the list will be available in Mosaic.
 - c. be moderated by resident/s (or attending/s, when no resident was involved)
 - i. all new clinical and computer-aided curative simulations
 - ii. palliative initial simulations

- iii. boost simulations
 - iv. brachytherapy cases
 - d. have the dual purpose of an educational discussion and peer review
 - e. be an open discussion to determine the residents' understanding and ability to discuss the disease process being treated and justification of the design of the target volumes, treatment fields, and all aspects of the treatment plan.
 - f. where the Faculty will be expected to test the knowledge of the residents, provide teaching points and useful comments, and lead a positive and constructive discussion.
 - g. be where the resident at CMC is responsible for presenting the CMC simulations
 - h. be where cases with significant changes (recommended by consensus) in the treatment plan will be re-presented after appropriate modifications for peer review
 - i. Journal Club presentation will be 10-15 minutes on Thursdays (designated at the beginning or end of the SIM conference). It will consist of a short presentation (of a recent high impact journal article/s) selected by a resident or an attending, pertaining to patients presented at simulation conference, emphasizing a large randomized clinical trial result/s, published within the last 5 years. They will discuss new treatment modalities (technology advances, translational research, orphan (low incidence) diseases and other review articles) and the study design (including potential study flaws and the appropriateness of the statistical analysis). Chief Resident/s will organize the presentation schedule and document the presentation.
 - j. Two attending faculty must be present for the majority of simulation conference and journal club presentations.
3. Clinical Didactic Lectures
- a. The clinical didactic lectures will cover site-specific malignancies and their current oncology management; cancer presentation, etiologic risk factors (including molecular biological factors); diagnostic work-up, staging, prognosis, risk of lymphatic and hematogenous spread; current treatment options including the integration of combined modality therapies, simulation and treatment planning, radiation therapy including altered fractionation regimens, radiosurgery, brachytherapy; expected acute reactions and late sequelae, normal tissue tolerances within the treatment field, tumor-dose response, dose prescription, and expectations of local control and survival; and core medical knowledge, where the faculty is expected to discuss particular biomedical ethics and aspects of the medical system that pertain to the cancer site; the sentinel scientific studies from which the current treatment regimens have evolved, but are not to be formatted as a Journal Club.
 - b. The lecture format should be partially didactic and partially Socratic Method with a strong component of appropriate resident questioning directed at the level of the resident as described in the Medical Knowledge Competency Milestone expectations.
4. The basic sciences will be taught through regularly-scheduled lectures, case presentations, conferences, and discussions relevant to the practice of radiation oncology. The department will provide funding for residents to attend national training conferences such as the University of Maryland Department of Radiation Oncology Resident Physics and Radiobiology Conference.
- a. Radiation Physics
 - i. Initially, all residents are required to take the UVA Radiation Safety Course given during the first month of the training program; pass the final examination to document competency in basic radiation safety, including, the safe handling of unsealed sources, the quality control procedures for instruments used to determine the activity of dosages, and procedures used to perform checks for proper operation of survey meters.
 - ii. The residents are required to attend physics lectures during their first and second years. These lectures will be provided by the Division of Medical Radiation Physics.
 - iii. These didactic lectures will cover radiation safety and radiation physics for both x-ray and electron external beam therapy and brachytherapy, and dose calculation, dosimetry, tissue penetration, effects of blocks and wedges, the functioning of a linear accelerator

- and brachytherapy afterloading devices, handling of sealed and unsealed radioactive sources, manual afterloading techniques, and radiation emergency procedures.
- iv. *The Physics of Therapeutic Radiology Syllabus & Study Guide*; Revised by S. K. Agarwal, Ph.D.; 2000; 5th Edition; American Association of Physicists in Medicine and American College of Radiology; is used as the syllabus for this course.
 - v. *The Physics of Radiation Therapy*; Faiz M. Khan, Ph.D.; John P. Gibbons, Ph.D.; 2014; 5th Edition; Lippincott Williams & Wilkins; and *Practical Radiation Oncology Physics*; Sonja Dieterich, Eric Ford, Dan Pavord, Jing Zheng; 2016; Elsevier; are the other books used as references for this class.
 - vi. Residents should take this didactic course again if they perform in the bottom quartile on the physics component of the annual In-Service Examination. Residents are welcome to attend the entire course or specific portions of the course during their final two years if they feel there are areas that they wish to improve.
 - vii. Junior Residents will be sent to the national radbio and physics refresher course annually held at the University of Maryland.
 - viii. The resident's knowledge level will be assessed with the annual ACR In-Service Examination all years of residency and the RAPHEX exam for the first three years of their residency. They will take the ABR Board examination in radiation physics at the beginning of their fourth year of training as another metric of accomplishment.
- b. Radiobiology
- i. The radiation and cancer biology lectures will be held in the spring of every year. A full, 17 lecture, course in odd numbered years; and a condensed, 6 lecture, course in even years.
 - ii. The curriculum must include didactic lectures on all aspects of radiation effects on normal and neoplastic tissues, as well as the fundamental biology of the causes, prevention, and treatment of cancer. The basics of radiobiology will be broken down into classical radiobiology including normal tissue tolerance to radiation and tumor dose response, molecular techniques, and molecular basis of carcinogenesis, including signal transduction. Covered in a didactic lecture series as outlined in *Radiobiology for the Radiologist* / Eric J. Hall and Amato J. Giaccia. 7th ed. 2011 by Lippincott Williams & Wilkins (the required text for this course).
 - iii. The clinical relevance of radiobiology will be emphasized. The residents are expected to attend Cancer Center Seminars that cover radiobiology topics. The residents will be required to attend Radiobiology lectures for the first two years of their residency and may elect to attend during the final two years. Junior Residents will be sent to the national radbio and physics refresher course annually held at the University of Maryland.
 - iv. The resident's knowledge level will be assessed with the annual ACR In-Service Examination every year of their residency and the ASTRO Radiobiology Review Exam the first three years of residency. They will take the ABR Board examination in radiobiology at the beginning of their fourth year of training as another metric of accomplishment.
- c. Medical Biostatistics
- i. The program will familiarize the resident with medical statistics through an organized program of lectures held every other year (even numbered years) in the spring. The 6 lectures on basic medical statistics given by UVA biostatisticians will include the basics of clinical research.
 - ii. The resident will be taught basic statistical methods of research design and analysis; so, they can critically review literature and perform the statistics on their Investigative Projects. These lectures will form a crucial foundation for future Practice Based Learning and Improvement.
5. Other Conferences: Residents are required to attend, prepare for, and participate in,
- a. Multi-Disciplinary Tumor Board Conferences
 - i. The residents are expected to attend the Multi-Disciplinary Tumor Board Conferences for their current clinical rotation per the [TB schedule](#) provided. All residents are encouraged to ask pertinent questions at these Tumor Boards. Senior residents are expected to take

an active part in the discussions at tumor boards. Tumor Boards are used to teach tumor histopathology, neoplastic findings on diagnostic radiology studies, and how interdisciplinary specialists communicate and use their discussions and interactions to benefit patient care.

- b. Morbidity and Mortality Conference (M & M)
 - i. Morbidity (defined as RTOG grade 4-5 complications, prolonged hospitalization, or other serious but non-lethal complications that arises as a direct result of radiation therapy) and Mortality (defined as any death that is felt to be a direct result of radiation therapy or combined modality therapy that involves radiation)
 - ii. M & M conference will be held 3-4 times per year and organized by the third year resident/s as part of their QA responsibilities.
 - iii. Residents should keep a list of patients with significant morbidity or mortality and give the list to 3rd year before M&M (appropriate information will be obtained). All records of this conference will be confidential.
- c. Monthly Clinical Trials Meeting
 - i. Held the first Thursday of each month after Sim Conference (8:30 to 9:00 AM ECCCC G253). Will be attended by the 2nd year residents.
- d. GME Institutional Core Lecture Series
 - i. The UVA GME office provides a seminar lecture series that covers core ACGME required lectures. It is the 2nd Wednesday of each month from 7:00 – 8:00 AM. Residents who attend 12 hours annually will receive a certificate.
 - ii. The UVA radiation oncology residents must attend the ACGME required lectures and are strongly encouraged to attend the other lectures.
- e. Residents are encouraged to attend Medical Center Hour, regional and national meetings to enhance their training.
- f. Residents must be aware of the [Current Lecture / Tumor Board Schedule](#).
- g. Opioid prescribing CME. Residents are required to complete annual CME credits on opioid prescribing and deterrence of abuse to maintain VA medical licensure. The Medical Director circulates a reminder each year for the requirement, including links to online resources. Due to the timeliness and importance of this topic, live lectures are also frequently available at UVA. This is a CME requirement for all physicians, including UVA faculty, and UVA requires this of all providers. UVA offers a 2 hour version through CME Village (www.cmevillage.com) that is available online at any time to provide credits.

VIII. Residency Documentation Process

A. The Main Residency Documentation will include:

1. Residency Program Guidelines and Requirements
2. Lecture / Tumor Board Schedule & Faculty and Resident Call Schedules
3. Physics Lecture Attendance
4. Radiobiology and Statistics Lecture Schedule and Attendance
5. Clinical Didactic Lecture & Grand Rounds Schedule and Attendance
6. Simulation Conference/Journal Club Attendance
7. Other Presentations and Attendance
8. M&M Conference and Visiting Professor Attendance
9. Resident Meeting Minutes
10. PEC, CCC, and other Meeting Minutes
11. Evaluation Forms
12. Correspondence
 - a. UVA GME correspondence and Internal Reviews and Responses
 - b. ACGME correspondence and Site Visit Reviews and Responses
 - c. NRMP/ERAS data including the rank order list

B. The Resident Documentation will contain:

1. Residency Requirement Checklist

2. Residency Program Guidelines for Rad Onc
3. Professional Information
4. Leave Requests & Calendars of Attendance
5. Rotation Schedules & Resident Call Schedule
6. Resident Patient Logs
7. Resident Research Project Information
8. In-service Exams, Raphex Exam, & Radiobiology Exam Scores
9. Journal Club & Other Presentations
10. Mock Oral Board & ABR Scores
11. Evaluations of the Residents
12. Program Director Evaluations & Residency Confirmations

C. This documentation will be kept in the Program Coordinator's office and is available for inspection.

Residents and Faculty are required to review the 2019 – 2020 Residency Guidelines and return this signed and dated form to the Program Director or Program Coordinator.

I have read the 2019 – 2020 UVA Radiation Oncology Residency Guidelines, I understand them fully, and I agree to participate in the UVA Radiation Oncology Residency Program in compliance with them.

Signature: _____

Date: _____

Print Name: _____

CURRENT LECTURE / TUMOR BOARD SCHEDULE

(revised 5/01/19)

<u>Monday</u>	8:00 – 9:00 AM 12:00 – 1:00 PM 12:00 – 1:00 PM	Simulation Conference (ECCCC Conference Room G253) Culpeper Tumor Board (4 th Monday each month) Resident Lecture (ECCCC Conference Room G253)
<u>Tuesday</u>	7:00 – 8:00 AM 7:30 – 8:30 AM 4:00 – 5:00 PM	Thoracic Tumor Board (ECCCC Conference Room 3303) Head & Neck ENT Tumor Board (Riggs Auditorium) Thyroid Cancer Meeting (last Tuesday of each month) (CA Center Conference Room 6191)
<u>Wednesday</u>	7:00 – 7:50 AM 7:00 – 8:00 AM 7:00 – 9:00 AM 7:00 – 8:00 AM 8:00 – 9:00 AM 12:00 – 1:00 PM 12:00 – 1:00 PM 4:00 – 5:00 PM	GME Core Lecture Series (2 nd Wednesday of each month) (Educational Resource Center Conference Room) Physics Lecture (ECCCC Physician Work Room G080) GU Tumor Board (ECCCC Conference Room G253) Neuro- Onc Tumor Board (2 nd Wednesday of each month) (West Complex, Barringer 3, Room 3450) Neuropathology/Neuroradiology (1 st Weds of each month) (Neurosurgery Conference Room, Barringer 3 rd Floor) Resident Lecture (ECCCC Conference Room G253) Sarcoma Conference (ECCCC Conference Room 3303) GYN Tumor Board (ECCCC Conference Room 3303)
<u>Thursday</u>	6:45 – 8:15 AM 7:30 – 9:00 AM 11:00a – 12:15PM 4:00 – 5:00 PM 4:00 – 5:00 PM	GI Tumor Board (CA Center Conference Room 6191) Simulation Conference / Journal Club / Clinical Trials (Clinical Trials 1 st Thursday only) (ECCCC Conference Room G253) Hematopathology Conference (Bone Marrow Reading Room 4231) Physics Lecture (ECCCC Conference Room G253) Pediatric Tumor Board (1 st Thursday of each month) (ECCCC Conference Room 3303)
<u>Friday</u>	7:30 – 8:30 AM 8:00 – 9:00 AM 11:15a – 12:15PM 12:00 – 1:30 PM 12:00 – 1:00 PM 12:30 – 1:30 PM 1:30 – 3:00 PM 3:30 – 4:30 PM	Palliative/Supportive Care Tumor Board (ECCCC 3303) Clinical Didactic Lecture (ECCCC Conference Room G253) Neuro-Onc/Brain Mets TB (1 st and 3 rd Fridays each month) (Hospital Expansion (HEP) 3 rd Floor, Room 3025) Hem/Onc Grand Rounds (CA Center Conference Room) Resident Lecture (ECCCC Conference Room G253) Cancer Center Seminar (McKim Hall Auditorium) Breast Tumor Board (ECCCC Conference Room 3303) Hepatocellular Tumor Board (Endoscopy Classroom)

*Note: Pathology and Diagnostic Radiology teaching will be provided at multi-disciplinary oncology tumor board conferences where the pathologist and radiologists will review the results of pertinent studies.

Resident Oral Examination – Radiation Oncology

Date of Exam: _____ Resident: _____ PGY X – 1st 2nd 3rd 4th year Rad Onc
 Examiner: _____ Cancer Sites Evaluated: _____

Please provide a score for the resident’s performance for each case (circle best answer).

Case 1: _____ Comments: _____

Level 1		Level 2		Level 3		Level 4		Level 5
1	1.5	2	2.5	3	3.5	4	4.5	5

Case 2: _____ Comments: _____

Level 1		Level 2		Level 3		Level 4		Level 5
1	1.5	2	2.5	3	3.5	4	4.5	5

Case 3: _____ Comments: _____

Level 1		Level 2		Level 3		Level 4		Level 5
1	1.5	2	2.5	3	3.5	4	4.5	5

Overall: Please provide a score for the resident’s overall performance (circle best answer).

Level 1		Level 2		Level 3		Level 4		Level 5
1	1.5	2	2.5	3	3.5	4	4.5	5

****Scoring Key:**

- Level 1:** The resident demonstrates milestones expected of an incoming resident.
- Level 2:** The resident is advancing and demonstrates additional milestones, but is not yet performing at a mid-residency level.
- Level 3:** The resident continues to advance and demonstrate additional milestones, consistently including the majority of milestones targeted for residency.
- Level 4:** The resident has advanced so that he or she now substantially demonstrates the milestones targeted for residency. This level is designed as the graduation target.
- Level 5:** The resident has advanced beyond performance targets set for residency and is demonstrating “aspirational” goals which might describe the performance of someone who has been in practice for several years. It is expected that only a few exceptional residents will reach this level.

 Faculty signature

 Resident signature



**Department of Radiation Oncology
 Agreement on Housestaff Extramural Professional Activities
 (Moonlighting Agreement 2019 – 2020)**

I, _____ recognize that extramural professional activities are not widely endorsed by the Department of Radiation Oncology. I recognize that graduate medical education is a fulltime educational experience that involves teaching, as well as patient care. However, I feel the need for extramural professional activities due to financial responsibilities.

I recognize that the Department does not openly endorse these activities but does not prohibit them. I clearly recognize that I must provide my own professional liability insurance, as well as, have a permanent license to practice medicine in the Commonwealth of Virginia. It is recognized that this form will be used to inform the Department of my moonlighting activities and my recognition of my liability and responsibilities.

Per Radiation Oncology Guidelines, I will be allowed to work up to a maximum of 3 shifts per month at Western State Hospital without having to use vacation time-- as long as there is no detrimental impact on my residency training. I cannot moonlight when I am on call for the UVA Department of Radiation Oncology. If it is felt that moonlighting is adversely affecting my education, the Program Director and/or the Chairman will request that I stop all moonlighting activities.

I know that Moonlighting cannot begin at Western State Hospital until the above requirements have been met and this form has been signed. I understand that my performance will be monitored for the effect of these activities and that adverse effects may lead to withdrawal of permission to "moonlight". I recognize that engaging in unauthorized extramural professional activities may result in penalties or severe disciplinary action that may include dismissal from the residency program.

Resident

Date

Einsley Janowski, MD, PhD, Program Director

Date

James Larner, MD, Chairman

Date



**Department of Radiation Oncology
Residency Training Program
Policy on Board Eligibility**

The Department of Radiation Oncology requires each trainee to be aware of issues related to requirements for board eligibility as stated in the guidelines in the "[UVA Radiation Oncology Residency Program Introduction-Section C](#)".

Trainees may find information relating to Board eligibility in Radiation Oncology here:

<https://www.theabr.org/radiation-oncology/initial-certification/initial-certifications-requirements/board-eligibility>

Trainees must be aware, specifically about the effect of leaves of absence, for any reason, on satisfying the criteria for completion of the training program. That information may be found here: <https://www.theabr.org/radiation-oncology/initial-certification/program-administration>

Effective: Date: February 1, 2010
Revised: May 9, 2013



PHYSICIAN POLICY

- A. SUBJECT: **Resident Supervision**
- B. EFFECTIVE DATE: 11/3/2014
- C. POLICY: This policy details resident supervision for clinical activities in the Department of Radiation Oncology, including all clinical sites. This is a clinical policy that summarizes more detailed policy from the residency program manual (available from the Program Director or Program Coordinator, stored on the Share Drive).

- D. PROCEDURE: This policy applies generally, but specific topics that warrant special mention include:
1. Image-guidance review by residents
 2. Authorized User status for HDR brachytherapy (Ir-192 source)
 3. Authorized User status for Gamma Knife radiosurgery

General: Resident physicians are a part of the team in the Department of Radiation Oncology. Residents practice under the supervision of Attending Physicians. Resident responsibility is increased gradually during the residency, as appropriate, and is described in detail in the UVA Radiation Oncology Residency guidelines. The radiation oncology policies for resident supervision are consistent with the UVA [GME Policy #12](#), which is included in the residency guidelines as an appendix item. Although residents may draft notes for patient consultation, simulation, treatment planning, and follow up, an Attending's review, editing and approval is required for each document. If the Attending physician has determined, based on evaluating the resident in the clinic, that it is appropriate, the resident may evaluate on-treatment patients to assist with management of toxicity or other medical problems. However, the Attending physician is required to see all patients with the residents and to document on-treatment visits with a weekly note (called a "to-be-seen" note at UVA). Typically, residents may begin assisting with management of toxicity mid-way through their first year of residency.

Image-guidance Review: All image-guidance films must be approved by an Attending physician prior to the next treatment. After a resident has demonstrated competence in evaluating image-guidance CT images, kV planar images, and port films, as evaluated by radiation oncology faculty members, the Program Director may grant Image-Guidance Review privileges. This typically happens at the beginning of the second year of radiation oncology residency (but may occur later based on faculty input). The Program Director communicates this privilege by sending an e-mail to all residents, physician faculty, physicists and radiation therapists. This privilege gives residents the privilege to review images while the patient is on the treatment table and to authorize the therapists proceed with treatment. Any image approved by a resident in this way is co-signed by an Attending physician prior to the next treatment. This privilege does not extend to stereotactic body radiation therapy or to fraction sizes larger than 5 Gy, which must be reviewed by an Attending prior to treatment.

HDR Brachytherapy Procedures: After a resident has completed the required training and has demonstrated competence in HDR brachytherapy, he/she may be designated as an Authorized User on the UVA license for HDR with Ir-192. This typically happens at the beginning of the 4th and final year of residency. This requires completion of an application process and approval by the UVA Radiation Safety Committee. This is communicated by announcement to all radiation oncology faculty and to the Chief Resident(s). Once an Authorized User, the resident may serve as the Authorized User for HDR brachytherapy with important rules. These important rules include: an Attending physician must review and approve the treatment plan; an Attending physician must be the Authorized User present at time of the first active dwell position; and, an Attending physician must be present in the building and readily available if needed.

Gamma Knife Radiosurgery: After a resident has completed the required training and has demonstrated competence in Gamma Knife radiosurgery, he/she may be designated as an Authorized User on the UVA license for Gamma Knife radiosurgery (with Cobalt). This typically happens at the beginning of the 4th and final year of residency. This requires completion of an application process and approval by the UVA Radiation Safety Committee. This is communicated by announcement to all radiation oncology faculty and to the Chief Resident(s). Once an Authorized User, the resident may serve as the Authorized User for Gamma Knife radiosurgery with important rules. These important rules include: an Attending physician must review and approve the treatment plan; an Attending physician must be the Authorized User present at the start of treatment; and, an Attending physician must be readily available if needed.

RECORD KEEPING: The latest version of this policy is maintained with the Departmental Policies, and updates require approval by the Medical Director and Director of Radiological Physics. The residency program guidelines are also available. A copy of the guidelines is emailed once each year to all departmental faculty and residents.

Created: 11/3/2014: Timothy N. Showalter, MD, MPH.
Last Modification: 11/3/2014: Timothy N. Showalter, MD, MPH.
Last saved: 12/4/2017: Jeffrey Siebers, Ph.D.



Cancer Center

Department of Radiation Oncology
UVA Faculty/Resident Behavioral Code of Conduct

The “[Graduate Medical Education Committee Policy No. 05](#)” cites the Policy and Procedures for the Assessment of Performance of Graduate Medical Trainees and the consequences for misconduct. “Medical Center Policy No. 0291” states “each member of the Clinical Staff be held to the highest personal and professional standards, with adherence to the University of Virginia Medical Center’s Core Values of: respect, integrity, stewardship and excellence”.

The University of Virginia Department of Radiation Oncology is committed to a culture of mutual respect and safety. This Code reflects the Department’s dedication to a positive working and learning environment in which every member of the Department, as well as those with whom we work in hospitals and other settings, are treated with professionalism and respect.

The Department is also committed to providing patient care of the highest quality, which requires that physician teams operate cohesively in an atmosphere of cooperation and respect. Inappropriate behavior can disrupt the proper functioning of the physician team and can create an environment in which members of the team are afraid to ask questions or make comments concerning appropriate patient care, to the detriment of the patient.

Inappropriate behavior by a Department member is also potentially destructive to his/her career. The University has reporting obligations to the National Practitioner Data Bank and must respond truthfully to credentialing questionnaires.

For all of these reasons, the Department has established this Code to address and prevent instances of inappropriate behavior.

i. Purposes:

- To optimize the effectiveness and reliability of the healthcare and departmental teams.
- To enhance communication and interpersonal relations among all individuals involved in patient care, research and education.
- To improve the quality of patient care and safety.
- To reinforce an atmosphere of mutual respect for all who interact with or are associated with the Department.
- To prevent conduct which:
 - Interferes with an individual’s ability to practice or work safely.
 - Creates a hostile or intimidating work environment.
 - Disrupts the delivery of patient care, research or educational activities.

ii. Scope

This Behavioral Code of Conduct applies to all University of Virginia Department of Radiation Oncology faculty and employees, regardless of where they work.

Department of Radiation Oncology faculty and administrative leaders will be expected to set an example of professional conduct and to model the behaviors expected of all faculty, staff members, and residents in the Department.

iii. Standards of Behavior

1. Expected Behaviors:

- Communication will take place in a timely fashion, involving the appropriate person(s), in an appropriate setting.
- Communications, including spoken remarks, written documents, and e-mails, will be honest and direct and conducted in a professional, constructive, respectful and efficient manner.
- Telephone communications will be respectful and professional.
- Cooperation and availability are expected of faculty, residents and staff whenever serving in a professional capacity. When individuals are paged, they will respond promptly and appropriately.
- Recognition that:
 - a variety of experience levels exists and
 - tolerance for those who are learning is expected.

2. Examples of Unacceptable Behaviors:

- Shouting, screaming or yelling
- Threatening or violent behavior
- Profane or disrespectful language
- Criticism of performance and/or competency:

- delivered in an inappropriate location (i.e., not in private) and/or
- not aimed at performance improvement
- Inappropriate arguments with patients, family, staff, and other physicians
- Sexual comments or innuendo
- Inappropriate touching, sexual or otherwise
- Racial, ethnic or discriminatory jokes/slurs
- Slamming or throwing objects in anger or disgust
- Hostile, condemning, or demeaning communications
- Other behavior demonstrating disrespect, dishonesty, intimidation, or disruption to the work environment
- Repeated failure to respond to call or pages
- Retaliation against any person who reports or addresses unacceptable behavior

iv. Expected Action if Unacceptable Behavior Occurs:

In situations where unacceptable behaviors occur and residents are involved, the Department expects witnessing faculty, residents, or staff member or the involved resident to recognize the unacceptable behavior and report this to the Program Director, Department Chairman, or to any faculty member that is not directly involved who will notify the Program Director or Chairman.

In recognition of the fact that situations involving improper conduct within the Department can involve a variety of circumstances, the Chairman and Program Director must retain flexibility in determining how best to address the problem in each particular situation. In the case of a faculty member with inappropriate behavior towards a resident, the resident will be temporarily removed from that service until the specific issues are resolved. In most instances, efforts will be made to encourage discussion between the individuals involved, with the assistance of a facilitator as appropriate. If necessary to prevent harm to patients, students, staff or faculty, the Department may determine that suspension of the faculty member from participating in the Residency Program for a specific time period is necessary until the issues have been resolved.

In addressing concerns of unprofessional conduct by Department members, the primary objective is to restore a collegial and safe environment for working, learning and patient care. Remedial measures may include, for example, sincere apologies and/or therapy/counseling. Disciplinary measures may also be warranted, including for example oral or written warnings or reprimands.

At the conclusion of the matter, the Department Residency Program Director or Chairman will prepare a written report summarizing: the complaint or concern; the Department’s review; and the outcome of the matter. This report will be saved in the Residency Program Files and Faculty’s records.

Retaliation against any individual who reports or addresses concerns under this Code is prohibited and will not be tolerated. Allegations of retaliation will be promptly reviewed by the Program Director and the Department Chair.



Department of Radiation Oncology Policy

- A. SUBJECT: Policy on Transitions of Care
- B. EFFECTIVE DATE: September 24, 2012
- C. POLICY: Policy on Transitions of Care
 - I. PURPOSE: Per UVA Graduate Medical Education Committee Policy No. 24 the Radiation Oncology Department has developed a Policy on Transitions of Care to ensure quality of care and patient safety.
 - II. DEFINITION AND SCOPE:

A transition of care (“handoff”) must include a communication of information to support the transfer of care and responsibility for a patient/group of patients from one service and/or team to another. The transition/hand-off process is an interactive communication process which must pass specific, essential patient information from one caregiver to another.

III. POLICY:

When a resident is scheduled: for a department clinical rotation, to go on vacation, or has an educational leave; they will observe the following transition/hand-off process. The hand-off process will involve a face-to-face interaction with both verbal and written/computerized communication. A sign-out sheet (see attached template); of the patients on treatment and the patients who are scheduled to undergo simulation in the next week, will be provided to the resident who will be covering the service of the on-leave resident. A copy of the Radiation Oncology Transitions of Care Sign-Out Sheet will be available on the secured network location to ensure compliance and patient safety.

The sign-out sheet will include:

- Identification of the patient, including:
 - name,
 - medical record number,
 - age,
 - diagnosis,
 - treatment unit,
 - site being treated, and
 - the dose and number of fractionation
- Whether the patient is receiving concurrent chemotherapy
- Identification of the attending physician
- Outstanding tasks – what needs to be completed (i.e., boost plan)
- Recent notable events, including changes in condition or treatment

In Radiation Oncology, the faculty does not rotate off-service; so, the patient has built-in continuity of care. As outlined in the Radiation Oncology Guidelines, faculty coverage (the appropriate supervision level) is available according to the “Progressive Radiation Oncology Milestone Expectations” per residency year of the scheduled resident and/or as needed to ensure patient safety. Each resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

Each academic year, the Program Director of the Residency Program distributes the ‘Resident Schedule’ to all faculty and staff which documents the attending and resident rotations for the year. At the beginning of each academic year, the hospital operators receive the ‘Radiation Oncology Call Schedule’ and any changes during the year will be emailed to the operators as they occur. Weekly, the department-specific ‘Clinic Coverage Schedule’ is sent to the department staff and faculty showing any changes to clinic coverage. This process creates safeguards for unexpected coverage changes in patient care due to circumstances, such as; resident illness, fatigue, or emergency.

During the semi-annual ‘Clinical Competency Committee Meeting’ each resident will be evaluated for his/her compliance with this Policy on Transitions of Care. At each semi-annual evaluation, the Program Director will document the committee’s assessment of the resident, discuss the analysis with the resident trainee, and create an action plan should one be needed with regards to this Policy on Transitions of Care.

Patient confidentiality and privacy is ensured in accordance with HIPAA guidelines; this includes the appropriate disposal of any written material in HIPAA-compliant receptacles, and encryption of any electronic devices used during the handoff process.

Reviewed: September 24, 2012

Reviewed/Approved: September 28, 2012

Revised: September 19, 2013



Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 02

- A. SUBJECT: Recruitment, Selection, and Appointment of Graduate Medical Trainees
- B: EFFECTIVE DATE: December 20, 2017 (R)
- C: POLICY: Policy on Recruitment, Selection, and Appointment of Graduate Medical Trainees

The University of Virginia Medical Center Graduate Medical Education (GME) Programs shall seek to provide all resident and fellow (hereinafter “graduate medical trainee”) applicants the right to a fair application process based on the criteria required by the accreditation organizations and/or specialty board in addition to the criteria set forth by the individual residency and fellowship programs.

In its recruitment of graduate medical trainees (GME Trainees), the University of Virginia Medical Center is committed to equal employment opportunity and affirmative action. To fulfill this commitment, the University of Virginia Medical Center administers its GME programs, procedures and practices without regard to age, color, disability, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family, medical or genetic information as required by Title IX of Education Amendments of 1972, the American Disabilities Act of 1990, as amended, Section 504 of the Rehabilitation Act of 1973, Titles VI and VII of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Governor’s Executive Order Number One (2014), and other applicable statutes and University policies.

All Accreditation Council for Graduate Medical Education (ACGME) accredited training programs must have a program specific policy addressing their eligibility and selection of trainees.

Definition

The term GME Trainees shall include those who are in either in a residency position or a fellowship position.

Graduate Medical Trainee Eligibility

1. The ACGME accredited training programs must adhere to the graduate medical trainee eligibility set forth by the ACGME’s Institutional, Common and Specialty specific program requirements. GME programs granted eligibility exceptions by their specialty Review Committee must seek the GMEC approval prior to submitting an offer through the Match or directly to the trainee.
2. Non-ACGME accredited programs or non-accredited programs must follow relevant GME policies and any eligibility requirements set forth by their accreditation organization when applicable.

GME Trainee Recruitment

All candidates for programs (applicants who are invited for an interview) must be informed, in writing or electronic means, of the terms, conditions, and benefits of their appointment, including financial support; vacations, parental, sick, and other leaves of absence; professional liability, hospitalization, health, disability and other insurance provided for the graduate medical trainee and their families; and the conditions under which the Sponsoring Institutions provides call rooms, meals, laundry services, or their equivalents (IR IV. A.3)

Graduate Medical Trainee Selection

1. Each program must ensure that it selects GME Trainees from among eligible applicants based on the applicants’ readiness, ability, aptitude, academic credentials, communication skills, and personal qualities such as motivation and integrity. Programs must not discriminate with regard to age, color, disability, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family medical or genetic information in the selection of GME Trainees.
2. In selecting from among qualified applicants, ACGME-accredited residency programs should participate in an organized matching program, such as the National Resident Matching Program (NRMP) or San Francisco Matching

Program, and adhere to its policies. Additionally, programs that do not fill through the Match are encouraged to register for the Supplemental Offer and Acceptance Program (SOAP) if applicable.

3. ACGME-accredited fellowship programs should follow any specialty requirements to participate in the Match.
4. The program director of any GME program into which a graduate medical trainee is transferring must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring graduate medical trainee.

Graduate Medical Trainee Appointment

1. Appointment to the University of Virginia Medical Center shall only be made once the applicant has fulfilled all the documentation required by the GME Office.
2. The Sponsoring Institution and the program directors must assure that GME Trainees are provided with a written agreement of appointment/contract (i.e. GME Contract) outlining the terms and conditions of their appointment to a program (IR IV.B.1).

Reviewed/Approved by GMEC: June 1, 2007

Reviewed/Approved by GMEC: November 18, 2009

GMEC Policy Subcommittee Reviewed: January 11, 2011, February 8, 2011

Reviewed/Approved by GMEC: February 16, 2011

GMEC Policy Subcommittee Reviewed/Revised: April 08, 2014

GMEC Reviewed/Approved: April 16, 2014

GME Policy Subcommittee Reviewed and Revised: September 08, 2015

GMEC Reviewed/Approved: September 16, 2015

GME Policy Subcommittee Reviewed/Revised: March 14, 2017

GMEC Reviewed/Approved: March 15, 2017

GME Policy Subcommittee Reviewed/Revised: December 12, 2017

GMEC Reviewed/Approved: December 20, 2017



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 03

A. SUBJECT: Leave of Absence from Graduate Medical Training

B. EFFECTIVE DATE: February 20, 2019 (R)

C. POLICY STATEMENT

The University of Virginia Health System shall seek to provide its residents and fellows (hereinafter "Trainees") with appropriate time off to ensure the Trainee's well-being and to comply with the sponsoring institution's policies and applicable requirements for accreditation and/or specific specialty/subspecialty board certification. Furthermore, any time away from training must adhere to department and/or program policies.

D. Definition of Terms:

Administrative Leave: An absence from duty with or without pay as approved by the Program Director and as determined by Medical Center Human Resources Policy 600.

Family and Medical Leave Act (FMLA): FMLA is a job-protected leave without pay for up to 12 work weeks (26 weeks for qualified Military Care Giver leave) during a leave plan year.

A leave plan year: A rolling 12-month period measured forward from the date an employee uses any leave under this policy, except in the case of Military Caregiver Leave, in which leave to care for a Covered Servicemember with a Serious Injury or Illness begins on the first day the employee takes leave for this reason and ends 12 months later, regardless of the 12-month period established for other types of FMLA leave.

Military Leave: Absence from work for military training or full-time service in the Uniformed Services in accordance with federal and state law.

Professional Leave: Time spent attending professional meetings or conferences, job or fellowship interviews, or taking board examinations or other examinations approved by the Program Director.

Unexcused Leave: An absence from duty not approved by the Program Director.

E. Procedures

1. Requests for Leave

- a. Trainees must submit requests in accordance with Program and Medical Center procedure and policies (see attached leave worksheet). Trainees should submit leave requests in a timely fashion, especially if rotating on another service and coverage must be arranged.
- b. Program Directors must approve all leaves of absence.
- c. All leaves of absence must be reported in New Innovations within 30 days of the planned absence.
- d. Leaves of absence resulting from a Disciplinary Action must be coordinated with and reported to the GME Office (GMEO) per GMEC Policy 31.
- e. See below for requests for PPL and FMLA for eligible Trainees.

2. Leaves Available for All Trainees regardless of Length of Employment

- a. **Administrative Leave:** The sponsoring institution provides Administrative Leave in accordance with Medical Center Human Resources Policy 600.
- b. **Military Leave:** The sponsoring institution shall provide the Trainee with the necessary time off from training if called upon by the government for service in the U.S. Armed Forces. For a Trainee in good standing, re-entry into the program upon completion of any military time shall be guaranteed by the Program Director of the program in which the trainee was granted the leave of absence. The postgraduate level at which the trainee returns to the program shall be at the discretion of the Program Director. The total leave period must be approved by the Program Director and communicated to the GMEO.
- c. **Professional Leave:** This leave is determined and granted by the individual Program Directors. Time spent attending professional meetings, conferences, job or fellowship interviews, or taking board examinations or other examinations is not counted as vacation if the activity is approved by the Program Director.
- d. **Sick Leave:** Trainees are provided up to fourteen calendar days per academic year of paid sick leave, inclusive of time needed for mental health. Beyond this, exceptional cases will be considered on an individual basis. In this regard, up to twenty-eight calendar days of additional paid leave time may be granted in cases of unusual illness or disability. Such additional leave would be granted through the GMEO only when the Program Director, DIO, or GMEO deem it acceptable. Paid sick leave does not carry forward.
- e. **Unexcused Leave of Absence:** Disciplinary or remedial action resulting from an unexcused leave of absence shall be at the discretion of the Program Director based on individual Department and/or accreditation requirements and regulations.
- f. **Vacation Leave:** Trainees must be provided fifteen business days of vacation time per academic year (unless otherwise specified by their Program Director). Vacation time does not carry forward, although exceptions can be made on an individual basis when specifically allowed by Trainee's certification board and approved in advance by the Program Director.
- g. **Additional Time for Completing Board Requirements:** In the event that additional training time is required to meet Board eligibility requirements (due to leave or other circumstances), the Trainee must be reappointed, with pay and benefits covered by the GMEO to continue for the extension.

3. Leaves Available to Trainees with Greater than One Year of Employment at UVA (Paid Parental Leave and Family and Medical Leave)

- a. **Paid Parental Leave (PPL):** PPL is available only to those employees who have been employed for at least 12 months and have worked at least 1,250 hours in the previous 12 months before the start of the leave.
 - PPL provides eligible Trainees up to 8 weeks of consecutive paid leave within 6 months of the event (birth, adoption, or placement).
 - PPL runs concurrently with FMLA (see below).
 - PPL is separate from vacation and sick leave (i.e., trainees may take vacation time in addition to approved PPL time).
 - PPL can be taken once in a 12 month period and only once per child.
 - Trainees may use 4 additional weeks of leave beyond the 8 weeks of PPL utilizing FMLA. Trainees may either use remaining paid vacation or sick leave for those 4 weeks, or may elect to take them unpaid. Trainees

must return to work at the end of the approved 12 weeks of PPL/FMLA time (8 weeks of PPL plus 4 additional weeks of FMLA time).

- PPL is requested through the Program Director and the GMEO and must be requested at least 3 months prior to the birth, adoption, or placement of a child, if possible. See worksheet and form at the end of this policy.
 - If both parents are eligible trainees, both parents are eligible to take PPL. However, the GMEO requests that both parents not take simultaneous PPL if both parents are being trained in the same program.
 - Unused PPL is forfeited.
 - Birth mothers must obtain a return-to-work statement from their providers and present it to either Program Director, or GME Director upon returning to work.
- b. **Family and Medical Leave Act (FMLA):** FMLA is available only to those employees who have been employed for at least 12 months and have worked at least 1,250 hours in the previous 12 months before the start of the leave.
- The FMLA grants up to 12 workweeks of family and medical leave of absence during any 12-month period in accordance with the FMLA to Eligible Employees who wish to take time off from work duties to fulfill family obligations relating directly to the birth of a child, adoption, and/or placement of a foster child in order to bond and care for the child ; to care for a child, spouse, or parent with a Serious Health Condition, as defined in this policy; or due to the employee’s own Serious Health Condition or disability.
 - Family and medical leave may not be used for a short-term period (incapacity requiring the absence of less than three calendar days), conditions for minor illnesses, and out-patient surgical procedures with expected brief recuperating periods. It does not provide for intermittent care of a child for commonplace illnesses (e. g., colds and flu).
 - For further information about FMLA definitions and procedures, see the Medical Center Human Resources Policy No. 600. The University complies with the Family and Medical Leave Act of 1993 (29 U.S.C. 2601 et seq., and Regulations 29 C.F.R Part 825).
4. Leaves for Trainees who are Not Eligible for Paid Parental Leave and FMLA
- Trainees who do not meet the PPL/FMLA eligibility requirements may take either maternity, paternity or adoption leave as follows:
- a. **Maternity Leave:** Maternity leave is granted as four paid, consecutive weeks of exceptional leave; trainees may also take any remaining unused annual sick leave or annual vacation time. The total leave period must be approved by the Program Director who must communicate this to the GMEO.
 - b. **Paternity Leave:** Paternity leave may be granted as one paid week (seven consecutive days) of exceptional leave; trainees may also take any remaining unused sick time or unused annual vacation time. The total leave period must be approved by the Program Director who must communicate this to the GMEO.
 - c. **Adoption Leave:** Adoption leave may be granted as four paid, consecutive weeks of exceptional leave for the primary caregiver; trainees may also take any remaining unused sick time or unused annual vacation time. The total leave period must be approved by the Program Director who must communicate this to the GMEO.

Revised/Approved, Graduate Medical Education Committee, 02/16/2005,

Revised/Approved, Graduate Medical Education Committee, 2/20/2008

Revised, GMEC Policy Subcommittee, 1/12/2012

Revised, GMEC Policy Subcommittee, 3/7/2012

Reviewed/Approved, GMEC, May 16, 2012

Revised, GMEC Policy Subcommittee, 12/10/2013

Reviewed/Approved, GMEC, 12/18/2013

Revised/Approved, GMEC, 02/15/2017

GMEC Policy Subcommittee Reviewed/Revised: March 13, 2018

GMEC Approved: March 21, 2018

GMEC Policy Subcommittee Reviewed/Revised: December 11, 2018

GMEC Policy Subcommittee Reviewed/Revised: January 8, 2019

GMEC Reviewed/Approved: January 16, 2019

GMEC Policy Subcommittee Reviewed/Revised: February 12, 2019



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 05

A. SUBJECT: Performance Assessment of Graduate Medical Education Trainees

B. EFFECTIVE DATE: March 20, 2019 (R)

C. POLICY

The following Performance Assessment of Graduate Medical Education Trainees Policy (hereinafter "Performance Policy") shall apply to all graduate medical education trainees (GME Trainees) at the University of Virginia Health System. The Performance Policy governs the qualification of GME Trainees to remain in training, promotion within their training program, as well as the certification requirements for completion of their training program, and its provisions shall apply in all instances in which such qualification, promotion and/or certification is in question.

This policy also addresses deficiencies in performance and options for performance improvement and remediation; failure to promote a trainee, and failure to renew a trainee for the educational program.

Definition:

Deficiency: Inadequate acquisition of or performance in any of the core competency areas, as expected for the GME Trainee's level of experience and education.

Remediation: A period of time at the discretion of the program director with advisement by the program's Clinical Competency Committee's recommendation imposed on a GME Trainee to improve the competency area(s) of deficiency. Remediation can include repeating one or more rotations or participation in a special remedial program and will be at least three months. Remediation per se is not appealable, but may be reportable. Adverse actions resulting from unsuccessful completion of remediation are appealable.

Non-promotion: The decision by a program director in collaboration with the program's Clinical Competency Committee not to advance a GME Trainee to the next level of training based on deficiency in core competency areas. The GME trainee may be required to repeat a full or part of an academic year, or the end date (i.e., graduation) of the training program may be extended based on requirements from either the program or the certification board.

Non-renewal: See [GME Policy](#) No. 04, Non-renewal of GME Trainees' Appointment.

Misconduct: See [GME Policy](#) No. 31, GME Procedures to Address Trainee Misconduct

Adverse Action: An adverse action may include suspension, non-promotion, nonrenewal of appointment, or dismissal of a GME Trainee from his or her training program. Adverse actions are generally reportable events and appealable.

Reportable Events: Those actions the program or institution must disclose to others upon request, including, but not limited to, future employers, privileging hospitals, and licensing and specialty certification boards and, if applicable, the Educational Commission for Foreign Medical Graduates (ECFMG).

D. PROCEDURE

1. PERFORMANCE ASSESSMENT AND REVIEW OF TRAINEES

Trainees shall be evaluated in a timely manner during each rotation or similar educational assignment in line with the relevant accreditation organization's requirements.

The evaluations of Trainee performance must be accessible for review by the Trainee, in accordance with institutional policy.

The program director for each training program has primary responsibility for monitoring the competence of the program's Trainees, for recommending promotion and board eligibility, and, when necessary, imposing any remediation or adverse action.

A CCC in each training program should review all Trainee evaluations regularly but no less than every six months. The CCC should evaluate each trainee with respect to the specialty-specific Milestones that each specialty's Residency Review Committee has designated. The CCC should advise the program director regarding Trainee progress, including promotion, deficiency(ies), remediation, and dismissal. There must be a written description of the responsibilities of the CCC in each program.

The program director must provide a summative evaluation for each Trainee upon completion of each training year and at time of graduation from the training program. The specialty-specific Milestones must be used for the ACGME accredited programs as one of the tools to ensure Trainees are able to practice core professional activities without supervision.

2. PROMOTION

Those Trainees judged by the program director in collaboration with the program's CCC to have completed satisfactorily the requirements for a specific level of training will be promoted to the next level of training unless the Trainee is enrolled in a training track of limited duration that is not designed to achieve full certification (e.g., a one-year preliminary position).

No Trainee shall remain at the same level of training for more than 24 months, exclusive of leave. A Trainee whose performance is judged to be satisfactory shall advance until the completion of the program/certification requirements.

A program director must provide timely verification of residency or fellowship education and summative performance evaluations for GME Trainees who may leave the program prior to completion.

3. COACH (Committee on Achieving Competence through Help)

The COACH program provides comprehensive assessment of the underperforming Trainee and development of an individualized coaching plan. Following assessment and development of a coaching plan, COACH faculty may act as a consultant to the learner's program leadership as the plan is carried out, and/or may participate in the actual coaching process. The COACH program is not directly involved in the learner's reassessment.

i. Trainee Self-Referral to COACH

Trainees may self-identify as needing help through the course of their training and seek assistance from the COACH team. Such a self-referral is independent of a formal remediation plan, and there is no required communication between COACH and the Trainee's training program leadership.

ii. Program directors may suggest that a Trainee consider self-referral to COACH. In this instance, such a recommendation would be outside of a formal remediation plan. The trainee may choose to self-refer to COACH in this instance, which would be voluntary and not mandatory. In this case, there is no required communication between COACH and the learner's training program leadership.

iii. Trainees may also be referred to the COACH team as part of a formal remediation process. In these cases, participation is a mandatory element and must be included in the trainees' remediation plan, and there is ongoing communication between COACH and the Trainee's training program leadership.

4. REMEDIATION

i. Letter of Remediation: When one (or more) deficiency(ies) is identified, the Program Director will issue the Trainee a Letter of Remediation. The Trainee must be informed in person of this decision and must be provided with a hard copy that includes the following:

- A statement identifying the area(s) of deficiency;
- A plan for remediation (which may include formal referral to COACH) including duration of the remediation;
- Criteria by which successful remediation will be assessed; and
- Written notice that failure to meet the conditions of remediation could result in additional remediation or extended training and/or suspension or dismissal from the training program at any point during the remediation period, or at the conclusion of the remediation period.

ii. The Program Director or designee must document that that meeting with the Trainee has occurred and that the Trainee was provided the Letter of Remediation. The Designated Institutional Official ("DIO") and the program's CCC Chairperson must receive a copy of the Letter of Remediation.

iii. At the end of remediation period, the program's CCC shall convene to determine if the remediation of the Trainee was successful. If the Trainee successfully completes the remediation, the program director shall notify the Trainee of successful completion. Written documentation must be included in the Trainee's file describing the satisfactory completion of the remediation. The DIO and the program's CCC Chairperson must receive a copy of the documentation.

iv. In the case of unsuccessful completion of the initial remediation, the CCC must determine further actions which may include extension of remediation, nonpromotion, non-renewal of appointment, summary suspension, or dismissal of a Trainee from his or her training program. If an adverse action is taken, the

Trainee must be given a copy of GMEC Policy 32, Adverse Actions and Appeals Process in Graduate Medical Education. The DIO and the GME Office must be notified of such decisions.

- v. A Letter of Remediation issued to a Trainee constitutes notification that dismissal from the program can occur at any time during or at the conclusion of remediation. Dismissal prior to the conclusion of a remediation period may occur if the deficiency that gave rise to the Letter of Remediation is repeated and jeopardizes patient safety and quality of patient care.

GMEC Reviewed and approved: January 19, 2000 MPC 06/06/2000;

GMEC Reviewed and Approved: June 19, 2002

GMEC Review and Approved: November 18, 2009

Reviewed/Revised: GMEC Policy Subcommittee, June 22, 2010

Reviewed: GMEC, July 21, 2010

GMEC Reviewed/Approved: August 18, 2010

GMEC Reviewed/Approved: January 19, 2011

GMEC Reviewed/Approved: April 20, 2011

GMEC Reviewed/Approved: September 21/27, 2011

GME Policy Subcommittee Reviewed/Revised: August 12, 2014

GMEC Policy Subcommittee Reviewed/Revised: January 12, February 9, March 8, and April 12, 2016

GMEC Reviewed/Approved: June 15, 2016

GMEC Policy Subcommittee Reviewed/Revised: February 12, 2019

GMEC Reviewed/Approved: March 20, 2019



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 06

- A. SUBJECT: Grievance
- B. EFFECTIVE DATE: January 17, 2018 (R)
- C. POLICY: Policy on Grievance

This policy is established to provide a mechanism for resolving disputes and complaints that may arise between a graduate medical education trainee (herein after "GME Trainees") and his or her program director or other persons involved with the administration of the graduate medical education (GME) program.

There shall be a process for adjudicating GME Trainee complaints and grievances related to the work environment or non-academic issues related to individual GME program or faculty.

Definitions

Complaint – A written or verbal expression of dissatisfaction with the working and learning environment, individual residency programs or the faculty.

Grievable Complaints ("Grievance") - A grievable complaint is a concern or issue that a GME Trainee may feel is unjust and/or an unfair practice that may affect his or her ability to carry out duties as required by both the Accreditation Council for Graduate Medical Education (ACGME) and the GME program.

Grievable complaints include the following:

- 1) A program's consistently exceeding the ACGME Duty Hour regulations without regard to the GME Trainee's well-being.
- 2) Complaints related to a GME Trainee feeling unsafe and/or unprotected due to lack of security provided by the program or Medical Center.
- 3) Complaints related to a disciplinary action other than adverse actions including nonrenewal of Trainee appointment or dismissal (please refer to GME Policy 04-Renewal and Non-Renewal of the GME Trainee

Appointment and 05 – Performance Assessment of GME Trainees) brought forth by the Program Director as a result of GME Trainee misconduct.

- 4) Complaints related to inappropriate behavior, including mistreatment, by any member of the clinical learning environment as outlined in Medical Center Policy 0262: Standards for Professional Behavior.

Complaints based solely on the following actions are not subject to this process and thus are considered "not grievable":

- 1) Decisions regarding and/or documentation of areas of deficiencies in academic performance or remediation (see GME Policy 05: Performance Assessment of GME Trainees).
- 2) Establishment and revision of stipends, position classifications, or general benefits
- 3) Work activity accepted by the GME Trainee as a condition of employment or work activity that may be reasonably expected to constitute a part of the job
- 4) The content of policies, procedures and other rules applicable to GME Trainees
- 5) Work and duty assignments within the Medical Center
- 6) Grievances related to discrimination on the basis of age, color, disability, gender identity, marital status, national or ethnic origin, political affiliation, race, religion, sex (including pregnancy), sexual orientation, veteran status, and family and genetic information shall be referred to Catherine Spear, Assistant Vice President, Office of Equal Opportunity Programs, P.O. Box 400219, Washington Hall, Charlottesville, VA 22904, (434) 924-3200, UVaEOP@virginia.edu

PROCEDURE:

- **Step 1:** (If Grievance is with Program Director, skip to Step 2.) The GME Trainee and program director shall make a good faith effort to resolve complaints informally. If the complaint is not resolved informally and if the complaint is grievable, as defined above, the GME Trainee shall, notify the program director in writing of the nature of the grievance, all pertinent information and evidence supportive of the grievance and a statement of the relief requested. Within 7 calendar days after receipt of this notice, the program director shall meet with the GME Trainee and attempt to reach a resolution along with a mutually agreeable third party (e.g., member of GME Office). Within 5 calendar days of this discussion, the program director shall notify the GME Trainee in writing of the resolution of the grievance and shall address both the issues raised and the relief requested. A copy of the program director's notification shall be provided to the appropriate Department Chair and to the Designated Institutional Official (DIO) and Associate Dean of Graduate Medical Education.
- **Step 2:** If the program director's written resolution is not acceptable to the GME Trainee the GME Trainee shall notify the Department Chair (if Program Director is Department Chair, skip to Step 3) in writing within 10 calendar days of receipt of the program director's notification of resolution. The GME Trainee's notification to the Department Chair shall include a copy of the program director's resolution and all other information supportive of the GME Trainee's grievance. Within 7 calendar days of receipt of the grievance, the Department Chair shall meet with the GME Trainee to discuss the grievance and attempt to reach a resolution with third party present. Within 5 business days of this meeting, the Department Chair shall send to the GME Trainee a written response to the issues and relief requested. A copy of this response shall be provided to the DIO.
- **Step 3:** If the GME Trainee disagrees with the decision by the Department Chair or the Program Director is the Department Chair, the GME Trainee shall present a written statement to the DIO within 10 calendar days of the receipt of the Program Director/Department Chair's decision. The statement shall describe the nature of and basis for the grievance and include copies of the decisions of the Program Director and the Department Chair. Failure to submit the grievance in the ten day period shall constitute waiver of the grievance process and the decision of the Program Director/Department Chair will be final. The DIO shall review all written information and decide whether further meetings or inquiry could be helpful to resolve the issue. If the DIO has a conflict, this responsibility would fall to the Associate DIO; if both have a conflict, this responsibility would fall to the Vice-Chair of the GMEC. Within 10 calendar days of receipt of the GME Trainee's statement, the DIO or her designee shall provide to the graduate medical trainee a written decision on the grievance. This decision shall be final.

D: The DIO or her designee may extend these times for good cause.

Confidentiality

All participants in Steps 1, 2 and 3 of the grievance process shall not discuss the matter under review with any third party except as may be required for purposes of the grievance procedure. The Chief Executive Officer of the Medical Center and the Dean of the School of Medicine may be notified of a grievance and such notification shall not constitute a breach of this

confidentiality requirement.

GMEC Approval: January 19, 2000
GMEC Approval: April 2007
GMEC Approval: September 16, 2009
Reviewed/Revised: GME Policy Subcommittee, December 10, 2013
Approved: GMEC, December 18, 2013
GME Policy Subcommittee Reviewed/revised: December 8, 2015 & January 12, 2016
GMEC Approval: January 20, 2016
GMEC Revised/Approved: January 18, 2018



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 07

A. SUBJECT: United States Medical Licensing Examination

B: EFFECTIVE DATE: December 20, 2017 (R)

C: POLICY:

This policy outlines minimum standards regarding licensing examinations to ensure Graduate Medical Education (GME) trainees' qualification for matriculation into a GME training program, promotion to advanced levels of training, and achieving board eligibility. This policy applies to all physician residents and fellows in the GME programs sponsored by the University of Virginia Medical Center.

1. Prior to matriculation into a GME program

Residents must successfully pass Step 1 and both parts of Step 2 of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) by contract start date in order to enroll in a GME program at the University of Virginia Medical Center. Exceptions must be approved by the Graduate Medical Education Committee (GMEC) in advance.

Fellows entering a GME training program must successfully pass USMLE or COMLEX Step 3 (or its equivalent) prior to entering their fellowship program. Exceptions must be approved by the GMEC in advance.

2. Following entry into a GME program

All residents who are currently enrolled in a GME training program must take and pass Step 3 of the USMLE or COMLEX by March 1st of their PGY-2 year. Failure to pass USMLE or COMLEX Step 3 by March of the PGY-2 year may result in non-renewal of their appointment.

Residents should register for the USMLE or COMLEX Step 3 examination (or its equivalent) no later than November 1st of their PGY-2 year to allow for scheduling, grading, and notification of results by March 1.

Residents who fail USMLE or COMLEX Step 3 (or its equivalent) after two attempts must be presented to the GMEC by the Program Director or Chair of the Department for discussion.

Since residents will not be expected to use vacation time to take the exam since it is a GME requirement, time spent taking the exam will be logged as duty hours.

Programs will be responsible for monitoring satisfactory completion of the USMLE or COMLEX Step 3 requirements for each of their residents. In compliance with the ACGME Institutional Requirements (IV.C. 1. a), programs must provide a resident/fellow who fails to meet the policy defined deadline with a written notice of intent when that resident's/fellow's agreement will not be renewed, when that resident/fellow will not be promoted to the next level of training, or when that resident/fellow will be dismissed.

3. Provisions for exception

Trainees who take extended sick leave or leave of absence for personal reasons may be granted an extension at the discretion of the trainee's Program Director. The Program Director need not present this extension to the full GMEC but must inform the GME Office in advance. Once the trainee returns to full duty, a plan for completion of the USMLE must be instituted and communicated to the GME Office.

The trainee will be given six months to pass the examination from the date of GMEC approval of his/her exception. The Program Director or trainee must report back to the GME Office successful completion (or failure to complete) of this requirement.

Trainees who fail to schedule the USMLE Step III must be brought before the GMEC where a plan will be established.

4. International Medical Graduates

International medical graduate is defined as a physician who received his/her medical degree or qualification from a medical school located outside the United States. Citizens of the United States who have completed their medical education in schools outside the United States are considered international medical graduates; non-U.S. citizens who have graduated from medical schools in the United States are not considered international medical graduates.

The Educational Commission for Foreign Medical Graduates (ECFMG), through its certification program, assesses whether international medical graduates have met minimum standards of eligibility to enter residency or fellowship programs in the United States accredited by the Accreditation Council for Graduate Medical Education (ACGME). ECFMG Certification is a requirement for international medical graduates who wish to enter GME training programs. To be eligible for ECFMG Certification, a physician must pass the USMLE Step 1 and Step 2. International medical graduate who received his/her medical training from a medical school accredited by the Royal College of Physicians and Surgeons of Canada and successfully passed the Medical Council of Canada Qualifying Examination (MCCQE) Part I and II are exempted from the USMLE requirements outlined in this policy. Specifically, MCCQE Part II is equivalent to the USMLE Step 3 in that it requires postgraduate training and measures equivalent areas of medical knowledge and skills assessed in the USMLE Step 3.

GMEC will consider exception request for International medical graduate entering fellowship programs when the host Program Director has sufficient evidence to prove the fellow's competency including, but not limited to, the following conditions;

- Trainee has obtained board certification in a country other than the United States in the specialty area that he/she is pursuing;
- Trainee has been an independent practitioner at least for one year in the specialty area that he/she is pursuing; and
- Trainee does not have intention to pursue specialty board certification in the United States.

These exceptions will be reviewed by the GME Education Subcommittee and presented in the full GMEC for approval.

GMEC Approval: November 19, 2008; applies to all residents and fellows matriculating July 1, 2009 and thereafter.

GMEC Policy Subcommittee Review – May 11, 2010 / GMEC Review/Approval: May 19, 2010

GMEC Reviewed: July 21, 2010 GMEC Reviewed/Approved: August 18, 2010

GMEC Policy Subcommittee Reviewed/Approved: February 14, 2012

GMEC Reviewed/Approved: February 15, 2012

GMEC Approved the amendment on the score reporting deadline: May 18, 2014

GMEC Policy Subcommittee Revised: February 10, 2015

GMEC Approved: February 18, 2015

GMEC Subcommittee Reviewed/Revised: December 12, 2017

GMEC Approved: December 20, 2017



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 10

(PLEASE NOTE: THIS IS NOT THE FULL GMEC POLICY! To consolidate space, this is only the portion pertaining to Moonlighting. The full policy can be found here: <https://med.virginia.edu/gme/institutional-policies/>)

A. SUBJECT: Learning and Working Environment for GME Trainees

B. EFFECTIVE DATE: May 16, 2018 (R)

C: REASONS FOR POLICY

The University of Virginia Medical Center (UVAMC) strives to provide excellence, innovation and superlative quality in the care of patients, the training of health professionals, and the creation and sharing of health knowledge within a culture that promotes equity, diversity and inclusiveness. To promote these goals, the UVAMC is committed to a safe and supportive learning and working environment for all members of its community. This policy outlines the responsibilities for Graduate Medical Education (GME) programs and the steps to be taken to ensure well-being and quality of clinical experiences and education of GME Trainees.

This policy shall apply to all GME Trainees at the UVAMC.

Definition of Terms:

Internal Moonlighting: Voluntary, compensated, medically-related work (not related with training requirements) performed within the institution in which the GME Trainee is in training or at any of its related participating sites.

External Moonlighting: Voluntary, compensated, medically-related work performed outside the institution where the GME Trainee is in training or at any of its related participating sites.

D. POLICY STATEMENT

3. Clinical Experience and Education

Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide GME Trainees with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

e) Moonlighting

- Moonlighting must not interfere with the ability of the GME Trainee or other Trainees in the program to achieve the goals and objectives of the educational program, and must not interfere with the GME Trainee's fitness for duty nor compromise patient safety.
- Time spent by GME Trainees in internal and external moonlighting must be counted toward the 80-hour maximum weekly limit.
- All ACGME-accredited GME Trainees in PGY-1 year are not permitted to moonlight.
- A GME Trainee who wishes to moonlight must follow the Moonlighting protocols outlined in Appendix B which is incorporated into this Policy.

GMEC Reviewed and approved: January 19, 2000 MPC 06/06/2000;

GMEC Reviewed and approved: June 19, 2002

GMEC Reviewed and Approved: June 19, 2002

GMEC Review and Approved: November 18, 2009

Reviewed/Revised: GMEC Policy Subcommittee, June 22, 2010

Reviewed: GMEC, July 21, 2010

GMEC Reviewed/Approved: August 18, 2010

GMEC Reviewed/Approved: January 19, 2011

GMEC Reviewed/Approved: April 20, 2011

GMEC Reviewed/Approved: September 21/27, 2011

GME Policy Subcommittee Reviewed/Revised: August 12, 2014

GMEC Policy Subcommittee Reviewed/Revised: January 12, February 9, March 8, & April 12, 2016

GMEC Policy Subcommittee Reviewed/Revised: May 9, June 13, July 11, August 8, 2017, April 10, 2018, and May 8, 2018

GMEC Reviewed/Approved: May 16, 2018

Appendix B: MOONLIGHTING PROTOCOLS

2. Programs and departments may have policies which are more restrictive than the institutional policy. Programs must not require GME Trainees to engage in moonlighting activities. Each department's policy regarding moonlighting activities must be well-publicized to its GME Trainees (e.g., handout materials; intranet).
3. Should a GME Trainee be approved by his/her program director for moonlighting, then an [application to moonlight](#) must be submitted to the Graduate Medical Education Office (GMEO) no less than 60 days prior to the intended start date of the moonlighting activity. Applications will be referred to the DIO for review and approval. GME Trainees shall not begin moonlighting prior to receiving DIO approval.

4. Approval of moonlighting by DIO is subject to the program director's attestation that the proposed moonlighting does not interfere with the ability of the GME Trainee to achieve the goals and objectives of the required educational program, and that the GME Trainee is in good standing in his/her training program.
5. Approval for moonlighting may be valid for an academic year. Any granted moonlighting shall expire on the proposed ending date or June 30th each year, whichever comes first. A new application must be submitted at the beginning of each academic year.
6. The program director has primary responsibility to monitor fatigue levels of all GME Trainees participating in all moonlighting activities. Additionally, faculty members and GME Trainees must be educated to recognize the signs of fatigue and sleep deprivation and in alertness management and fatigue mitigation processes. Each GME programs must adopt policies to prevent and counteract potential negative effects of fatigue on patient care and learning.
7. Approval for moonlighting can be revoked at any point by the program director or DIO in any of the following cases. Reinstating the revoked approval for moonlighting is at the program director's discretion.
 - a) When it is determined that a GME Trainee's moonlighting activities negatively impact his/her ability to fulfill their clinical duties and patient care; or
 - b) When it is determined that a GME Trainee's moonlighting activities negatively impact the learning and working environment for other trainees in the program; or
 - c) When the GME Trainee is deemed unfit for clinical and/or non-clinical duties due to mental or physical impairment including injury, illness, and fatigue; or
 - d) When the program director or the program's Clinical Competency Committee issued a Letter of Deficiency to a GME Trainee: or
 - e) When the GME Trainee is suspended from his/her training program activities or clinical activities; or
 - f) When the GME Trainee is found to be non-compliant with the Medical Center and GME policies and regulations including, but not limited to, non-compliance with the mandatory NetLearning courses, flu-shot, TB-testing, and respiratory mask-fit deadlines; or
 - g) When the GME Trainee is found to be in Clinical and Educational Work Hours violation.
8. Time spent by trainees in any moonlighting activity must be counted towards the 80 hour Maximum Weekly Clinical and Educational Work Hours Limit. All moonlighting hours must be recorded in New Innovations as moonlighting hours in addition to the Clinical and Educational Work Hours for the regular educational activities.
9. In consideration of Clinical and Educational Work Hours restrictions, no GME Trainees assigned to inpatient service requiring in-house call shall engage in any moonlighting activity during that rotation.
10. Audits of moonlighting hours logged will be performed by the GMEO and the GME trainee's program director.
11. In view of the serious legal implications of GME Trainees engaging in unauthorized moonlighting activities, noncompliance with this policy may result in certain disciplinary or adverse actions, including dismissal from the residency or fellowship training program. Specific disciplinary or adverse actions will be determined by the program director, department chair, or DIO.



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 12

A. SUBJECT: Graduate Medical Education Trainee Supervision Policy

B: EFFECTIVE DATE: November 9, 2017 (R)

C: POLICY:

This policy outlines the University of Virginia Graduate Medical Education (GME) requirements regarding progressive responsibility of GME Trainees (hereinafter "Trainees") and Trainee supervision. The Policy incorporates all applicable University of Virginia Medical Center and Accreditation Council of Graduate Medical Education institutional policies,

procedures and standards of accreditation. Note that where appropriate, program-specific standards for supervision may exist and supersede institutional requirements, which are minimum standards.

D. Procedure

1. Levels of Supervision

To promote oversight of GME Trainee supervision while providing for graded authority and responsibility, the following classification of supervision must be employed:

- a. Direct Supervision – the supervising physician is physically present with the trainee and patient.
- b. Indirect Supervision:
 - with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision.
 - with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide direct supervision within 30 minutes after contact.
- c. Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

2. Supervision and Accountability

GME Programs, in partnership with UVA Health System, must:

- i. Ensure that each patient must have an identified, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care; this information must be available to Trainees, faculty members, other members of the health care team, and patients;
- ii. Assure Trainees and faculty must inform each patient of their respective roles in that patient's care when providing direct patient care;
- iii. Demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. Programs must be in compliance with relevant accreditation requirement(s) which specifies which activities require different levels of supervision;
- iv. Delegate each Trainee progressive authority and responsibility, conditional independence, and a supervisory role in patient care assigned by the program director and the program's Clinical Competency Committee;
- v. Ensure that senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress towards independence, based on the needs of each patient and the skills of the individual resident or fellow;
- vi. Establish a mechanism of 1) providing feedback and program notification if either a member of the faculty or a Trainee identifies a problem with supervision; 2) action to be taken if the supervising attending physician is unavailable, does not respond to attempts at communication, or does not provide adequate supervision and 3) action to be taken in emergency situations where a Trainee is beyond his/her level of experience or competence;
- vii. Ensure sufficient duration of faculty supervision assignments in assessing the competency of each Trainee and in delegating the Trainee the appropriate level of patient care authority and responsibility; and
- viii. Ensure that adequate supervision is provided to the Trainee rotating to participating institutions and at away elective rotation sites.

3. Trainee Responsibilities

- c. Trainees must be aware and adhere to the institutional and program-level policies on Trainee supervision.
- d. Licensed Trainees at all levels of training may write orders under the supervision of an attending physician. All orders shall include the date signed by the Trainee. Requirements for the completeness and timing of the patient history and physical exam ("H&P"), including a listing of the minimum contents to be included in the medical record by trainees, shall comply with appropriate medical records policies and applicable hospital licensing and Joint Commission standards.
- e. Trainees must request supervision from the attending physician or supervisor if asked to perform a procedure when he/she has insufficient experience with the procedure and/or universal protocol, or when the procedure is beyond the Trainee's competence.
- f. If IRPA (In-house Rescue Physician Adult) is activated, the attending IRPA physician can assume the supervisory role for that patient for the IRPA event, but the Trainee must notify the regular attending of the activation within 90 minutes.
- g. A Trainee must notify the responsible Attending Physician within 90 minutes of any of the following events in line with the Medical Center Policy 0324: Clinical Communication and Escalation of Care/Inpatient Services. Individual

departments may have additional events or more urgent time restrictions that qualify for notifying the responsible Attending Physician. The attending must review this list and discuss their expectations for Escalation of Care at the start of each rotation.

- Patient admission to hospital and/or service
- Transfer of patient to or from the intensive care unit or to a higher level of care
- Need for intubation or ventilator support
- Cardiac arrest or significant changes in hemodynamic status (e.g. Code 12 or MET team activation)
- Significant change in clinical status
- Development of significant neurological changes
- Development of major wound complications
- Medication errors requiring clinical intervention
- Any significant clinical problem that will require an invasive procedure or operation
- Patient death
- Notification of patient representative that family wishes to lodge a formal complaint
- Activation of IRPA for anything other than routine procedures
- Patient and/or family request to see, or to speak with the attending physician
- Whenever a GME Trainee believes that his/her ability to provide care to the patient is impeded.

Approved, GMEC, University of Virginia Health System: September 1992

Revised: GMEC, June 20, 2001

Approved, Medical Policy Council, October 2, 2001

Reviewed: GMEC, November 20, 2002

Reviewed and Approved GMEC, May 31, 2007

Reviewed GMEC, November 18, 2009

Reviewed: GMEC Policy Subcommittee, April 13, 2010

Reviewed/Approved: GMEC, April 21, 2010

Reviewed/Approved: GMEC Policy Subcommittee, July 5, 2011 and August 23, 2011

GMEC Reviewed/Approved: March 21, 2012

GMEC Policy Subcommittee Reviewed: August 14, 2012

GMEC Reviewed/Approved: August 15, 2012

Reviewed/Approved: GMEC Policy Subcommittee, August 20, 2013

Revised/Approved: GMEC: January 21, 2015

GMEC Policy Subcommittee Reviewed/Revised: October 11 and Online, 2017

GMEC Reviewed/Approved through Online Review and Voting: November 9, 2017



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 13

- A. SUBJECT: Other Learners
- B. EFFECTIVE DATE: October 18, 2017 (R)
- C. POLICY: Policy on Presence of Other Learners

The presence of other learners in the GME programs clinical learning environment must not interfere with the appointed trainees' education. The program director must report the presence of other learners who interfere with trainee education to the DIO and GMEC. GME trainees can also report presence of other learners who interfere with their education.

The GMEC encourages programs to review the results of the anonymous ACGME resident survey with their graduate medical trainees, addressing the question of interference from other learners.

GMEC Reviewed/Approved: March 18, 2009

GMEC Reviewed/Approved: July 15, 2009
GMEC Policy Subcommittee: February 11, 2011 and March 8, 2011
GMEC Reviewed/Approved: March 16, 2011
GMEC Policy Subcommittee Reviewed/Revised: April 08, 2014
GMEC Reviewed/Approved: April 16, 2014
GMEC Policy Subcommittee: September 12, 2017
GMEC Reviewed/Approved: October, 18, 2017



Office of Graduate Medical Education

GRADUATE MEDICAL EDUCATION COMMITTEE POLICY NO. 15

- A. SUBJECT: Trainees Rotating Off Service
- B: EFFECTIVE DATE: October 18, 2017 (R)
- C: POLICY: Graduate Medical Trainees rotating in other program's services

Definitions:

Primary Program – Residency/Fellowship Program in which Graduate Medical Education (GME) Trainee is based.
Host Program – Residency/Fellowship Program in which GME Trainee from another UVA GME program rotates.
Off-Service Trainee – GME Trainee within the UVA system rotating to another clinical service other than his/her primary/home program.

D: PROCEDURE:

The University of Virginia Medical Center seeks to provide the appropriate educational experiences for GME Trainees. This often involves GME Trainees rotating from their primary program to another program within the sponsoring institution. In order to formalize this interaction, the following guidelines govern this interaction:

1. If any GME training requires a rotation to another Department other than the GME Trainee's primary Department, program directors from both the primary and host residency programs must agree to this collaboration.
2. The host program must distribute level specific goals and objectives of the rotation to the off service trainee and the primary program's Program Director along with any other education materials.
3. A rotation schedule must be made in advance allowing the two programs involved to make the needed adjustments to accreditation and/or board certification requirements and regulations as well as the individual needs of each Department. It is suggested that rotation schedules are distributed to the other services as early as April, but no later than May.
4. If a host program is no longer able to accommodate GME Trainees other than their own, a minimum of 6 months must be given to the primary residency to make the necessary schedule/rotation adjustments.
5. Host program will determine availability of leave, and will be communicated between Program Directors. If scheduled leave is allowed, off-service trainees will submit requests for leave at the time yearly schedules are made. However, a request for leave must be made at least 60 calendar days prior to the start of the rotation in which the leave is being requested. Requests for leave will be submitted by the off service trainee to the host program's Chief Resident or other individual who is responsible for that program's scheduling.
6. In programs where off-service trainees are scheduled on a regular basis and/or where the presence of those trainees is required to meet the patient care needs of the host program, any changes in the complement of those trainees must be communicated by the primary program to the host program well in advance of the deadline for NRMP or similar match programs are declared (in general, February) to allow the host program adequate time for any necessary adjustments.
7. In the event an off service trainee has continuity clinic and/or mandatory didactic session during his/her rotation with the host program, the host Department in which the trainee is rotating must be informed of this at the time of initial agreement to host the trainee. Upon completion of the continuity clinic and/or mandatory didactic

program, the off service trainee must return or at a minimum check with the hosting Department to see if he or she needs to return for clinical duties.

8. Host Program Directors and/or program faculty are responsible for the evaluation of the off service trainee on their service. However, it is the responsibility of the primary residency program to distribute the evaluation to the host program in a timely manner (suggested end of rotation basis).
9. The off service trainee will follow the Clinical and Educational Work Hours requirements of the host program.

Reviewed/Approved GMEC: October 3, 2007, January 13, 2011

Reviewed/Approved Policy Subcommittee: April 12, 2011

Reviewed/Approved GMEC: April 20, 2011

Reviewed/Approved GMEC: July 16, 2014

GMEC Policy Subcommittee: October 10, 2017

GMEC Reviewed/Approved: October 18, 2017

**Radiation Oncology
Oral I-131 & Parenteral Administration Log**

Resident Name

University of Virginia Radiation Oncology
Program

48-01-01-3____
Program Number

Date	Disorder	Radionuclide	Dose Administered	Preceptor Name / Signature
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Oral I-131 (>33 mCi)

- | | | | | |
|----|-------|--------------|-------|-------|
| 1. | _____ | <u>I-131</u> | _____ | _____ |
| 2. | _____ | <u>I-131</u> | _____ | _____ |
| 3. | _____ | <u>I-131</u> | _____ | _____ |
| 4. | _____ | <u>I-131</u> | _____ | _____ |

Parenteral

- | | | | | |
|----|-------|-------|-------|-------|
| 1. | _____ | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ | _____ |
| 5. | _____ | _____ | _____ | _____ |