

2023 - 2024

UNIVERSITY OF VIRGINIA HEALTH SYSTEM

Charlottesville, Virginia

Urology Residency Handbook

The Department of Urology



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Faculty

“Urologists are first and foremost surgeons, and excellence in urologic surgery can be achieved only through diligent and exhaustive application to both the fundamentals of surgery and the advancing technology of the urologic specialist” – James F. Glenn, MD

Chair:

Kirsten Greene, M.D.-Dr. Greene is the Chair of the Department of Urology and joined the faculty in 2019. Dr. Greene completed her Urology residency at UCSF and joined UCSF as Clinical Instructor in the Department of Urology (2006). She was then promoted to assistant (2008), associate (2013), and full professor (2018). She was named to the Frank Hinman Jr., MD Endowed Professorship in Urologic Education in (2018). During her time at UCSF, Dr. Greene served as Associate Chair for Education and Vice Chair and Chief of the Urology Service at the San Francisco Veterans Affairs Medical Center (SFVAMC). Dr. Greene’s clinical interests include urologic cancer outcomes, screening, quality of life, minimally invasive surgery, and novel imaging technology.

Adult Staff:

Raymond Costabile, M.D.- Dr. Costabile is a Professor of **Urology** and is responsible for specialty urology services in andrology, male sexual medicine, male reconstruction, and general urology. He has extensive experience in urologic trauma and reconstructive surgery. Dr. Costabile reviews overall educational goals with the residents in addition to monitoring performance during conferences. Dr. Costabile oversees the residents’ responsibility of outpatient clinics and operative management.

Stephen Culp, M.D., Ph.D. – Dr. Culp completed an oncology fellowship at the M.D. Anderson Cancer Center in 2011. His research and clinical interests focus on renal cell carcinoma. He spends time conducting research and in clinical endeavors. Dr. Culp serves on the Program Evaluation Committee. He is the Medical Director of the Urology clinic at Fontaine.

Mikel Gray, Ph.D. – Dr. Gray is a Certified Urologic Nurse Practitioner who has internationally recognized expertise in neurological voiding dysfunction, urinary incontinence, neurogenic bladder, and interstitial cystitis. His research interests are in urinary incontinence, bio-feedback therapy, neurogenic bladder, moisture associated skin damage, and incontinence associated dermatitis.

Tracey L. Krupski, M.D., MPH – She serves as **Vice-Chair of the Department**. Dr. Krupski is a genitourinary oncologist, specializing in: renal, bladder, testicular, and prostate

cancer. She is the Department's expert in outcomes research. She is chair of the Clinical Competency Committee. She also heads the Department's section on Clinical Trials.

Dr. David Rapp, M.D. – Dr. Rapp joined the faculty in 2018. He is a specialist in female and pelvic reconstruction and neurourology. His research interests include outcomes research in female urology. He also has an interest in Global Medicine and conducts several surgical missions a year to Belize and Africa.

Noah Schenkman, M.D. - Dr. Schenkman has experience in minimally invasive surgery, robotic surgery and laparoscopy. He has expertise in all aspects of urinary tract stone disease. He has established a laparoscopic curriculum and is an **Associate Program Director for the Urology Residency Program** after serving as the Program Director and stepping down in 2021.

Ryan Smith, M.D. – Dr Smith joined the faculty in 2013 after completion of an andrology fellowship at Baylor School of Medicine. Dr. Smith is **Program Director for the Urology Residency Program** and is responsible for the overall conduct of the residency program. He is a specialist in men's health with emphasis on benign disease of the prostate, male sexual dysfunction and male fertility. He is also co-Director of the Andrology Fellowship and the Medical Student Clerkship Director.

Sumit Isharwal, M.D. – Dr Isharwal is a genitourinary oncologist, specializing in: prostate, bladder, kidney, and testicular cancer. He has expertise in robotic-assisted laparoscopic surgery as well as open surgery. This includes nerve-sparing prostatectomy, cystectomy, and retroperitoneal lymph node dissection.

Nico Ortiz, M.D.: Dr. Ortiz joined the Urology faculty in 2020 after completing a fellowship in Reconstructive Urology at UT Southwestern. Prior to that he completed his Urology resident at the University of Miami.

Haerin Beller, M.D., M.Sc: Dr. Beller joined the Urology faculty in 2021 after completing her residency here in June 2021. She is a general urologist with a special interest in treating simple and complex kidney stone disease, benign prostatic hyperplasia, and voiding dysfunction.

Tracy Downs, M.D.: Dr. Downs is a urologic oncologist and joined the faculty in 2021. In addition to providing patient care, Dr. Downs serves as UVA's first Chief Diversity & Community Engagement Officer. He joins us from the University of Wisconsin School of Medicine and Public Health, where he was Associate Dean for Diversity and Multicultural Affairs and Professor of Urologic Oncology

Christine Ibilbor, M.D., M.Sc: Dr. Ibilbor joined the faculty in 2021 after completing a urologic oncology fellowship at University of Texas Health Science Center at San Antonio.

Charles "Buckley" Gillock, M.D.: Dr. Gillock joined us in 2022. He is a general urologist and specializes in treating conditions such as benign prostatic hyperplasia, prostate cancer, kidney stones, incontinence, and neurogenic bladder. Dr. Gillock earned his undergraduate degree at UVA, and completed medical school and residency training at VCU.

Jacqueline Zillioux, M.D.: Dr. Zillioux returned to UVA as faculty in September 2022 after completing her residency here in 2020 as well as an FPMRS fellowship at Cleveland Clinic in 2022.

Kenneth Sands, D.O., MBA: Dr. Sands joined the faculty in August 2023. He completed fellowship at Washington University School of Medicine and residency at Michigan State University.

Mei Tuong, M.D.: Dr. Tuong returned to UVA as faculty in August 2023 after completing her residency here in 2022 as well as a GURS fellowship at the University of Iowa 2023.

Pediatric Staff:

Sean T. Corbett, M.D. – Dr. Corbett is a subspecialist in pediatric urology and has experience in complex pediatric surgical procedures. He is a pioneer in use of robotic laparoscopy in the pediatric population. Dr. Corbett has critical roles in carrying out our teaching mission on the undergraduate level, participating in the NexGen Curriculum, and at the Graduate level, serving on the Clinical Competency Committee and serving as chair of the Program Evaluation Committee.

Nora Kern, M.D, MPH.: Dr. Kern joined the faculty in 2015, after finishing a fellowship in pediatric urology as National Children’s Medical Center. She has a specialty in outcomes research and is a dynamic educator. Dr. Kern is an **Associate Program Director** for the Urology Residency Program and Director of the 4th year Urology Acting Internship.

Residents

PGY – 5 (Chief Residents)

- Alexander Henry
- Clinton Yeaman (Academic Leadership)

PGY – 4

- David Tella
- Dylan Hutchison (Academic Leadership)

PGY – 3

- Kaitlyn Berry
- Katherina Chen (Academic Leadership)

PGY- 3 Academic Leadership (non-accredited)

- Fionna Sun (Academic Leadership)

PGY-2

- Jeunice Owens-Walton
- Bahrom Ostad

PGY-1

- Emmett “Bard” Kennady
- Grace Ignozzi

Introduction

Welcome to the University of Virginia Urology Residency Program. This handbook outlines important aspects of the training program and will guide you during your residency. The handbook includes goals and objectives for each year-level of training, each rotation as well as the responsibilities expected of residents. You will also find in this handbook the expectations of the faculty, schedule of your training including the various conferences, as well as the methods to evaluate your progress. Additional information about the institutional policies and regulations regarding residency training may be found in the Graduate Medical Education Institutional Resident Guidelines. The Accreditation Council for Graduate Medical Education (ACGME) website provides essential information about the program requirements and faculty/resident responsibilities.

The Urology faculty is here to serve as a guide as you learn the art and science of Urology. We pledge to stimulate your intellect and give timely feedback and direction to ensure that you fulfill your potential as a urologic surgeon. We ask you to pursue excellence in everything you do, providing the best possible patient care and to fulfill your maximum potential as students of Urology.

Noah Schenkman, MD
Associate Program Director, Urology Residency

Educational Program

Mission Statement

- Train physicians to provide humane clinical care, innovative research, and self-motivated education in all aspects of urologic diseases.

Vision Statement:

- Develop urologists that focus care on patient needs and are continuously innovating to discover better solutions for urologic disease.

Scope of Residency

The UVa Urology Program is a five year program of postgraduate education with progressively increasing levels of responsibility each year. The program consists of five years of Urology. Every year two fourth year medical students are selected to enter into the program.

ACGME Accreditation

The UVa Urology Program is fully accredited by the ACGME and completed its last Residency Review Self Study visit in August 2018.

Core Curriculum

With direction from the ACGME, we have emphasized the importance of six core competencies: **patient care**, **medical knowledge** (clinical science), **practice-based learning and improvement**, **interpersonal skills** and **communication**, **professionalism**, and **systems-based practice**. Each of these competencies is the focus of several key milestones upon which progression through the residency is documented. The goals outline below are patterned after the ACGME Milestones for Urology available at:

<https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/UrologyMilestones.pdf>

It is critical that residents review the milestones annually to help guided self assessment of progression through the program.

The curriculum for each year reflects these six competencies. A mastery of urology involves obtaining and understanding a larger body of information.

General Competency Based Goals and Objectives

(I) Patient Care

Goal: Provide care appropriate, effective and compassionate medical and surgical care to patients with urological health problems.

Objectives:

1. Obtain a complete and accurate history and physical examination from patients with genitourinary complaints.
2. Interpret and obtain appropriate laboratory studies for the evaluation of urologic disorders.
3. Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.
4. Apply current scientific evidence using information technology to facilitate the diagnosis and treatment of urologic disease.
5. Appropriately counsel and educate patients and their families about specific urologic problems.
6. Know the health care services aimed at preventing urologic problems and maintaining health.
7. Work with other medical and surgical disciplines and health care professionals to provide multidisciplinary care to the urology patient.
8. Competently perform all diagnostic and invasive procedures required for the appropriate management of genitourinary disorders in the outpatient setting.
9. Perform all urologic surgical procedures including open, endourologic and laparoscopic cases, in a competent manner.

Evaluation Methods:

1. Global faculty evaluation
2. Case based presentations
3. 360 degree evaluation

(II) Medical Knowledge

Goal: Acquire basic scientific and clinical knowledge of the full spectrum of genitourinary disorders and be able to apply this knowledge to care of the urologic patient.

Objectives:

1. Know the embryology, anatomy and physiology of the genitourinary system.
2. Apply knowledge of the pathophysiology of urologic disorders to the care of individual patients.
3. Obtain and process knowledge about urologic disorders from reading sources, the literature and didactic teaching sessions.
4. Perform well on standardized examinations (both written and oral) assessing fund of basic science and clinical knowledge.
5. Dedication to improvement in medical knowledge through a commitment to continued medical education.

Evaluation Methods:

1. Written examination-In-service examination and Self-Assessment Exam- AUA-SASP
2. Global faculty evaluation
3. Case Based Presentations

(III) Practice-Based Learning and Improvement

Goal: Improve urologic patient care practices by the critical evaluation of current practice patterns and by the appraisal and assimilation of scientific evidence.

Objectives:

1. Critically analyze on a regular basis current practice experience using a systematic and reliable methodology.
2. Perform practice-based improvement by implementing a change in practice based on newly acquired clinical information.
3. Locate, appraise and assimilate scientific studies from the urologic literature applicable to management.
4. Understand scientific study design and statistical analysis to allow evaluation and appraisal of clinical studies.
5. Use information technology to access medical information for themselves and the patient
6. Be an effective teacher of medical students, junior urology residents and other health care professionals.

Evaluation Methods:

1. Global faculty evaluation
2. Portfolio- Morbidity/Mortality Reports, and Journal Club Reports, Safety and Quality Projects.

(IV) Interpersonal and Communication Skills

Goal: Develop interpersonal and communication (verbal and writing) skills that will allow effective exchange of information with urologic patients, their families and other health care professionals.

Objectives:

1. Develop rapport with urologic patients and their families.
2. Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal, explanatory and patient interview skills.
3. Formulate and write coherent and legible notes in the medical record.
4. Write clear, concise and comprehensible manuscripts for publication in the urologic literature.
5. Prepare and deliver oral or case presentations in a thoughtful, organized and coherent manner.
6. Work effectively with others (urologic residents and faculty) as a member or leader of the Urology health care team.
7. Interact and communicate effectively with nurses and other health professionals and hospital staff

Evaluation Methods:

1. Global faculty evaluation
2. Review of medical records
3. 360 degree evaluation- Nursing and Peer to Peer evaluations

(V) Professionalism

Goal: Be professional by adherence to high ethical standards, professional responsibilities and sensitivity to the diverse urologic patient population.

Objectives:

1. Have respect, compassion and integrity in your interactions with patients, their family members and other health care professionals.
2. Accept responsibility readily, be industrious and self-motivated, and bring assigned tasks to completion.
3. Function as an effective leader of the Urology health care team.
4. Understand and commit to the ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent and urology business practices.
5. Be sensitive and responsive to the urology patients' culture, age, gender and disabilities.

Evaluation Methods:

1. Global faculty evaluation
2. 360 degree evaluation-Nursing Evaluations

(VI) Systems-Based Practice

Goal: Be aware of and responsive to the health care system in which you practice, and use available resources from this health care system to optimize care of the urologic patient.

Objectives:

1. Understand how urology patient care practices affect other health care professionals within the local, regional and national military health care system.
2. Describe how elements of the military health care system affect your individual urology practice.
3. Understand differences between various types of medical practices and delivery systems (eg HMO, academic, military, private practice, etc.), especially with regard to health care costs and allocation of resources.
4. Readily identify and correct health care system deficiencies that may result in less than optimal care of the urology patient.
5. Assist urology patients in dealing with health care system complexities.
6. Practice cost-effective health care and resource allocation without compromising quality of patient care.
7. Know how to partner with health care managers or other providers in efforts to improve coordination and effectiveness of the health care system

Evaluation Methods:

1. Faculty Global Evaluation
2. Nursing 360 evaluations
3. Annual Safety and Quality Project.

Block Diagram:

UVA Urology Residency Program

Urology Residency Fillable Block Diagram
Review Committee for Urology

YEAR 1

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	1				1				1	1	1	1
Rotation Name	General Urology				General Surgery				EGS	SICU	Peds	Colorectal
% Operative	90%				90%				90%	90%	90%	90%
% Non-Operative	10%				10%				10%	10%	10%	10%
% Research	<i>Dedicated research time not permitted.</i>											

YEAR 2

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	1			1			1			1		
Rotation Name	Pediatric Urology			Endourology			Urologic Oncology			Andrology/Reconstruction		
% Operative	90%			90%			90%			90%		
% Non-Operative	10%			10%			10%			10%		
% Research	0%			0%			0%			0%		

YEAR 3

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	1				1				1			
Rotation Name	Endourology				Urologic Oncology				Andrology/Reconstruction			
% Operative	90%				90%				90%			
% Non-Operative	10%				10%				10%			
% Research	0%				0%				0%			

YEAR 4

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	1						1		1			1
Rotation Name	Outpatient/Inpatient Urologic Surgery						Urogynecology		Pediatric Urology			Surg(Chief)
% Operative	90%						90%		90%			90%
% Non-Operative	10%						10%		10%			10%
% Research	0%						0%		0%			0%

YEAR 5

Block	1	2	3	4	5	6	7	8	9	10	11	12
Site	1						1					
Rotation Name	Minimally Invasive Surgical Experience (Chief)						Open Surgical Experience (Chief)					
% Operative	90%						90%					
% Non-Operative	10%						10%					
% Research	<i>Dedicated research time not permitted.</i>											

Program Goals and Objectives by Year

The American Urological Association (AUA) provides a core curriculum that all residents should be familiar with. It can be found at:

<https://www.auanet.org/university/search.cfm?byYear=undefined&CourseType=6&CourseTrack=&keyword=&language=&intl=>

Each year the curriculum reflects the experiences gained from multiple sources: didactic conferences, journal club, discussions at patient management and pediatric conferences, learning gained from caring for patients on an inpatient and outpatient basis and self-directed learning. The curriculum rests upon the foundation of the experiences of the previous year, and assumes the curriculum of the previous year has been mastered. Specific rotational goals are emphasized in the resident evaluation forms that are rotation and level specific.

PGY-1 Urology Residents

PGY-1 (Uro-1) Residents are assigned to three months of outpatient urology, and eight months of core surgical education in rotations outside of urology designed to foster competence in basic surgical skills, the peri-operative care of surgical patients, and inter-disciplinary patient care

coordination, including: three months of general surgery, and five months of additional non-urological surgical training. This includes at least one month of general surgery at the Veterans Affairs Medical Center in Salem, Virginia.

PGY-1 urology residents are expected to assume responsibilities similar to a PGY-1 general surgery resident, as well as actively participate in urology conferences and journal clubs. The goals of the first year of residency are to provide the trainee with a basic foundation of the scientific basis of surgical disease and a framework for applying knowledge and skills to provide optimum patient care and to ensure patient safety.

University of Virginia Hospital – Inpatient/Outpatient

Patient Care

Goal – Perform a complete interview and accurate history from patients with urologic disorders encountered in the urology outpatient clinic setting.

- ❖ Using appropriate and effective interview techniques, elicit, and characterize an accurate history of the present illness from patients presenting with genitourinary complaints.
- ❖ Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal and explanatory skills
- ❖ Formulate and write notes in the electronic health record.
- ❖ Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.
- ❖ Counsel and educate patients and their families about specific urologic problems.
- ❖ Develop empathy, understanding, compassion, and honesty during interactions with patients and their families.
- ❖ Develop sensitivity and responsiveness to the Urology patients' culture, age, gender, and disabilities.

Goal – Competent care and evaluation of the preoperative and postoperative urologic patient.

- ❖ Perform and write clear and appropriately detailed history and physical examination on all preoperative patients.
- ❖ Prepare and write clear and detailed admission orders.
- ❖ Assess and discuss the operative and anesthetic risks of surgical procedures.
- ❖ Obtain informed consent for all surgical procedures.
- ❖ Discuss the physiologic response of the normal patient to surgical procedures and factors that modify these responses.
- ❖ Discuss and evaluate wound healing as it relates to surgical incisions.
- ❖ Treat and evaluate pain in a safe and effective manner in the post-surgical patient.
- ❖ Discuss and evaluate the role of peri-operative pharmacological agents, singly or in combination, and apply this knowledge to the care of the surgical patient.
- ❖ Understand the influence of other diseases and co-morbidities upon surgical care.
- ❖ Recognize and correct nutritional defects in the surgical patient.
- ❖ Recognize and deal effectively with the psychological and emotional problems associated with anxiety imposed by urologic surgery

Medical Knowledge

Goal – Accurate performance and interpretation of commonly performed urologic laboratory studies.

- ❖ Demonstrate ability to perform and interpret laboratory studies including routine urinalysis, residual urine measurements, expressed prostatic secretions (EPS), and semen analysis.
- ❖ Interpret and discuss laboratory studies including serum PSA levels and free/total PSA, urinary electrolyte studies, serum electrolyte studies and acid-base analysis, serum creatinine and BUN, and creatinine clearance.

Goal – Perform and accurately interpret radiographic studies performed in the outpatient clinic.

- ❖ Be able to competently perform and interpret radiographic studies including plain films of the kidney, ureters and bladder (KUB), intravenous pyelogram (IVP), retrograde pyelogram, retrograde urethrogram, voiding cystourethrogram (VCUG), and transrectal prostatic ultrasound.
- ❖ Be able to accurately interpret an abdominal/pelvic CT scan, MRI scan, renal ultrasound, and radionuclide studies of the genitourinary tract.

Goal – Perform a detailed and appropriately focused urologic physical examination.

- ❖ Discuss and demonstrate ability to perform a detailed examination of the following genitourinary organ systems:
 - Abdominal examination of the kidneys (inspection, palpation, and percussion)
 - Inspection, percussion and palpation of the bladder
 - Inspection and palpation of the penis
 - Inspection, palpation and trans-illumination of the scrotum and its contents including the testis, testicular tunics and adnexa, spermatic cord and vas deferens
- ❖ Discuss and demonstrate ability to perform a detailed male rectal examination to include:
 - Assessment of the anal sphincter and lower rectum
 - Prostate palpation to characterize its size, consistency, mobility and the presence or absence of abnormalities such as nodules or induration
 - Prostatic massage
 - Palpation of the seminal vesicles
- ❖ Discuss and demonstrate an appropriate vaginal and recto-vaginal examination in the female. Be able to evaluate and grade pelvic organ prolapse (POP-Q).
- ❖ Be able to perform and interpret a focused Neuro-urologic examination.
- ❖ Demonstrate ability to recognize visually and to palpate enlarged lymph nodes in regions related to genitourinary disease and to discuss their importance relative to differential diagnosis to various disorders.
- ❖ When performing physical examination, be sensitive and responsive to the patients' culture, age, and gender.

Goal – Performance of diagnostic and therapeutic procedures encountered in urology outpatient clinic.

- ❖ Be able to perform outpatient procedures including transrectal ultrasound guided prostate biopsy, flexible and rigid cystoscopy, suprapubic tube placement, vasectomy, spermatic cord and penile block, circumcision, intravesical administration of chemotherapeutic or immunotherapeutic agents, and urethral dilation.

Goal - Develop an understanding of the pathophysiology, presentation, evaluation, treatment and management of common urologic conditions.

- ❖ Become proficient in the diagnosis and medical management of Benign Prostatic Hypertrophy (BPH)
- ❖ Become proficient in the surgical and minimally invasive management of BPH. Show an understanding of how to manage the complications of these treatments.

- ❖ Demonstrate proficiency in the evaluation of microscopic and gross hematuria
- ❖ Demonstrate proficiency in the evaluation and diagnosis of acute and chronic scrotal pain. Be able to discuss the presentation and differentiate epididymitis, testicular torsion, appendiceal torsion, orchitis, hernia, hydrocele, varicocele, spermatocele, testis mass and referred pain.
- ❖ Demonstrate proficiency in the management of acute and chronic urinary retention.
- ❖ Demonstrate proficiency in the ability to place a foley catheter in the setting of altered anatomy or previous traumatic catheterization.
- ❖ Become proficient in the diagnosis and management of acute and chronic prostatitis
- ❖ Demonstrate proficiency in the management of phimosis and paraphimosis.

Practice-Based Learning and Improvement

Goal – Acts as a leader/teacher in the education of medical students and other medical care professionals.

- ❖ Ability to write a clinical protocol based on previous research and the presentation of this protocol in the setting of an IRB meeting, compile data and present the results.
- ❖ Discuss the differences between Phase I, II, and III clinical studies
- ❖ Describe the relevant issues surrounding the design of clinical trials including principles of sample size computation, appropriate selection of patient population, the use of control groups, differences between various trial designs, difference between statistical and clinical significance, and the demonstration and understanding of experimental methods, data analysis, and statistics.
- ❖ Prepare a manuscript for submission.
- ❖ Present a research project at a local and/or national meeting.
- ❖ Know the pertinent surgical literature and ability to use print and electronic resources effectively.
- ❖ Attend and actively participate in M&M and other educational conferences.

Goal – Competent review and critique of basic science and clinical papers published in the urologic literature.

- ❖ Demonstrate ability to appropriately critique articles reviewed at the monthly Urology Journal Club meeting.
- ❖ Be able to analyze literature in the process of preparation of research proposals.

Interpersonal and Communication Skills

Goal – Develop presentation skills, healthy study habits and plan for upcoming research rotations.

- ❖ Present cases to faculty at conferences, on rounds, on call and in clinic. It is through these presentations that the resident develops skills in taking a history, putting the facts together and developing a treatment plan.
- ❖ Learn to speak and present effectively in front of their peers and faculty. Be able to handle questions and prepare well throughout responses.
- ❖ Develop study habits and a regular reading schedule so that they are prepared for rounds, conferences and the In-Service exam.
- ❖ Attend the Department of Clinical Investigation’s course entitled “Introduction to Clinical research.”
- ❖ Pick or be assigned a faculty who will mentor them and serve as their advisor for the research endeavors.

Professionalism

Goal – To have residents develop attitudes and skills, which provide the best possible care for urological patients and which conform to acceptable standards of medical and professional ethics.

- ❖ Treat nurses and technicians with respect.
- ❖ Treat families with respect.
- ❖ Serve as a role model for medical students.
- ❖ Present oneself as a professional in appearance, use of language, and in all forms of communication.
- ❖ Respect patient confidentiality.
- ❖ Complete medical records in a thorough and timely manner.

Systems-based Practice

Goal – To serve as a resource for Albemarle County and the State of Virginia for the management of urologic disease, particularly those of a complex nature.

- ❖ Effectively utilize social work, home health care and rehabilitative services for patients.
- ❖ Understand the indications for obtaining consultation with other health care specialists prior to the surgical procedures in select patients.

PGY-2 Urology Residents

PGY-2 (Uro-2) Residents are assigned for the entire year to the UVa hospital based outpatient clinic and inpatient non-private Urology Service. During these twelve months the resident is assigned to: 1) a staff-mentored clinic on a rotating schedule, 2) work under the supervision of the Chief Resident in the management of inpatients and 3) operative cases by the Chief Resident. In addition one full month is spent in: 1) Urologic Ultrasound and 2) Urodynamics.

This is a pivotal year in which the resident begins to develop the knowledge base and experience that will be expanded upon during each year of training. Residents will be expected to master the basics of history taking, examination, become proficient in basic procedural and operative skills as well as become exposed to and read about disease processes from each of the domains of Urology. The following lists the goals, objectives, and competencies for the PGY-2 year, which also serve as the foundation of knowledge, and experience for the ensuing years.

University of Virginia Hospital – Inpatient/Outpatient

Patient Care

Goal – Perform a complete interview and accurate history from patients with urologic disorders encountered in the urology outpatient clinic setting.

- ❖ Using appropriate and effective interview techniques, elicit, and characterize an accurate history of the present illness from patients presenting with genitourinary complaints.
- ❖ Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal and explanatory skills
- ❖ Formulate and write notes in the electronic health record.
- ❖ Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.
- ❖ Counsel and educate patients and their families about specific urologic problems.
- ❖ Develop empathy, understanding, compassion, and honesty during interactions with patients and their families.

- ❖ Develop sensitivity and responsiveness to the Urology patients' culture, age, gender, and disabilities.

Goal – Competent care and evaluation of the preoperative and postoperative urologic patient.

- ❖ Perform and write clear and appropriately detailed history and physical examination on all preoperative patients.
- ❖ Prepare and write clear and detailed admission orders.
- ❖ Assess and discuss the operative and anesthetic risks of surgical procedures.
- ❖ Obtain informed consent for all surgical procedures.
- ❖ Discuss the physiologic response of the normal patient to surgical procedures and factors that modify these responses.
- ❖ Discuss and evaluate wound healing as it relates to surgical incisions.
- ❖ Treat and evaluate pain in a safe and effective manner in the post-surgical patient.
- ❖ Discuss and evaluate the role of peri-operative pharmacological agents, singly or in combination, and apply this knowledge to the care of the surgical patient. Bert2248!
- ❖
- ❖ Understand the influence of other diseases and co-morbidities upon surgical care.
- ❖ Recognize and correct nutritional defects in the surgical patient.
- ❖ Recognize and deal effectively with the psychological and emotional problems associated with anxiety imposed by urologic surgery

Medical Knowledge

Goal – Accurate performance and interpretation of commonly performed urologic laboratory studies.

- ❖ Demonstrate ability to perform and interpret laboratory studies including routine urinalysis, residual urine measurements, expressed prostatic secretions (EPS), and semen analysis.
- ❖ Interpret and discuss laboratory studies including serum PSA levels and free/total PSA, urinary electrolyte studies, serum electrolyte studies and acid-base analysis, serum creatinine and BUN, and creatinine clearance.

Goal – Perform and accurately interpret radiographic studies performed in the outpatient clinic.

- ❖ Be able to competently perform and interpret radiographic studies including plain films of the kidney, ureters and bladder (KUB), intravenous pyelogram (IVP), retrograde pyelogram, retrograde urethrogram, voiding cystourethrogram (VCUG), and transrectal prostatic ultrasound.
- ❖ Be able to accurately interpret an abdominal/pelvic CT scan, MRI scan, renal ultrasound, and radionuclide studies of the genitourinary tract.

Goal – Perform a detailed and appropriately focused urologic physical examination.

- ❖ Discuss and demonstrate ability to perform a detailed examination of the following genitourinary organ systems:
 - Abdominal examination of the kidneys (inspection, palpation, and percussion)
 - Inspection, percussion and palpation of the bladder
 - Inspection and palpation of the penis
 - Inspection, palpation and trans-illumination of the scrotum and its contents including the testis, testicular tunics and adnexa, spermatic cord and vas deferens
- ❖ Discuss and demonstrate ability to perform a detailed male rectal examination to include:
 - Assessment of the anal sphincter and lower rectum

- Prostate palpation to characterize its size, consistency, mobility and the presence or absence of abnormalities such as nodules or induration
- Prostatic massage
- Palpation of the seminal vesicles
- ❖ Discuss and demonstrate an appropriate vaginal and recto-vaginal examination in the female. Be able to evaluate and grade pelvic organ prolapse (POP-Q).
- ❖ Be able to perform and interpret a focused Neuro-urologic examination.
- ❖ Demonstrate ability to recognize visually and to palpate enlarged lymph nodes in regions related to genitourinary disease and to discuss their importance relative to differential diagnosis to various disorders.
- ❖ When performing physical examination, be sensitive and responsive to the patients' culture, age, and gender.

Goal – Performance of diagnostic and therapeutic procedures encountered in urology outpatient clinic.

- ❖ Be able to perform outpatient procedures including transrectal ultrasound guided prostate biopsy, flexible and rigid cystoscopy, suprapubic tube placement, vasectomy, spermatic cord and penile block, circumcision, intravesical administration of chemotherapeutic or immunotherapeutic agents, and urethral dilation.

Goal - Develop an understanding of the pathophysiology, presentation, evaluation, treatment and management of common urologic conditions.

- ❖ Become proficient in the diagnosis and medical management of Benign Prostatic Hypertrophy (BPH)
- ❖ Become proficient in the surgical and minimally invasive management of BPH. Show an understanding of how to manage the complications of these treatments.
- ❖ Demonstrate proficiency in the evaluation of microscopic and gross hematuria
- ❖ Demonstrate proficiency in the evaluation and diagnosis of acute and chronic scrotal pain. Be able to discuss the presentation and differentiate epididymitis, testicular torsion, appendiceal torsion, orchitis, hernia, hydrocele, varicocele, spermatocele, testis mass and referred pain.
- ❖ Demonstrate proficiency in the management of acute and chronic urinary retention.
- ❖ Demonstrate proficiency in the ability to place a foley catheter in the setting of altered anatomy or previous traumatic catheterization.
- ❖ Become proficient in the diagnosis and management of acute and chronic prostatitis
- ❖ Demonstrate proficiency in the management of phimosis and paraphimosis.

Practice-Based Learning and Improvement

Goal – Acts as a leader/teacher in the education of medical students and other medical care professionals.

- ❖ Ability to write a clinical protocol based on previous research and the presentation of this protocol in the setting of an IRB meeting, compile data and present the results.
- ❖ Discuss the differences between Phase I, II, and III clinical studies
- ❖ Describe the relevant issues surrounding the design of clinical trials including principles of sample size computation, appropriate selection of patient population, the use of control groups, differences between various trial designs, difference between statistical and clinical significance, and the demonstration and understanding of experimental methods, data analysis, and statistics.
- ❖ Prepare a manuscript for submission.
- ❖ Present a research project at a local and/or national meeting.

- ❖ Know the pertinent surgical literature and ability to use print and electronic resources effectively.
- ❖ Attend and actively participate in M&M and other educational conferences.

Goal – Competent review and critique of basic science and clinical papers published in the urologic literature.

- ❖ Demonstrate ability to appropriately critique articles reviewed at the monthly Urology Journal Club meeting.
- ❖ Be able to analyze literature in the process of preparation of research proposals.

Interpersonal and Communication Skills

Goal – Develop presentation skills, healthy study habits and plan for upcoming research rotations.

- ❖ Present cases to faculty at conferences, on rounds, on call and in clinic. It is through these presentations that the resident develops skills in taking a history, putting the facts together and developing a treatment plan.
- ❖ Learn to speak and present effectively in front of their peers and faculty. Be able to handle questions and prepare well throughout responses.
- ❖ Develop study habits and a regular reading schedule so that they are prepared for rounds, conferences and the In-Service exam.
- ❖ Attend the Department of Clinical Investigation’s course entitled “Introduction to Clinical research.”
- ❖ Pick or be assigned a faculty who will mentor them and serve as their advisor for the research endeavors.

Professionalism

Goal – To have residents develop attitudes and skills, which provide the best possible care for urological patients and which conform to acceptable standards of medical and professional ethics.

- ❖ Treat nurses and technicians with respect.
- ❖ Treat families with respect.
- ❖ Serve as a role model for medical students.
- ❖ Present oneself as a professional in appearance, use of language, and in all forms of communication.
- ❖ Respect patient confidentiality.
- ❖ Complete medical records in a thorough and timely manner.

Systems-based Practice

Goal – To serve as a resource for Albemarle County and the State of Virginia for the management of urologic disease, particularly those of a complex nature.

- ❖ Effectively utilize social work, home health care and rehabilitative services for patients.
- ❖ Understand the indications for obtaining consultation with other health care specialists prior to the surgical procedures in select patients.

During this first year, the resident will be assigned work with an attending outpatient clinic on a monthly rotation, perform preoperative and postoperative care, and handle inpatient and emergency room consults. Through these clinical experiences they will be exposed to the different subspecialties representing the domains of Urology. Assignment to a different staff urologist on a monthly basis will assure that residents will be exposed to all subspecialties of urology through clinic experience, conference and reading assignments. The residents will be expected to build

experiences throughout Urology training in addition to the competencies listed above. The following is a list of goals and objectives for each of the Urological subspecialties:

Erectile Dysfunction and Infertility

Goal – Be proficient in diagnosis, evaluation, and treatment of patients with erectile dysfunction.

- ❖ Describe the normal development and demonstrate the anatomy and function of the penis and male urethra.
- ❖ Describe the normal physiology of penile erection
- ❖ List the etiologies of erectile dysfunction
- ❖ Discuss common medical and psychological disorders associated with erectile dysfunction
- ❖ Describe in depth the evaluation of patients with erectile dysfunction including sexual history, medical history, surgical history, physical examination, laboratory evaluation and specialized testing.
- ❖ Describe in detail the various treatments of erectile dysfunction to include the medical treatment, intracavernosal injection, vacuum constriction devices, psychological and sexual therapy, surgical procedures, implantation of penile prosthesis, microvascular arterial bypass procedures, and venous ligation procedures
- ❖ Be able to describe the pathophysiology and management of Peyronie's Disease
- ❖ Demonstrate proficiency in the diagnosis and management of a penile fracture.

Goal – Demonstrate ability to diagnose, evaluate, and treatment of patient with idiopathic priapism and prolonged penile erection secondary to intracavernosal injection of vasoactive drugs.

- ❖ Describe the normal development and surgical anatomy of the penis.
- ❖ Discuss disturbances in the mechanism of normal erection resulting in priapism.
- ❖ List and describe the various etiologic factors in priapism.
- ❖ Demonstrate the ability to take a pertinent history and physical examination in patients with idiopathic or PIP induced priapism.
- ❖ Demonstrate knowledge of the diagnostic studies that are helpful in establishing the etiology of priapism.
- ❖ Given a patient of patient history with supportive data, select and defend alternative methods for the management of priapism
- ❖ Describe the vascular shunting procedures used in the treatment of priapism
- ❖ Discuss the complication of each therapeutic method and appropriate treatment of these complications

Goal – Understand the basic science of male reproductive physiology and infertility.

- ❖ Demonstrate an understanding of the hypothalamic-pituitary-gonadal (HPG) axis and its endocrine control of testicular function.
- ❖ Identify the hormones involved in the HPG axis, their origins, function, reciprocal interrelationships and feedback control
- ❖ List the endocrinopathies, both exogenous and endogenous, that may interfere with the normal testicular axial relationship and specify the nature of these alterations.
- ❖ Describe the anatomy, physiology and pathophysiology of the male reproductive tract, spermatogenesis, sperm transport and capacitation.

- ❖ Identify the sequence of sperm maturation, the cell types found within and between the seminiferous tubules and the time sequence of spermatogenesis.
- ❖ Describe the mechanism of ejaculation including neurologic control and the anatomic structures involved.
- ❖ Identify disease states that interfere with ejaculation and the manner in which these states disrupt normal ejaculatory mechanisms.
- ❖ Describe the difference between emission and ejaculation.

Goal – Competent diagnosis, evaluation, and treatment of patients with male infertility.

- ❖ List the important components of a historical review in males presenting with infertility.
- ❖ Describe the components of the physical examination of infertile males
- ❖ List the specific laboratory studies that should be obtained as part of the male infertility evaluation and the manner in which abnormal results may contribute to or reflect the extent of infertility.
- ❖ Select the surgical diagnostic techniques used in patients with male infertility including vasography, rectal sonography and testicular biopsy.
- ❖ Identify exogenous drugs that may suppress fertility, ejaculation and erectile function.
- ❖ Identify the appropriate surgical or medical therapies for patients with male infertility and defend the rationale and indications for clinical application of these modalities.
- ❖ List and describe in detail the assisted reproductive techniques commonly used in patients with male factor infertility.

Urolithiasis

Goal – Know the etiology and pathophysiology of urinary tract stone disease.

- ❖ Understand the epidemiology of urolithiasis to include the following:
 - Geographic distribution of urinary calculus incidence in this country and the world
 - Incidence in relation to race, sex, age and climatic factors
 - The effects of dietary and fluid intake on occurrence
- ❖ Describe the crystalline architecture of urinary calculi and theoretical factors affecting crystallization.
- ❖ Describe the part played by matrix in the architecture and possible prevention or initiation of stone formation.
- ❖ Describe the role of urinary tract obstruction in the etiology of urolithiasis.
- ❖ Present a working classification of the etiology of stone disease to include renal tubular syndromes, enzyme disorders, hypercalcemic conditions, hypercalciuric states, uric acid lithiasis, secondary urolithiasis, and iatrogenic urolithiasis.

Goal – Be proficient in the evaluation and diagnosis of a patient with urolithiasis.

- ❖ Elicit a history compatible with stone disease from a patient including a list of pertinent problems referable to stone formation.
- ❖ Discuss the information to be gained from urinalysis including the appearance of typical crystals.
- ❖ Know the relationship of stone formation to urinary bacteria and pH.

- ❖ Select appropriate serum studies in the evaluation of stone disease including assessment of serum creatinine, calcium, phosphate and uric acid.
- ❖ Describe the role of stone analysis in the diagnosis and treatment of patients with stone disease.
- ❖ Have and in depth knowledge of the radiographic evaluation of patients with stone disease including the use of both plain film radiography and Spiral Computed Tomography.

Goal – Select appropriate management strategies for patients with stone disease.

- ❖ Describe the role of dietary restriction and fluid intake modifications
- ❖ Discuss in detail the medical therapy of patients with metabolic stone disease.
- ❖ Discuss in detail and perform various procedures used in the treatment of stone disease to include ESWL, percutaneous nephrolithotomy, pyelolithotomy, ureteroscopy, cystolithotomy, and litholopaxy.
- ❖ Given a patient with recurrent stone disease, develop a plan for follow-up care including metabolic evaluation, appropriate treatment by diet, fluid intake or medications and subsequent evaluation by radiographic studies.

Goal – Demonstrate competence in the use of ESWL in the treatment of urolithiasis.

- ❖ List the types of ESWL machine available including the sources of energy, methods of coupling energy to patient, and the methods for imaging and targeting stones.
- ❖ Describe the physics of shock wave stone fragmentation including the absorption of energy at the acoustical interface, internal reflections of shock wave within the stone and cavitation bubbles.
- ❖ List the indications and contraindications for the use of ESWL
- ❖ Be familiar with pre-lithotripsy management including the indications for pre-treatment stents and selection of methods of anesthesia.
- ❖ Demonstrate ability to treat various stone types and describe initial energy levels used, total energy delivered and the use of contrast to assist stone targeting.
- ❖ Discuss the post-treatment management of patients treated with ESWL.
- ❖ List the complications and risks of ESWL.

Goal – Develop competence in the use of endourologic techniques to treat upper urinary tract stones.

- ❖ Describe the surface relationships of the kidney and the structures traversed when a needle is passed into the renal pelvis through a posterior calyx.
- ❖ Know the intrarenal anatomy important to percutaneous renal access.
- ❖ Discuss the equipment used commonly in endourology including guide wires, balloon dilators, stents, stone baskets and lithotriptors.
- ❖ Demonstrate knowledge of the various types of fluoroscopy equipment and the risks of fluoroscopy.
- ❖ Understand the technique of percutaneous nephrostomy placement, the use of fluoroscopy or ultrasound for guidance and the potential complications of this access procedure.
- ❖ Know the methods and instruments used for stone removal including forceps, baskets, and various grabbers, and know which stones can be removed with each.
- ❖ Discuss various methods of power lithotripsy including ultrasound, electrohydraulic and laser lithotripsy.
- ❖ Know the complication of percutaneous stone removal and understand methods for their management

- ❖ Discuss the appropriate selection of patients for percutaneous lithotripsy as compared to ESWL.
- ❖ Discuss in detail the use of percutaneous stone dissolution and describe various chemolytic agents including Renacidin, Suby's solution and THAM.
- ❖ List the complications specific to various types of stone dissolution techniques.

Goal – Develop competence in the use of endourologic techniques to treat lower urinary tract stones.

- ❖ Demonstrate ability to perform both rigid and flexible ureteroscopy in the treatment of ureteral and renal stones.
- ❖ Understand the use of baskets, forceps and other devices for ureteroscopic stone removal.
- ❖ Have a thorough knowledge of lithotripsy methods used via the ureteroscope to fragment ureteral stones.
- ❖ Describe the immediate and long-term complications of ureteroscopy including extravasation, ureteral stricture and avulsed ureter.
- ❖ Discuss the indications for ureteroscopic stone extraction as compared to the use of ESWL in the treatment of ureteral stones.

Urologic Oncology

Goal – Know how to diagnose, evaluate and treat patients with kidney cancer.

- ❖ Understand the normal development, function and surgical anatomy of the kidney.
- ❖ Identify and discuss the gross and histopathologic features of the various types of renal tumors
- ❖ Discuss the natural history and epidemiology of kidney cancer
- ❖ Know the paraneoplastic syndromes that may be associated with renal cell carcinoma.
- ❖ Know and discuss the clinical and pathological staging systems used for renal cancer, and identify the prognosis as a function of the TNM stage of disease.
- ❖ Discuss the evaluation and plan a course of therapy for selected patients with various stages of renal cell carcinoma.
- ❖ Demonstrate the ability to select the best surgical approach (radical versus partial versus laparoscopic nephrectomy) in patients with kidney cancer.
- ❖ Discuss adjuvant therapy for patients with renal cancer including the roles of radiotherapy, chemotherapy and use of biologic response modifier therapies.
- ❖ Identify and discuss the appropriate follow-up, including the role of radiographic imaging, of patients after radical or partial nephrectomy for renal cancer.

Goal – Competent diagnosis, evaluation, and treatment of patient with cancer of the renal pelvis and ureter.

- ❖ Understand the normal development, function and anatomy of the ureter and renal pelvis.
- ❖ Discuss the theories regarding the etiology of cancer of the renal pelvis and ureter, and know the natural history and risk factors for tumor progression.
- ❖ Know the histopathologic features of transitional cell carcinoma of the upper urinary tract, including evaluation of urinary cytology.
- ❖ Demonstrate ability to elicit a history compatible with cancer of the upper urinary tract and discuss findings on physical examination.

- ❖ List and be able to interpret the appropriate laboratory studies necessary to diagnose and stage cancer of the renal pelvis and ureter.
- ❖ Accurately select and interpret imaging studies of the upper urinary tract.
- ❖ Demonstrate competence in evaluation of the ureter and renal pelvis using endoscopic techniques.
- ❖ Discuss the rationale for various surgical procedures used in the treatment of patients with ureteral or renal pelvic cancer.
- ❖ Discuss the rationale, methodology, agents used and potential toxicities of intracavitary agents used in the treatment of superficial tumors.
- ❖ For patients with invasive or metastatic tumors of the upper urinary tract, discuss the role and potential toxicities of systemic chemotherapy.

Goal – Competent diagnosis, evaluation, and treatment of patients with cancer of the bladder.

- ❖ Understand the embryology, normal development, function and anatomy of the bladder.
- ❖ Discuss the epidemiology of the various forms of bladder cancer, the concepts of initiation and promotion of carcinogenesis and risk factors for bladder cancer development.
- ❖ Know the natural history of superficial and muscle invasive bladder cancer.
- ❖ Know and discuss the clinical and pathological staging systems used for bladder cancer, and identify the prognosis as a function of the TNM stage of disease.
- ❖ Demonstrate the ability to recognize the signs and symptoms of patients with bladder cancer and be able to perform a bimanual examination of the bladder under anesthesia.
- ❖ Demonstrate the ability to interpret the results of laboratory and imaging studies in the diagnosis and staging of bladder cancer.
- ❖ Demonstrate competence in the performance of urethroscopy and cystoscopy in the evaluation and follow-up of patients with bladder cancer.
- ❖ Describe the endoscopic approaches to treatment of bladder cancer.
- ❖ Know and discuss the indications, efficacy and complications associated with the use of intravesical therapies.
- ❖ Know and discuss the role of open surgical therapy for patients with bladder cancer, and discuss the role of lymph node dissection.
- ❖ Describe the various types of urinary diversion and considerations of their suitability in the context of extent of disease and patient preferences.
- ❖ Discuss the role of radiotherapy and chemotherapy in the treatment (adjuvant and therapeutic) of advanced bladder cancer.

Goal – Be proficient in the diagnosis, evaluation, and treatment of patients with prostate cancer.

- ❖ Understand the embryology, normal development, function and anatomy of the prostate
- ❖ Discuss the pathophysiology and theories regarding the etiology of prostate cancer.
- ❖ Know the gross and microscopic histopathology of prostate cancer and be able to differentiate these from other common histologic entities.
- ❖ Discuss the natural history and epidemiology of prostate cancer
- ❖ Elicit a detailed and appropriate history from patients with prostate cancer.
- ❖ Demonstrate ability to perform a digital rectal examination, including location and size of induration or nodules, pelvic sidewall and seminal vesicle extension of cancer.

- ❖ Discuss the appropriate diagnostic and staging studies used to evaluate cancer of the prostate and interpret their results.
- ❖ Demonstrate ability to perform an adequate transrectal ultrasound and biopsy of the prostate, and understand the rationale for various biopsy strategies.
- ❖ Discuss the risks, complications and benefits of the various treatment options for prostate cancer, and demonstrate the ability to select appropriate patients for each treatment modality.
- ❖ Discuss with patients and families the prognosis and complications associated with prostate cancer treatment and understand the medical and psychological management of these complications.
- ❖ Know the appropriate follow-up regimens for patients after radical prostatectomy and radiation therapy for prostate cancer.
- ❖ Discuss the indications and controversies surrounding the use of adjuvant therapy after definitive therapy (radical prostatectomy or radiotherapy).

Goal – Competent diagnosis, evaluation, and treatment of patient with testicular cancer.

- ❖ Understand the embryology, normal development, function and surgical anatomy of the testis and paratesticular structures.
- ❖ Know and discuss the lymphatic drainage of the testicle and the pattern of lymphatic progression of disease to the retroperitoneum.
- ❖ Discuss various factors in the possible etiology of testis cancer.
- ❖ Know and differentiate the gross and histopathologic features of seminomatous, nonseminomatous and non-germ cell tumors.
- ❖ Demonstrate the ability to elicit a history compatible with testicular cancer.
- ❖ Perform a complete and accurate physical examination of patients with testicular cancer including evaluation for lymphadenopathy and gynecomastia.
- ❖ List the appropriate diagnostic and staging studies used to evaluate cancer of testicle and be able to interpret the results of these studies.
- ❖ Discuss the use of serum tumor markers in patients with testis cancer.
- ❖ Interpret testicular ultrasound and abdominal/pelvic CT findings in patients with testis cancer.
- ❖ Discuss the relative roles of retroperitoneal lymph node dissection and surveillance in patients with Stage I nonseminomatous testis cancer.
- ❖ Understand and discuss the selection of radiotherapy for the treatment of patients with testis cancer.
- ❖ Discuss various chemotherapeutic agents used in the treatment of advanced testis cancer and their relative value, depending on tumor type and stage.

Goal – Competent diagnosis, evaluation, and treatment of patients with penile cancer.

- ❖ Understand the embryology, normal development, function and surgical anatomy of the penis and urethra.
- ❖ Discuss the incidence, epidemiology and potential etiologic factors of penile cancer.
- ❖ Identify and discuss treatment and follow-up of premalignant penile lesions.
- ❖ Know and use the TNM staging system for squamous cell carcinoma of the penis.
- ❖ Demonstrate an appropriate examination of the penis and inguinal lymph nodes in patients diagnosed with penile cancer.
- ❖ Describe the surgical treatment options and their applicability to various stages of penile cancer.

- ❖ Discuss the strategies and indications for inguinal lymph node dissection.
- ❖ Discuss the roles of radiotherapy and chemotherapy in the treatment of local and advanced penile cancer.

Goal – Understand the role of chemotherapeutic agents in the treatment of genitourinary malignancies.

- ❖ Classify the commonly used chemotherapy agents used in urologic cancers.
- ❖ Discuss the pharmacology of the various types of chemotherapeutic drugs used in the treatment of urologic cancers.
- ❖ Describe the current chemotherapeutic regimens for genitourinary cancers.
- ❖ Know the specific complications of chemotherapy, both immediate and long-term, and the treatment of these complications.
- ❖ Discuss the treatment results and expected response rates of chemotherapy regimens used for the treatment of various genitourinary malignancies.

Goal – Understand the role of radiotherapy in the treatment of genitourinary malignancies.

- ❖ Discuss the physical properties of ionizing radiation, including the fundamental units used to describe the interaction of radiation with matter and the differences in penetration and absorption between different types of radiation.
- ❖ Know the differences between external beam and interstitial radiotherapy.
- ❖ Discuss the isotopes used for interstitial radiotherapy including differences in energy emitted, half-lives and the clinical utilization of each.
- ❖ Discuss the biologic factors impacting the effectiveness of radiotherapy.
- ❖ Demonstrate a basic understanding of radiotherapy treatment principles as it relates to genitourinary malignancy.
- ❖ Discuss the commonly employed curative and palliative radiotherapeutic doses, schedules and fields for urologic tumors.
- ❖ Demonstrate knowledge of potential complications of radiotherapy both in general and those associated with the treatment of specific urologic tumors.

Female Urology and Voiding Dysfunction

Goal - Understand the normal development, function, and surgical anatomy of the female urethra, bladder, and pelvis.

- ❖ Describe and explain the developmental processes by which the urethra progresses to tubular form and the hormonal influences on urethral development
- ❖ Describe female urethral function by which urinary continence is maintained and the functional role of secondary structures such as striated muscle.
- ❖ Know the blood, lymphatic and nerve supply of the female bladder and urethra.
- ❖ Understand the normal anatomy and support of the female pelvis including all involved organs and the supporting ligaments, muscles and fascias.

Goal – Competent evaluation, diagnosis, and treatment of females presenting with urinary incontinence.

- ❖ Perform and demonstrate a complete medical history applicable of female patients presenting with urinary incontinence
- ❖ Demonstrate an appropriate and complete physical examination of women with incontinence.

- ❖ Describe the laboratory studies that may assist with the diagnosis of women with incontinence.
- ❖ Demonstrate the ability to choose and carryout the appropriate therapy for the following conditions associated with female incontinence:
 - Stress incontinence due to anatomical changes
 - Stress incontinence due to sphincteric damage
 - Urge incontinence and bladder instability
 - Neurogenic bladder dysfunction
 - Urinary retention and obstruction
 - Urethral diverticula
- ❖ Understand the role of pelvic floor neuromodulation in the treatment of patients with refractory voiding dysfunction due to pelvic floor dysfunction.

Goal – Understand the evaluation, diagnosis, and treatment of women with pelvic prolapse syndromes.

- ❖ Perform and demonstrate a complete medical history applicable of female patients presenting with pelvic floor prolapse.
- ❖ Demonstrate an appropriate and complete physical examination of women pelvic prolapse.
- ❖ Be able to grade pelvic organ prolapse via POO-Q classification systems
- ❖ Describe any adjunctive studies that may assist in the diagnostic workup of women with pelvic floor prolapse to include any radiologic studies and urodynamics.
- ❖ Demonstrate the ability to choose and carryout the appropriate therapy, both surgical and non-surgical, for the following conditions associated with pelvic floor prolapse:
 - Anterior compartment relaxation with or without associated urinary incontinence
 - Middle compartment relaxation with or without associated urinary incontinence
 - Posterior compartment relaxation with or without associated urinary incontinence

Goal – Know how to perform urodynamic studies in patients with voiding dysfunction.

- ❖ Discuss the value and indications for urodynamic evaluation of the lower urinary tract.
- ❖ Have an in depth knowledge of the relationship of specific parts of the urodynamic study to the filling/storage and emptying phases of micturition.
- ❖ Demonstrate the ability to independently set up and perform filling and voiding cystometry and be able to identify and interpret urinary flow rate, residual urine volume, flow patterns, bladder compliance, involuntary bladder contractions, abnormal bladder sensation, leak point pressures, bethanechol supersensitivity test, and pressure/flow studies.
- ❖ Demonstrate the ability to independently set up and perform videourodynamics
- ❖ Demonstrate the ability to independently set up and perform electromyography utilizing both needle and patch electrodes.

Goal – Know how to evaluate, diagnose, and treat patients with pelvic pain syndromes including interstitial cystitis.

- ❖ Demonstrate an understanding of the epidemiologic aspects of interstitial cystitis.

- ❖ Be familiar with the common theories regarding the pathogenesis of interstitial cystitis.
- ❖ List the typical symptoms of interstitial cystitis in men and women.
- ❖ Discuss the differential diagnosis of the symptoms of interstitial cystitis
- ❖ Be familiar with the cystoscopic findings in patients with interstitial cystitis and the indications and limitations of bladder biopsy.
- ❖ Explain the therapeutic rationale for the various treatments used in interstitial cystitis and be familiar with their benefits, efficacy and side effects.
- ❖ List the systemic and intravesical pharmacotherapies used to treat interstitial cystitis.
- ❖ Know the role of bladder hydrodistention in patients with interstitial cystitis.
- ❖ Know the role of pelvic floor neuromodulation in the treatment of patients with interstitial cystitis and other pelvic pain syndromes.
- ❖ Know the role of surgical therapy for patients with refractory interstitial cystitis.
- ❖ Demonstrate proper selection of interstitial cystitis patient for surgical therapies.

Goal – Be competent in the diagnosis and treatment of patients with vesico-vaginal and uretero-vaginal fistulae.

- ❖ List the signs and symptoms commonly associated with vesico-vaginal (VVF) and ureterovaginal (UVF) fistulae.
- ❖ Describe the pathogenesis of VVF including iatrogenic, post-irradiation and obstetric trauma induced fistulae.
- ❖ Describe the important components of the history and physical examination in patients with VVF and UVF.
- ❖ Distinguish between VVF and UVF using historical and diagnostic techniques.
- ❖ Discuss the surgical principles involved in repair of these fistulas including the biology of wound repair and the preparation of tissues for surgery.
- ❖ Describe the conservative management of VVF and UVF.
- ❖ Discuss in detail the surgical repair options for patients with VVF or UVF.

Neuro-Urology

Goal – Know the appropriate evaluation, diagnosis, and treatment of various neurogenic bladder disorders in patients with spinal cord lesions.

- ❖ Describe the normal innervation and neuromuscular physiology of the bladder, urethra and surrounding striated musculature of the bladder and urethra.
- ❖ Discuss the expected lower urinary tract sequelae of injuries to the peripheral innervation of the bladder, spinal cord at various levels, and supraspinal pathways.
- ❖ Describe the pathophysiology of lower urinary tract dysfunction associated with the following neurogenic bladder (NGB) disorders including diabetes mellitus, multiple sclerosis, spinal cord tumors and vascular insults, cerebrovascular accidents and brain tumors, Parkinson’s disease, radical pelvic surgery, myelomeningocele, and Shy-Drager syndrome.
- ❖ Discuss the significant aspects of the history in the evaluation of neurogenic bladder dysfunction.
- ❖ Perform an adequate physical examination to aid in the diagnosis of patients with NGB including neurologic exam and bulbocavernosus reflex.
- ❖ Discuss the use and indications as well as the results of urinalysis, serum creatinine, excretory urography, VCUG, ultrasound and cystoscopy in the evaluation of the NGB.

- ❖ Select and carry out appropriate therapy for patients with NGB including non-surgical and surgical management options.
- ❖ Describe the potential long-term sequelae and complications of NGB including deterioration of renal function, autonomic dysreflexia and development of bladder malignancy.

Goal - Perform and interpret a complete and appropriate urodynamic study in patients with spinal cord lesions.

- ❖ Describe the use of urine flow rates and patterns, and residual urine volumes, in patients undergoing urodynamic study.
- ❖ Describe the critical aspects of filling cystometry including appropriate methodology and conduct of the examination, phases of filling cystometry, concept of bladder compliance, significance of involuntary bladder contractions, significance of normal or absent bladder sensation, differences between classical and valsalva leak point pressures, and the role and significance of the bethanochol supersensitivity test.
- ❖ Describe the methodology and significance of the pressure/flow phase of a urodynamic study
- ❖ Describe the role of videourodynamics and recognize findings in situations where videourodynamics is specifically helpful.
- ❖ Discuss the primary value of electromyography (EMG) in urodynamic assessment.
- ❖ Understand the role of urethral profilometry (UPP) in patients undergoing urodynamic study.

Pediatric Urology

The PGY-2 resident will be exposed to pediatric urologic through a 3 month rotation on the pediatric service.. They will see clinic and attend and participate in cases that are appropriate for their level of training. They are expected to meet the following goals and objectives:

Goal - Develop a sound understanding of the examination, diagnosis and management of the Urologic pediatric patient.

- ❖ Familiarize with basic concepts of the pathophysiology, evaluation and treatment for the following disorders:
 - Cystic diseases of the kidney
 - Obstructive uropathy
 - Enuresis
 - Uretero-pelvic junction obstruction
 - Wilm’s tumor and other genitourinary malignancies
 - Neurogenic bladder
 - Urinary incontinence
 - Anterior and posterior urethral valves
 - Epispadias and bladder exstrophy
 - Hypospadias
 - Urologic problems associated with imperforate anus
 - Intersex disorders
 - Vesico-ureteral reflux

- Megaureter
- Ureteral duplication and ureterocele
- The acute scrotum
- Cryptorchidism
- Pediatric urinary tract infection
- Pediatric urinary tract trauma
- Neonatal emergencies
- Management of the myelomeningocele patient

PGY-3 Urology Residents

In a similar manner to the PGY-2 year, the PGY-3 (Uro-3) Urology residents are assigned for the entire year to the UVa hospital based outpatient clinic and inpatient Urology Service. During these twelve months the resident will be assigned to: 1) outpatient clinic, with direct faculty supervision, 2) work under the supervision of the Chief resident in the management of inpatients and 3) be assigned operative cases by the Chief Resident. As expected with their increased fund of knowledge, they play a direct role in patient diagnosis and management by seeing their own patients in Urology Resident clinic under the direct supervision of dedicated faculty. PGY-3 Residents are expected to evaluate, diagnose and treat basic urological diseases learned during the previous year. Additional operative experience is gained from the Genitourinary OR (endourological) and outpatient surgery center (UVA-Outpatient Surgery Area), as well as assisting in major operative procedures.

University of Virginia Hospital – Inpatient/Outpatient

Patient Care

Goal – Perform a complete interview and accurate history from patients with urologic disorders encountered in the urology outpatient clinic setting.

- ❖ Using appropriate and effective interview techniques, elicit, and characterize and accurate history of the present illness from patients presenting with genitourinary complaints.
- ❖ Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal and explanatory skills
- ❖ Formulate and write coherent and legible notes in the medical records.
- ❖ Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.
- ❖ Appropriately counsel and educate patients and their families about specific urologic problems.
- ❖ Be empathetic, understanding, compassionate, and honest in dealings with patients and their families.
- ❖ Be sensitive and responsive to the Urology patients' culture, age, gender, and disabilities.

Goal – Competent care and evaluation of the preoperative and postoperative urologic patient.

- ❖ Perform and write clear, legible and an appropriately detailed history and physical examination on all preoperative patients.
- ❖ Prepare and write clear and detailed admission orders.
- ❖ Assess and discuss the operative and anesthetic risks of surgical procedures.
- ❖ Obtain informed consent for all surgical procedures.

- ❖ Discuss the physiologic response of the normal patient to surgical procedures and factors that modify these responses.
- ❖ Discuss and evaluate wound healing as it relates to surgical incisions.
- ❖ Treat and evaluate pain in a safe and effective manner in the post-surgical patient.
- ❖ Discuss and evaluate the role of pharmacological agents, singly or in combination, and apply this knowledge to the care of the surgical patient.
- ❖ Understand the influence of other diseases and co-morbidities upon surgical care.
- ❖ Recognize and correct nutritional defects in the surgical patient.
- ❖ Recognize and deal effectively with the psychological and emotional problems associated with anxiety imposed by urologic surgery

Medical Knowledge

Goal – Accurate performance and interpretation of commonly performed urologic laboratory studies.

- ❖ Demonstrate ability to perform and interpret laboratory studies including routine urinalysis, residual urine measurements, expressed prostatic secretions (EPS), and semen analysis.
- ❖ Interpret and discuss laboratory studies including serum PSA levels and free/total PSA, urinary electrolyte studies, serum electrolyte studies and acid-base analysis, serum creatinine and BUN, and creatinine clearance.

Goal – Perform and accurately interpret radiographic studies performed in the outpatient clinic.

- ❖ Be able to competently perform and interpret radiographic studies including plain films of the kidney, ureters and bladder (KUB), intravenous pyelogram (IVP), retrograde pyelogram, retrograde urethrogram, voiding cystourethrogram (VCUG), and transrectal prostatic ultrasound.
- ❖ Be able to accurately interpret an abdominal/pelvic CT scan, MRI scan, renal ultrasound, and radionuclide studies of the genitourinary tract.

Goal – Perform a detailed and appropriately focused urologic physical examination.

- ❖ Discuss and demonstrate ability to perform a detailed examination of the following genitourinary organ systems:
 - Abdominal examination of the kidneys (inspection, palpation, and percussion)
 - Inspection, percussion and palpation of the bladder
 - Inspection and palpation of the penis
 - Inspection, palpation and trans-illumination of the scrotum and its contents including the testis, testicular tunics and adnexa, spermatic cord and vas deferens
- ❖ Discuss and demonstrate ability to perform a detailed male rectal examination to include:
 - Assessment of the anal sphincter and lower rectum
 - Prostate palpation to characterize its size, consistency, mobility and the presence or absence of abnormalities such as nodules or induration
 - Prostatic massage
 - Palpation of the seminal vesicles
- ❖ Discuss and demonstrate an appropriate vaginal and recto-vaginal examination in the female. Be able to evaluate and grade pelvic organ prolapse (POP-Q).
- ❖ Be able to perform and interpret a focused Neuro-urologic examination.
- ❖ Demonstrate ability to recognize visually and to palpate enlarged lymph nodes in regions related to genitourinary disease and to discuss their importance relative to differential diagnosis to various disorders.

- ❖ When performing physical examination, be sensitive and responsive to the patients' culture, age, and gender.

Goal – Performance of diagnostic and therapeutic procedures encountered in urology outpatient clinic.

- ❖ Be able to perform outpatient procedures including transrectal ultrasound guided prostate biopsy, flexible and rigid cystoscopy, suprapubic tube placement, vasectomy, spermatic cord and penile block, circumcision, intravesical administration of chemotherapeutic or immunotherapeutic agents, and urethral dilation.

Goal - Develop an understanding of the pathophysiology, presentation, evaluation, treatment and management of common urologic conditions.

- ❖ Become proficient in the diagnosis and medical management of Benign Prostatic Hypertrophy (BPH)
- ❖ Become proficient in the surgical and minimally invasive management of BPH. Show an understanding of how to manage the complications of these treatments.
- ❖ Demonstrate proficiency in the evaluation of microscopic and gross hematuria
- ❖ Demonstrate proficiency in the evaluation and diagnosis of acute and chronic scrotal pain. Be able to discuss the presentation and differentiate epididymitis, testicular torsion, appendiceal torsion, orchitis, hernia, hydrocele, varicocele, spermatocele, testis mass and referred pain.
- ❖ Demonstrate proficiency in the management of acute and chronic urinary retention.
- ❖ Demonstrate proficiency in the ability to place a foley catheter in the setting of altered anatomy or previous traumatic catheterization.
- ❖ Become proficient in the diagnosis and management of acute and chronic prostatitis
- ❖ Demonstrate proficiency in the management of phimosis and paraphimosis.

Practice-Based Learning and Improvement

Goal – Acts as a leader/teacher in the education of medical students and other medical care professionals.

- ❖ Ability to write a clinical protocol based on previous research and the presentation of this protocol in the setting of an IRB meeting, compile data and present the results.
- ❖ Discuss the differences between Phase I, II, and III clinical studies
- ❖ Describe the relevant issues surrounding the design of clinical trials including principles of sample size computation, appropriate selection of patient population, the use of control groups, differences between various trial designs, difference between statistical and clinical significance, and the demonstration and understanding of experimental methods, data analysis, and statistics.
- ❖ Prepare a manuscript for submission.
- ❖ Present a research project at a local and/or national meeting.
- ❖ Know the pertinent surgical literature and ability to use print and electronic resources effectively.
- ❖ Attend and actively participate in M&M and other educational conferences.

Goal – Competent review and critique of basic science and clinical papers published in the urologic literature.

- ❖ Demonstrate ability to appropriately critique articles reviewed at the monthly Urology Journal Club meeting.
- ❖ Be able to analyze literature in the process of preparation of research proposals.

Interpersonal and Communication Skills

Goal – Develop presentation skills, healthy study habits and plan for upcoming research rotations.

- ❖ Present cases to faculty at conferences, on rounds, on call and in clinic. It is through these presentations that the resident develops skills in taking a history, putting the facts together and developing a treatment plan.
- ❖ Learn to speak and present effectively in front of their peers and faculty. Be able to handle questions and prepare well throughout responses.
- ❖ Develop study habits and a regular reading schedule so that they are prepared for rounds, conferences and the In-Service exam.
- ❖ Attend the Department of Clinical Investigation's course entitled "Introduction to Clinical research."
- ❖ Pick or be assigned a faculty who will mentor them and serve as their advisor for the research endeavors.

Professionalism

Goal – To have residents develop attitudes and skills, which provide the best possible care for urological patients and which conform to acceptable standards of medical and professional ethics.

- ❖ Treat nurses and technicians with respect.
- ❖ Treat families with respect.
- ❖ Serve as a role model for medical students.
- ❖ Present oneself as a professional in appearance, use of language, and in all forms of communication.
- ❖ Respect patient confidentiality.
- ❖ Complete medical records in a thorough and timely manner.

Systems-based Practice

Goal – To serve as a resource for Albemarle County and the State of Virginia for the management of urologic disease, particularly those of a complex nature.

- ❖ Effectively utilize social work, home health care and rehabilitative services for patients.
- ❖ Understand the indications for obtaining consultation with other health care specialists prior to the surgical procedures in select patients.

PGY-4 Urology Residents

At the PGY-4 (Uro-4) level, residents will build on their general urology and subspecialty exposure at the PGY-3 level to evaluate and manage more complex urologic problems. The rotations include: 1) Two month rotation with the Urogynecology service (additional female urology is available throughout the year with Dr. Rapp) 2) Four month rotation on the Pediatric Urology service 3) 6 month rotation on the Endourology and Genitourinary Operating Room (GUOR) service. The residents will be expected to write well crafted notes in the patients' outpatient medical record. Should patients need hospital admission; the resident will be responsible for performing the admission history and physical examination, writing admission orders and formulating the appropriate treatment plan in conjunction with the admitting faculty member. The resident should be familiar with common complications and sequelae of urologic surgery and should gain competence in counseling for procedures. The resident will build on the PGY-3 clinic experience to perform and interpret radiographic studies that are commonly used in the outpatient urology clinic setting. This will include the evaluation of KUB, CT, US, and MRI studies and the performance and interpretation of retrograde

pyelograms, cystograms, voiding cystourethrograms (VCUG) and retrograde urethrograms (RUG).

The goals and objectives of this assignment are similar to those presented previously for the PGY-3. It is expected that the PGY-4 resident will take on more responsibility for patient management, instructing junior residents and interns. In the current five-year program, the PGY-4 begins to assume roles of the Chief Resident as the Chief Resident begins to transition and graduate. The PGY-4 residents are responsible for the medical student experience on the inpatient service and act as mentors and teachers.

University of Virginia Hospital – Inpatient/Outpatient

Patient Care

Goal – Perform a complete interview and accurate history from patients with urologic disorders encountered in the urology outpatient clinic setting.

- ❖ Using appropriate and effective interview techniques, elicit, and characterize and accurate history of the present illness from patients presenting with genitourinary complaints.
- ❖ Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal and explanatory skills
- ❖ Formulate and write coherent and legible notes in the medical records.
- ❖ Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.
- ❖ Appropriately counsel and educate patients and their families about specific urologic problems.
- ❖ Be empathetic, understanding, compassionate, and honest in dealings with patients and their families.
- ❖ Be sensitive and responsive to the Urology patients' culture, age, gender, and disabilities.

Goal – Competent care and evaluation of the preoperative and postoperative urologic patient.

- ❖ Perform and write clear, legible and an appropriately detailed history and physical examination on all preoperative patients.
- ❖ Prepare and write clear and detailed admission orders.
- ❖ Assess and discuss the operative and anesthetic risks of surgical procedures.
- ❖ Obtain informed consent for all surgical procedures.
- ❖ Discuss the physiologic response of the normal patient to surgical procedures and factors that modify these responses.
- ❖ Discuss and evaluate wound healing as it relates to surgical incisions.
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Medical Knowledge

Goal – Accurate performance and interpretation of commonly performed urologic laboratory studies.

- ❖ Demonstrate ability to perform and interpret laboratory studies including routine urinalysis, residual urine measurements, expressed prostatic secretions (EPS), and semen analysis.
- ❖ Interpret and discuss laboratory studies including serum PSA levels and free/total PSA, urinary electrolyte studies, serum electrolyte studies and acid-base analysis, serum creatinine and BUN, and creatinine clearance.

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- ❖ Demonstrate proficiency in the management of phimosis and paraphimosis.

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- ❖ Describe the relevant issues surrounding the design of clinical trials including principles of sample size computation, appropriate selection of patient population, the use of control groups, differences between various trial designs, difference between statistical and clinical significance, and the demonstration and understanding of experimental methods, data analysis, and statistics.
- ❖ Prepare a manuscript for submission.
- ❖ Present a research project at a local and/or national meeting.
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Goal – Competent review and critique of basic science and clinical papers published in the urologic literature.

- ❖ Demonstrate ability to appropriately critique articles reviewed at the monthly Urology Journal Club meeting.
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Systems-based Practice

Goal – To serve as a resource for Albemarle County and the State of Virginia for the management of urologic disease, particularly those of a complex nature.

- ❖ Effectively utilize social work, home health care and rehabilitative services for patients.
- ❖ Understand the indications for obtaining consultation with other health care specialists prior to the surgical procedures in select patients.

Pediatric Urology

Goal - Develop a sound understanding of the examination, diagnosis and management of the Urologic pediatric patient.

- ❖ Be able to discuss the pathophysiology, evaluation and treatment for the following disorders:
 - Cystic diseases of the kidney
 - Obstructive uropathy
 - Enuresis
 - Uretero-pelvic junction obstruction
 - Wilm's tumor and other genitourinary malignancies
 - Neurogenic bladder
 - Urinary incontinence
 - Anterior and posterior urethral valves
 - Epispadias and bladder exstrophy
 - Hypospadias
 - Urologic problems associated with imperforate anus
 - Intersex disorders
 - Vesico-ureteral reflux
 - Megaureter
 - Ureteral duplication and ureterocele
 - The acute scrotum
 - Cryptorchidism
 - Pediatric urinary tract infection
 - Pediatric urinary tract trauma
 - Neonatal emergencies
 - Management of the myelomeningocele patient

Goal - Develop an understanding of the surgical management and postoperative care of the pediatric patient.

- ❖ Develop an understanding of fluid management, pain management and medication dosing in the pediatric surgical patient

- ❖ Develop a understanding of tube and drain management in the pediatric patient
- ❖ Display an understanding of the evaluation and management of post-operative complications in the pediatric patient

Goal – Be able to perform and interpret radiographic studies and outpatient procedures in the pediatric patient.

- ❖ Be able to perform and interpret a VCUG
- ❖ Be able to perform and interpret urodynamics in the pediatric patient
- ❖ Be able to perform a neonatal circumcision in an outpatient setting

Minimally Invasive Surgery and Endourology

Goal - Demonstrate and understanding and become proficient in the indications and performance of endourologic procedures.

- ❖ Continue to develop ureteroscopic skills and be able to perform more complex cases.
- ❖ Understand and be able to perform an endopyelotomy (retrograde vs. antegrade) for the management of Ureteropelvic Junction Obstruction and ureteral strictures.
- ❖ Understand the indications and techniques for the management of Upper Tract Transitional Cell Carcinoma.
- ❖ Gain additional experience in obtaining percutaneous access and nephrostomy tract formation.
- ❖ Understand and be able to manage complications of endourologic procedures.
- ❖ Continue to develop skills in performing TUR procedures (i.e. TURP, TUIP, TUR bladder tumor and TUIBN, DVIU).

Goal - Develop an understanding of the application of laparoscopy to the practice of Urology and develop the necessary laparoscopic skills to perform laparoscopy competently.

- ❖ Understand the basic principles, techniques and physiologic considerations of laparoscopy.
- ❖ Understand the techniques of establishing access for pneumoperitoneum/pneumoretroperitoneum, patient positioning, and port placement.
- ❖ Understand the indications, techniques and complications of laparoscopic nephrectomy, partial nephrectomy, adrenalectomy, pyeloplasty, cyst decortication and other applications.
- ❖ Help organize and present lectures at the Urology Service laparoscopic training lab.

Female Pelvic Medicine Rotation

Each of the PGY-4 residents has a two month rotation in Female Pelvic Medicine. This is conducted under the auspices of the Department of Gynecology, Division of Urogynecology. Future rotators will have the benefit of additional instruction with Dr. Rapp who was a recent addition to the Urology faculty.

Goal - Demonstrate knowledge about biomedical, clinical, and cognate (epidemiological and social-behavioral) sciences and the application of this knowledge to patient care.

- ❖ Demonstrate a thorough knowledge of the anatomy of the pelvis, pelvic floor and urethra. Describe common variations in anatomic relationships, including both

normal variations and those seen in pathologic conditions, especially pelvic organ prolapse.

- ❖ Understand the physiology of micturition and bladder control, including neurologic circuits and the role of both autonomic and somatic innervation.
- ❖ Be able to differentiate stress from urge urinary incontinence, using history, physical examination and adjunct testing. State appropriate indications for referral of a patient for multichannel urodynamic studies. Understand the large-scale economic impact of urinary incontinence, as well as the psychological, social, and sexual impact on the individual patient.
- ❖ Understand neurologic control of anorectal function and fecal continence. Recognize the different types of fecal incontinence and the means by which to differentiate between them (history, physical findings, adjunct studies). State appropriate indications for imaging or neurologic testing. Understand the psychological, social, and sexual impact of fecal incontinence on the individual patient.
- ❖ Understand the neurologic control of pelvic floor function including maintenance of pelvic floor support during voiding, defecation, and increased intraabdominal pressure. Describe the obstetric events that can affect pelvic floor function and potential measures to prevent such sequelae. Understand the prevalence, etiologies, symptoms, and anatomic findings of the various pelvic support defects.
- ❖ Understand the treatment modalities appropriate to different types of urinary incontinence, including surgery, pharmacologic management, including the costs of and contraindications to the various agents, and pelvic floor exercise/behavior modification.
- ❖ Understand the appropriate evaluation of patients with chronic pelvic pain, with particular understanding of abdominal wall and pelvic floor myofascial pain.

Goal – The resident should be able to discuss the surgical alternatives, the relative pros and cons of both abdominal and vaginal approaches, and demonstrate and understanding of relevant anatomy.

- ❖ Perform and interpret the results of office testing appropriate to this subspecialty area:
 - Urinalysis and culture
 - Post-void residual
 - Q-tip test
 - Stress test
 - Pelvic organ prolapse quantitative examination (POP-Q)
 - Single channel cystometrogram
 - Voiding diary
- ❖ Recognize candidates for the use of vaginal pessaries and incontinence devices, and appropriately fit and care for complications of the use of such devices.
- ❖ Understand indications for, independently perform, and dictate operative notes for the following surgical procedures:
 - Intraoperative cystoscopy
 - Minimally invasive sling
 - Burch colposuspension
 - Anterior and posterior colporrhaphy
 - Repair of rectovaginal septum defect
 - Vaginal vault suspension and/or sacrospinous ligament suspension

- Abdominal and vaginal culdoplasty
- LeFort colpocleisis and vaginal colpectomy
- Perineorrhaphy
- Abdominal paravaginal defect repair.
- ❖ Understand and manage the following post-operative complications:
 - Urinary tract injury
 - Third and fourth degree obstetric laceration
 - Breakdown of episiotomy repair
 - Urinary retention
- ❖ Diagnose and treat infections of the urinary tract in non-pregnant and pregnant women. Understand the role of prophylaxis against recurrent infection. Indicate an understanding of the role of and indications for in-depth evaluation.

Goal – Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

- ❖ Elicit a complete history relevant to the presenting problem (pelvic organ prolapse, incontinence, sexual dysfunction, pelvic pain). Perform a physical examination that appropriately assesses the patient’s complaint. Adequately describe to the attending physician the findings at patient examination and formulate a plan (surgical or otherwise) based on the examination. Perform an appropriate preoperative workup, including referral for necessary tests. Explain the plans and rationale to the patient in appropriate, culturally sensitive terms.

PGY-5 Urology Residents

The Chief Urology Resident PGY-5 (Uro-5) spends a full 12 months on the urology service at UVA. The Chief resident is responsible for the management of the inpatient urology service and supervises twice daily rounds on all urologic inpatients. The Chief Resident supervises junior residents, interns and students in the clinic and inpatient setting. He/she performs all of the more complicated urological operative procedures with direct faculty supervision.

The Chief Resident will also be responsible for organization of the operative schedule, delegation of surgical cases to more junior residents, adherence to the academic schedule and team attendance at teaching conferences and rounds. They will also be responsible for developing the resident call schedule. The resident at this level assumes a key role in the teaching and education of more junior residents. At the end of this year, the PGY-5 resident will be fully competent in the management of outpatient, surgical and postoperative patients.

Patient Care

Goal – Perform a complete interview and accurate history from patients with urologic disorders encountered in the urology outpatient clinic setting.

- ❖ Using appropriate and effective interview techniques, elicit, and characterize and accurate history of the present illness from patients presenting with genitourinary complaints.
- ❖ Develop effective listening skills and be able to elicit and provide information using appropriate nonverbal and explanatory skills
- ❖ Formulate and write coherent and legible notes in the medical records.
- ❖ Formulate treatment plans based on patient information and preferences for specific genitourinary diseases.

- ❖ Appropriately counsel and educate patients and their families about specific urologic problems.
- ❖ Be empathetic, understanding, compassionate, and honest in dealings with patients and their families.
- ❖ Be sensitive and responsive to the Urology patients' culture, age, gender, and disabilities.

Goal – Competent care and evaluation of the preoperative and postoperative urologic patient.

- ❖ Perform and write clear, legible and an appropriately detailed history and physical examination on all preoperative patients.
- ❖ Prepare and write clear and detailed admission orders.
- ❖ Assess and discuss the operative and anesthetic risks of surgical procedures.
- ❖ Obtain informed consent for all surgical procedures.
- ❖ Discuss the physiologic response of the normal patient to surgical procedures and factors that modify these responses.
- ❖ Discuss and evaluate wound healing as it relates to surgical incisions.
- ❖ Treat and evaluate pain in a safe and effective manner in the post-surgical patient.
- ❖ Discuss and evaluate the role of pharmacological agents, singly or in combination, and apply this knowledge to the care of the surgical patient.
- ❖ Understand the influence of other diseases and co-morbidities upon surgical care.
- ❖ Recognize and correct nutritional defects in the surgical patient.
- ❖ Recognize and deal effectively with the psychological and emotional problems associated with anxiety imposed by urologic surgery

Medical Knowledge

Goal – Accurate performance and interpretation of commonly performed urologic laboratory studies.

- ❖ Demonstrate ability to perform and interpret laboratory studies including routine urinalysis, residual urine measurements, expressed prostatic secretions (EPS), and semen analysis.
- ❖ Interpret and discuss laboratory studies including serum PSA levels and free/total PSA, urinary electrolyte studies, serum electrolyte studies and acid-base analysis, serum creatinine and BUN, and creatinine clearance.

Goal – Perform and accurately interpret radiographic studies performed in the outpatient clinic.

- ❖ Be able to competently perform and interpret radiographic studies including plain films of the kidney, ureters and bladder (KUB), intravenous pyelogram (IVP), retrograde pyelogram, retrograde urethrogram, voiding cystourethrogram (VCUG), and transrectal prostatic ultrasound.
- ❖ Be able to accurately interpret an abdominal/pelvic CT scan, MRI scan, renal ultrasound, and radionuclide studies of the genitourinary tract.

Goal – Perform a detailed and appropriately focused urologic physical examination.

- ❖ Discuss and demonstrate ability to perform a detailed examination of the following genitourinary organ systems:
 - Abdominal examination of the kidneys (inspection, palpation, and percussion)
 - Inspection, percussion and palpation of the bladder
 - Inspection and palpation of the penis
 - Inspection, palpation and trans-illumination of the scrotum and its contents including the testis, testicular tunics and adnexa, spermatic cord and vas deferens

- ❖ Discuss and demonstrate ability to perform a detailed male rectal examination to include:
 - Assessment of the anal sphincter and lower rectum
 - Prostate palpation to characterize its size, consistency, mobility and the presence or absence of abnormalities such as nodules or induration
 - Prostatic massage
 - Palpation of the seminal vesicles
- ❖ Discuss and demonstrate an appropriate vaginal and recto-vaginal examination in the female. Be able to evaluate and grade pelvic organ prolapse (POP-Q).
- ❖ Be able to perform and interpret a focused Neuro-urologic examination.
- ❖ Demonstrate ability to recognize visually and to palpate enlarged lymph nodes in regions related to genitourinary disease and to discuss their importance relative to differential diagnosis to various disorders.
- ❖ When performing physical examination, be sensitive and responsive to the patients' culture, age, and gender.

Goal – Performance of diagnostic and therapeutic procedures encountered in urology outpatient clinic.

- ❖ Be able to perform outpatient procedures including transrectal ultrasound guided prostate biopsy, flexible and rigid cystoscopy, suprapubic tube placement, vasectomy, spermatic cord and penile block, circumcision, intravesical administration of chemotherapeutic or immunotherapeutic agents, and urethral dilation.

Goal - Develop an understanding of the pathophysiology, presentation, evaluation, treatment and management of common urologic conditions.

- ❖ Become proficient in the diagnosis and medical management of Benign Prostatic Hypertrophy (BPH)
- ❖ Become proficient in the surgical and minimally invasive management of BPH. Show an understanding of how to manage the complications of these treatments.
- ❖ Demonstrate proficiency in the evaluation of microscopic and gross hematuria
- ❖ Demonstrate proficiency in the evaluation and diagnosis of acute and chronic scrotal pain. Be able to discuss the presentation and differentiate epididymitis, testicular torsion, appendiceal torsion, orchitis, hernia, hydrocele, varicocele, spermatocele, testis mass and referred pain.
- ❖ Demonstrate proficiency in the management of acute and chronic urinary retention.
- ❖ Demonstrate proficiency in the ability to place a foley catheter in the setting of altered anatomy or previous traumatic catheterization.
- ❖ Become proficient in the diagnosis and management of acute and chronic prostatitis
- ❖ Demonstrate proficiency in the management of phimosis and paraphimosis.

Practice-Based Learning and Improvement

Goal – Acts as a leader/teacher in the education of medical students and other medical care professionals.

- ❖ Become competent in all aspects of clinical and surgical treatment of patients with urological disease. They should be proficient in all of the previously listed goals and objectives.
- ❖ Demonstrate proficiency in instructing the junior residents on all standard procedures.
- ❖ Be able to manage all inpatient and outpatient urological problems and be able to function independently
- ❖ Become an effective manager the operating room schedule, resident schedules, and academic schedule
- ❖ Complete and present any research started during the previous years.

- ❖ Review didactic material in preparation for Part I of the American Board of Urology Certifying Exam.

Goal – Competent review and critique of basic science and clinical papers published in the urologic literature.

- ❖ Demonstrate ability to appropriately critique articles reviewed at the monthly Urology Journal Club meeting.
- ❖ Be able to analyze literature in the process of preparation of research proposals.

Interpersonal and Communication Skills

Goal – Develop presentation skills, healthy study habits and plan for upcoming research rotations.

- ❖ Present cases to faculty at conferences, on rounds, on call and in clinic. It is through these presentations that the resident develops skills in taking a history, putting the facts together and developing a treatment plan.
- ❖ Learn to speak and present effectively in front of their peers and faculty. Be able to handle questions and prepare well throughout responses.
- ❖ Develop study habits and a regular reading schedule so that they are prepared for rounds, conferences and the In-Service exam.
- ❖ Attend the Department of Clinical Investigation’s course entitled “Introduction to Clinical research.”
- ❖ Pick or be assigned a faculty who will mentor them and serve as their advisor for the research endeavors.

Professionalism

Goal – To have residents develop attitudes and skills, which provide the best possible care for urological patients and which conform to acceptable standards of medical and professional ethics.

- ❖ Treat nurses and technicians with respect.
- ❖ Treat families with respect.
- ❖ Serve as a role model for medical students.
- ❖ Present oneself as a professional in appearance, use of language, and in all forms of communication.
- ❖ Respect patient confidentiality.
- ❖ Complete medical records in a thorough and timely manner.

Systems-based Practice

Goal – To serve as a resource for Albemarle County and the State of Virginia for the management of urologic disease, particularly those of a complex nature.

- ❖ Effectively utilize social work, home health care and rehabilitative services for patients.
- ❖ Understand the indications for obtaining consultation with other health care specialists prior to the surgical procedures in select patients.

Medical Student Rotations

Resident Responsibilities:

Medical students rotate to the Urology service at UVa in two distinct roles: 1) Surgical selective during 3rd year of medical school and 2) Acting internship (AI), during 4th year. Dr. Ryan Smith serves as the department’s 3rd year clerkship director Dr. Nora Kern is the 4th year clerkship director. Meghan Rover is the medical student coordinator.

3rd year medical students: 2 week selective: Two third-year medical students rotate on the service for two weeks at a time. The students are expected to integrate into the urology team and rotate through inpatient perioperative care, inpatient and outpatient surgery, and outpatient clinic settings. The medical students are to be treated as valued members of the urologic team, and will be under the overall supervision of the chief residents and the Clerkship Director, Dr. Smith. Daily coordination of medical student assignments and general liaison with the 3rd year students is conducted by the R-4 Urology residents. Medical students should be encouraged to attend clinics of individual attendings to gain a one-on one experience with staff urologists. All medical students are evaluated for Entrustable Professional Activities (EPA's) while on the Urology service by Dr. Smith. The students are expected to follow 1-3 patients at a time, present their patients on daily rounds, and attend all departmental conferences. The students have reading assignments based on the AUA Medical Student curriculum and a topic presentation upon completion of the rotation. Faculty, chief residents and R-4 residents are expected to give detailed evaluations of student performance at the end of the rotation. In addition, residents should provide formative feedback to students on a daily basis.

4th year medical students: Acting Internship: Medical students interested in rotating on the UVa Urology Service must contact the Medical Education office to make the necessary arrangements. The office will assist the students in arranging transportation and housing during their rotation. Each student will be assigned a faculty/resident sponsor to help ensure their rotation and experience at UVA is educational and enjoyable. On average, 1-2 students per month are assigned with one-month rotations being the norm. The rotations are usually in the spring, summer, and fall prior to the late fall urology interview season. Students on fourth-year rotations function as acting interns. Medical students are involved in both the inpatient and outpatient care of urology patients. They participate as a member of a urology team in the management of urologic inpatients. The medical students will write daily progress notes under the supervision of residents or faculty. In the outpatient clinics, they perform the initial interview and examination of patients and develop treatment plans under the supervision of staff physicians. History and physicals exams are performed on patients who are admitted under their care and the medical student follows these patients while hospitalized. Medical students also have the opportunity to participate in the surgical treatment of urology patients. With faculty and resident supervision, they perform circumcisions, vasectomies, and other outpatient urologic surgery in the minor operating room. They will be introduced to the techniques of cystoscopy and actively participate in endoscopic procedures.

Medical students are expected to attend all academic conferences and actively participate in the reading and interpretation of urological x-ray studies. At the end of the rotation, students are expected to give a brief formal presentation on a urologic topic of their choice using PowerPoint slides. Medical students are not required to take call but are invited to do so with the on call Urology resident if they so desire.

Medical Student Objectives

- ❖ Demonstrate the fundamentals of the genitourinary examination and in eliciting a urologic history.

- ❖ Demonstrate competence in performing and interpreting the following urologic laboratory tests including urine analysis, post vasectomy semen analysis, urinary flow tests, and post void residual urine testing.
- ❖ Develop a working knowledge of commonly performed uroradiology studies including the indications for and interpretation of these studies.
- ❖ Be familiar with the diagnosis and management of the common acute and chronic urologic problems that are likely to be encountered in the student's future medical career...
- ❖ Become familiar with surgical indications for urologic operations through reading and attending conferences.
- ❖ Demonstrate knowledge of pre-operative work-up, surgical indications, surgical and non-surgical treatment options and complications of commonly performed urologic surgical procedures.
- ❖ Attend all academic conferences with proper preparation for subject content.
- ❖ Participate in morning working rounds and evening ward rounds.
- ❖ Demonstrate basic surgical skills in the operating room.
- ❖ Become familiar with endourologic equipment.
- ❖ Develop a basic working knowledge of the domains of urology including infections, cancers, calculi, infertility, erectile dysfunction, pediatric urology, and female urology.
- ❖ Actively read and study the American Urological Association Medical Student Curriculum
- ❖ Present a 5-minute talk on a Urology topic of interest, chosen with resident or staff assistance at the end of the rotation with slides and a handout.
- ❖ If interested in pursuing a career in Urology each medical student is recommended to arrange interviews with as many Urology faculties as possible and with the Program Director of the Urology Residency.

Conferences

Radiologic Imaging Conference:

This conference is held monthly and is done via teleconferencing with Dr. Robert Older. Various aspect of conventional radiography, ultrasonography, computed tomography, magnetic resonance imaging, and scintigraphy are reviewed. The conferences are usually organized around a theme such as retroperitoneal masses or ureteric lesions, and emphasis is placed on differential diagnosis and look-alikes.

Imaging Case Conference

This conference is held monthly on Wednesdays. Current adult patients are discussed at length with a thorough review of all relevant imaging, building on the lessons from the Radiology/Imaging Conference. Residents are expected to be able to interpret imaging examinations in an oral board style manner in the larger context of urologic disease process. These cases will be integrated into monthly Urology Core Curriculum conference topics.

Combined Morbidity/Mortality-Quality Assurance/Improvement Conference

This conference is held monthly on Wednesday mornings. Each complication or adverse event that occurs on a urologic patient is presented. The resident involved in the patient's care

presents the case, the care provided, the complication, management and outcome. The resident is expected to discuss the complication and review the literature on the subject. Specific focus is given to the general competencies of practice-based learning and systems based practice.

GME Topics Conference

This conference is held every Wednesday and may vary in length depending on topic. The curriculum relies heavily on topics common to all GME programs, and is attended by most of the surgical services in the hospital. Topics of a general nature, such as fatigue mitigation and quality and safety concerns are reviewed. Resident led presentations are featured in an interactive format.

Resident Teaching Conference

This conference is held weekly on Wednesday mornings. At this conference a designated faculty member with expertise in the assigned topic or chief resident will review a chapter of the AUA Core curriculum. The format depends upon the assigned faculty member or Chief Resident but will usually involve a brief oral quiz, review of questions from the study guide, review of questions from the American Urological Association's Self-Assessment Exam, structured case discussion, and directed review of the chapter for 1-1.5 hours. The schedule for topic review will allow complete coverage of the curriculum over approximately two years and thus ensure all domains of urology as outlined in the program requirements. This ensures that the important basic science as well as the clinical aspects of urology of Urology will be addressed. Residents, interns and medical students are expected to have read and reviewed the assigned chapter prior to the conference. The Urology Service provides for each resident a copy of the Campbell's Urology text in hard copy and on a compact disc.

Indications Conference

This conference is held weekly on Wednesday mornings to review all major surgical cases for the following week. This conference is attended by all residents and faculty of the department. Review of the cases allows for teaching to the residents to understand the surgical management of urologic patients and indications which prompts them to surgery. It also allows for complex cases to be discussed and allows for various faculty members to input their expertise regarding best practice management. The best plan of action can then be implemented for the patient well in advance of their surgery date in the event a change in plan occurs. Additionally this conference ensures appropriate imaging and tests are performed prior to the surgeries to improve patient care and quality control.

Tumor Board

A multidisciplinary tumor conference is held bi-weekly on Wednesdays. This conference serves to educate residents in pathology and the value of multidisciplinary approach to complex urologic cases. This conference is attended by urology residents, urology attendings, pathologists, medical oncologists, and radiation oncologists. Challenging urologic cancer cases are presented and resident education will be enhanced by reviewing cases in an academic setting. Pathology slides are reviewed, with pathologists giving special attention to resident education. Gross and microscopic specimens are presented and discussed by Dr. Henry Frierson and Dr. Helen Cathro of the Dept. of Pathology

Inpatient Unit Rounds

Averaging once per week, a faculty supervisor along with all urology residents and medical students review the urology service going to patient bedsides. Residents use a 15 minute discussion before each patient is evaluated. Residents and medical students are queried regarding the level of knowledge on the topic as well as their planned evaluation and management strategy. All attendings on monthly call will also round with the residents to discuss patients and consults

Research Conference

This conference occurs monthly and is attended by all residents, faculty, research nurses, clinical trial coordinators and database managers. Current active clinical trials, research protocols and their progress are presented. Each resident is to prepare and present a report of the progress they have made on their research projects. This conference also serves as the forum in which new research ideas are presented and research projects formulated with input from all attendees. The resident assigned to the research rotation is to report to the Urology service on their progress.

Journal Club

This conference is held monthly and is usually scheduled for the 4th Wednesday of the month. All faculty, residents, interns, medical students and community urologists attend this conference. Each resident is assigned an article to review. Approximately five to six articles are reviewed. The articles are predominantly assigned from the Journal of Urology and Urology, but may come from any peer reviewed medical journal with an article that pertains to care of urological disease. The resident is expected to review the article and fill out a brief report summarizing the article, statistical methods, results and discussion. They are also expected to present a critique of the article with specific attention to practice-based learning and systems based practice. They discuss this with their paired faculty prior to formal presentation during the conference. Supervising faculty provides feedback and the resident saves the write-up in their portfolio.

The following are a brief description of the conferences that the resident on away rotations will be expected to attend. The resident is expected to check with the director of each rotation on the schedule of conferences and what is expected at each conference. The following is expected to serve as an overview and is subject to change.

Pediatric Conference

This conference is held twice a month on Thursday mornings. It is attended by the pediatric resident on service, all pediatric urology attendings, and pediatric urology clinic staff including nurses, medical assistants, and NPs. Additionally any available resident is able to attend. Designated topics covering the field of pediatric urology are discussed, and lectures are given by the pediatric resident on service, NPs, or guest lecturers from other specialties pertaining to pediatric urology including radiology, neurosurgery, nephrology, developmental pediatrics etc. Additionally the second part of the conference is used for indications, to discuss surgical cases for the upcoming 2 weeks as well as discuss any interesting cases seen in clinic.

Annual Conferences:

Vest Conference and Howards Pediatric Visiting Professorship

The Vest visiting professorship is a two day conference, attended by residents, attendings, local urologists and a large segment of University of Virginia alumni. Residents prepare cases spanning the full range of urology, with particular focus on the subspecialty of the visiting

professor. All residents present cases and these cases are discussed by the visiting professor and opened to the entire audience for comment. Residents are responsible for obtaining imaging studies and presenting slides as well as organizing the case presentation. The visiting professor presents 2-3 lectures on topics of his choice with the purpose of stimulating discussion. A similar format is implemented for the Howards pediatric visiting professorship which is a one day event held in the Fall.

Basic Science for Urology Residents Course

For the past 20 years the American Urologic Association Basic Science Course has been held at the University of Virginia. The location of the course has recently changed, but its value remains very high for R-2 residents. .. R-2 residents are required to attend the conference.

Scholarly Activity Requirements

The Urology Service requires resident and faculty research. Each resident is required to participate in a research project and present and/or publish the research. In order to provide exposure research and develop a basic understanding of study design, performance, analysis and reporting each resident is required to complete a basic online module on clinical investigation. The residents are instructed on how to improve their skills in literature search, research design, statistics, and tips on the preparation of oral presentations, posters and manuscripts. Residents perform their clinical investigation projects during lulls in the normal clinical schedule. It is suggested that residents meet on a regular basis with a faculty mentor /project sponsor and present their progress at the monthly Urology Research meeting.

Requirements

RESIDENTS ARE REQUIRED TO SUBMIT AND/OR PRESENT AT A UROLOGICAL MEETING TWO MANUSCRIPTS DURING THEIR RESIDENCY. FAILURE TO DO SO MAY RESULT IN FORFEITURE OF A FAVORABLE ACTION, PROGRAM LEVEL REMEDIATION, PROBATION, OR EXTENSION OF THE TRAINING PROGRAM IN ORDER TO ACCOMPLISH THIS REQUIREMENT.

Resources for Scholarly Activity

Each resident is provided with ample space and facilities to conduct research. Each resident is provided with an office that is equipped with a desk, telephone, bookshelves, file cabinets and personal computers. Each resident has their own personal computer which has access via LAN to the internet, the institution's library, hospital intranet and the institution's patient information database. In addition there is a service conference room in which there is a video presenter, audiovisual equipment, a library and educational videos. Located within the clinic are a research nurse, clinical research coordinator and a database manager.

Health Sciences Library

The Claude Moore Health Sciences Library is the major healthcare information resource for the University of Virginia. It serves faculty, students, and staff of the University as well as health professionals throughout the Commonwealth.

Hours - Monday-Thursday 7:30 am -12:00 midnight, Friday 7:30 am - 7:00 pm, Saturday 9:00 am - 7:00 pm, Sunday 9:00 am - 12:00 midnight. Holiday hours are announced.

Collection

The Library houses a large open-use collection of books, journals, and audiovisual materials. Standard medical texts are located in the Reserve Collection adjacent to the Circulation Desk. Journals are shelved alphabetically by title. Recent journals are housed in the Journal Room. Older materials (generally older than 10 years) are located in the Cabell Room, Historical Collections and off-site at Ivy Stacks. Specific location information for each volume is found in the Library's online catalog.

Computerized Information Systems

All basic library services such as checkout of materials are computerized. Access to the public databases is available from the terminals in the Library and from remote locations. The library also offers a broad electronic library of health care databases containing journal citations and full text information. Access to all systems is free-of-charge to the University of Virginia affiliates.

- ❖ **Online Catalog** - gives up-to-date information on the library's collection of books journals, audiovisuals, computer software and related materials.
- ❖ **OVID** - contains a wide selection of health care databases such as MEDLINE, PsycLit, Evidence Bases Medicine Reviews, HealthStar and Bioethicsline:
- ❖ **Full Text Materials** - includes a selected group of full text medicals books and reference materials. In addition, the library offers access to a collection of full text online journal. The MD Consult System offers online full text access to 35 major medical textbooks, a collection of full text journals and other clinically oriented resources. Information and links to full textbooks and journals are available from the Library's website.
- ❖ **World Wide Web (WWW)** - the Library's WWW Homepage is <http://www.med.virginia.edu/hs-library>. It contains general information about Library services and policies as well as links to Library resources such as the online catalog, OVID, and other online resources. The WWW interact links users with a national and international network of computerized information systems. To assist users in finding useful information on the WWW, the Library has developed the Electronic Desk (ERD). ERD offers quality-filtered health-related information from the WWW packaged in two different information tools-General references, including online reference sources, and Pathfinders, listing core information resources available in a specific subject area. All resources are carefully compiled and maintained by the Library Information Services staff.

MicroComputing and Audiovisual Services

The MicroComputer Lab, located in the Learning Resources Center (LRC), houses a variety of computer workstations supporting both IBM and compatible and Macintosh computers. There are two computer classrooms for instructional purposes that function as

part of the open lab when not in use for classes. A collection of general purpose and medically related software and CAL programs is available for use in the Lab. LRC staff can provide basic assistance in using software and equipment. The LRC is open the same hours as the library.

A core collection of audiovisual software and viewing equipment is available in the LRC. The library maintains a small collection of AV equipment that may be checked out for use with the Health System.

Meetings

Urology residents participate actively in regional and national academic urology meetings by presentation of research performed at UVa. Residents are encouraged to submit their research for presentation at these academic forums. In general, residents attend the annual **Mid-Atlantic Section AUA Meeting, National AUA Meeting** if abstracts to these meetings are accepted for presentation. On occasion, other national or regional meetings are attended to present research abstracts. Several regional meetings, such as the Virginia Urological Society (April) and Mid-Atlantic AUA Residents Seminar (March) allow residents to hone their presentation and debating skills while networking with their colleagues. Travel and attendance at these meetings is supported through funding obtained from the Urology department through its varied research grants.

In addition, residents participate in several other scheduled conferences and events outside of the UVA program including the following:

AUA Annual Review Course

The Chief residents each year are encouraged to attend this four day course given annually by the AUA. This course serves as an important review prior to sitting for Part I of the ABU Certifying Exam. The course is free and travel and lodging is supported by Urology Service funds.

Industry Sponsored Educational Meetings

Throughout the year various educational conferences are sponsored by private industry and residents are encouraged to attend if their schedule permits.

In-Service Examination

Performance

The AUA Office of Education conducts the annual in-service examination each November (usually the third Saturday). No leave or absences are allowed during this time. The exam is given to all urology residents in the United States. Scores are reported as absolute number correct (raw score) and percentile ranking within each resident level cohort. The following requirements are important for you to remember.

- ❖ Individual subject scores must all be above 25 **percent** (raw score).

- ❖ The Composite Score all individual subjects combined must be above the 25th percentile compared to the resident's year group.

Failure to meet these minimal standards will result in counseling and program level remediation. This training is up to the discretion of the program director and may include mandatory reading assignments, self-assessment tests (available from the AUA Office of Education), oral examinations, etc. Failure to show improvement may result in academic probation.

Duty Hour Policy

The Urology residency at UVA adheres to the guidelines set forth by the ACGME Working Group on Resident Duty Hours. As such, the following duty hour guidelines for the urology residency program are currently in effort.

- ❖ Residents are not scheduled for more than 80 duty hours per week, averaged over a four-week period. This does not include “home call” unless the resident is required to come into the hospital for patient care. Hours are tracked by each resident and reviewed by the Program Director.
- ❖ Residents are not scheduled for more than 80 duty hours per week, averaged over a four-week period. This does not include “home call” unless the resident is required to come into the hospital for patient care. Hours are tracked by each resident and reviewed by the Program Director.
- ❖ One day in seven free of clinical responsibilities, averaged over a four-week period
- ❖ Call no more frequently than every third night, averaged over a four-week period (not applicable since a call is done from home)
- ❖ Call at all levels of training is taken from home (beeper call). However, if the resident is called into the hospital for patient care responsibilities, the time spent in the hospital is counted toward the weekly duty hour limit. The resident is responsible for responding to ER consults, Inpatient consults and urology patient phone calls at night. You are expected to document all patient interactions, including phone calls in the Electronic Health Record (EPIC).

The work hour policy is circulated to the residents by the Program Director and in the Institutional Guidelines provided by the Director, Graduate Medical Education each year and they are required to sign the memorandum and Institutional Guidelines stating they have read and understand the work hour guidelines.

Levels of Responsibility for the Urology Service

PGY-1 (Uro-1)

PGY-1 residents assigned to the Urology Service will undergo orientation to the service by the Chief Residents and the faculty. All patients that they evaluate will be presented to a supervising resident and faculty. The exam will be repeated by the faculty if

indicated and all notes will be reviewed and countersigned by the supervising faculty. The PGY-1 may write admission orders and all orders will be checked by a more senior resident. The PGY-1 may write admission history and physicals but these must be checked by a more senior resident and countersigned by the involved faculty. The PGY-1 may assist a faculty member in performing procedures in the clinic and operating room. They may not perform any procedure on a patient without a supervising faculty or senior resident present.

PGY-2 (Uro-2)

The PGY-2 Resident assigned to the Urology Service will undergo orientation at the beginning of the rotation by the Chief Resident and the Program Director. The PGY-2 resident will be able to evaluate patients in the outpatient, inpatient and emergency room setting. All patients they see will be presented to a supervising faculty who will then also examine the patient with the resident. The PGY-2 will be responsible for writing all notes for the patients they see in the outpatient setting and have them countersigned by the supervising faculty. In the care of inpatients they will be supervised by the Chief Resident or a designated senior resident. Progress of all inpatients will be reviewed with the involved or on-call faculty. The PGY-2 may assist faculty or a more senior resident in performing procedures in the clinic. They are not to perform any procedure on a patient without a supervising faculty present or given permission by the faculty that they may be supervised by a more senior resident. The PGY-2 will be directly supervised by a designated faculty for all procedures to be done in the operating room.

PGY-3 (Uro-3)

The PGY-3 resident will be oriented to the Urology service by the Chief Resident and the Program Director. The PGY-3 resident will evaluate patients in the clinic, emergency room and inpatient consults. They will gather a history, perform a physical exam, develop a differential diagnosis, and propose a treatment plan. The resident will then present this to a supervising faculty. There will be no patient disposition without the approval of a faculty member. The PGY-3 resident may obtain advice and guidance from a more senior resident but this will need to be cleared with a faculty member. The PGY-3 resident will be expected to perform procedures in the clinic. They will at first be directly supervised by a faculty or the Chief Resident and as they progress in their training and experience they may perform procedures without a faculty being present but are required to discuss the indications for the procedure with faculty prior to starting. The resident will be notified of their progression in responsibility at their semiannual evaluation with the Program Director. Surgical cases performed by the PGY-3 will be commensurate with their level of training. The operative schedule is determined by the Chief resident. The operative experience for the PGY-3 will include scrotal/inguinal surgery, uncomplicated endoscopic cases, and ESWL. When available they can assist on the larger open cases. The PGY-3 will be directly supervised by a faculty in all operating room cases. With faculty approval, supervision in the operating room may be provided by the Chief Resident on select cases. The supervising faculty is required to be readily available. The PGY-3 will be expected to provide guidance and supervision of medical students, interns and the PGY-2 in the management of inpatients. They are to review orders written by the previously mentioned as well as provide instruction on patient care.

PGY-4 (Uro-4)

The PGY-4 resident while at UVa Medical Center will serve as the senior resident and be oriented by the Chief Resident and Program Director. As such the PGY-4 resident will be able to evaluate patients in the outpatient and inpatient settings. They are given more

autonomy in that each patient need not be examined by a supervising faculty but they are required to discuss each case with the faculty member and annotate this in the note. They may perform procedures in the clinic without direct supervision but must discuss the indication for the procedure with a faculty member prior to starting the procedure. In the operating room the PGY-4 will be directly supervised by a faculty member. On select cases and per the supervising faculty discretion, the senior resident may be supervised by the Chief Resident in the operating room. The senior resident will be assigned cases that are more complex than those that they performed as a PGY-3. They will be involved in more complex endourologic cases, gain exposure to reconstructive urology (male and female), and exposure to the uses of prosthetics in urology. They will also be given the opportunity to assist the Chief Resident in the operating room when possible to gain exposure to the larger and more complex cases. The involved faculty member will be readily available to provide assistance if needed.

The PGY-4 will be expected to provide supervision and instruct the more junior members of the Urology team. When the Chief Resident is absent the PGY-3 will assume the roles of the Chief Resident.

During the off site rotations, the PGY-4 will be oriented to the service by the rotation director. The resident will be responsible for preparing for each operation and taking care of the patients on whom they operate. They will be expected to expand their exposure to more complex cases with emphasis on oncologic cases. They will be exposed to more complex urologic reconstructive procedures, laparoscopy and endourologic cases.

PGY-5 (Uro-5)

The Chief Resident will be granted the responsibility of managing the inpatient and outpatient services and will be oriented as to their duties and level of responsibility by the Program Director. They will be responsible for providing supervision of the more junior members of the Urology team. In the outpatient setting they will see their own patients and develop treatment plans. They will be required to discuss each case with a faculty and faculty will not be required to see each patient unless deemed necessary. Each note will identify the involved faculty. They may perform procedures in clinic without direct supervision but required to have identified a supervising faculty prior to performing the procedure. The Chief Resident will be directly supervised in the operating room by a faculty member and the supervising faculty may allow the Chief Resident to perform procedures without them faculty member being in the operating room with prior approval. A faculty member may allow the Chief Resident to act as Teaching Assistant and perform a procedure with a more junior resident on select cases and with prior approval. The involved faculty member will be readily available should this occur. The Chief Resident will perform all complex and larger endoscopic and open cases. They may hand certain cases down to more junior residents if they are not available or have proven to be competent in these cases.

Supervision Policy

The policy for supervision of residents closely follows the UVa institutional policy for graduate medical education. Graduated levels of responsibility are placed upon residents as they advance in their training (PLEASE SEE ABOVE). This responsibility is defined by the program director at semiannual residency evaluations. Faculty members are responsible

for, and must be personally involved in, the care provided to every single patient. Confirmation of supervision is documented in all resident notes. Each outpatient and inpatient record must name the attending.

Direct Supervision: the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the resident for guidance and is available to provide appropriate direct supervision.

Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

The urology service is fortunate to have a faculty to resident ratio of 1.6:1, which allows for close supervision at all times. Rapid communication with the supervising attending is enhanced by having all staff offices co-located with the residents. The call roster is published at least 10 days prior to the start of each month and is disseminated throughout the hospital. We have a must call list for residents to inform faculty of any changes in patient's clinical conditions or urgent/emergent operative needs.

The following are the program standards for supervision:

- ❖ **Patient Admissions:** For each admission, the resident notifies the attending staff of his/her assessment and plan. If after hours, the attending will decide whether to see the patient immediately based upon the acuity of the problem. If the resident expresses any uncertainty about the patient's condition, the attending will immediately come in. The attending will provide direct supervision over every case that goes to the operating room after hours.
- ❖ **Attending Call:** A urology attending is always on call on a weekly rotating basis, and supervises the residents on all patients after hours and on weekends. The attending will be required to round at least once on weekends with the on-call resident. He or she writes a staff note on all admissions within 24 hours, reviews the charts of all hospitalized patients and writes a note daily on patients that are in the intensive care unit.
- ❖ **Procedures:** All procedures performed in the urology clinic and operating room are directly supervised by attending staff. With graduated levels of responsibility, residents may perform certain procedures without the immediate presence of the attending in the room (indirect supervision), as long as he/she has demonstrated competence in performing the specific procedure. The attending must be immediately available (indirect supervision) in the clinic however. Once the resident has demonstrated competency, he/she can supervise junior house staff on basic procedures under the close supervision of the attending.
- ❖ **Clinic:** Depending on the level of training, fund of knowledge, skill and attitudes, the resident will be given a degree of autonomy to workup patients and implement a treatment plan. Attending staff will provide direct supervision to the

care given to each patient each note and will annotate the involved faculty. There may be occasions where indirect supervision or oversight is appropriate depending on the clinical scenario and resident experience.

- ❖ **Operating Room:** All cases performed by a resident in the operating room will have a directly supervising faculty present. A Senior Resident with permission of the supervising faculty may act as a teaching assistant for a more junior resident. The involved faculty will be readily available should this occur.

While no procedure or clinical scenario always requires the presence of supervising physician, until competency has been determined by the clinical competency committee, the presence of a supervising physician may be required for some procedures.

Patient Care Responsibilities

Inpatient (Ward) Management

- ❖ The urology house staff are a team that takes care of our patients and consults together. Patients belong to the team, not just the resident surgeon who did the case or who admitted the patient.
- ❖ The intern follows all patients and acquires all pertinent information for morning and afternoon rounds. The chief resident is responsible to ensure history & physical and daily notes are completed. Resident admits and counseling notes are required for each admission. Staff notes are written for each admission and major events in patient care.
- ❖ The junior resident has primary responsibility of all ward patients and teaching the intern and medical students. The junior resident will be responsible for presenting the inpatient service at morning report. They are expected to be fully knowledgeable about the patients. They will be expected to present the pertinent physical findings, laboratory data, interpret radiographic studies if indicated and present and defend a treatment plan.
- ❖ The involved faculty and/or the “on call faculty” will round once a day with the residents.
- ❖ In-patient consults will be seen the same day by the house staff under supervision of the chief resident.
- ❖ All charts from Medical records must be signed weekly. Currently, the charts are signed electronically. Failure to do so will result in disciplinary action.
- ❖ All patients on the consult service (i.e., non-urology patients) must have a daily note with a plan of care clearly outlined until the case is signed off.
- ❖ Some inpatient procedures, within the residents level of training, may be appropriate for indirect supervision or oversight by the attending faculty such as complex Foley catheter placement and cystoscopy with ureteral stent removal.

Call

The resident on call will be available by telephone or pager at all times and will respond promptly. The resident on call will remain no further than 30 minutes from the hospital while on call. All cases will be discussed with the staff physician on call and will be presented at morning report. A resident will never be faulted for calling the staff physician for assistance. The on-call resident is responsible for triaging, coordinating, and completing the urologic care and follow-up

of the consults received during his/her call. The call schedule must be submitted to the Department of Surgery in a timely fashion.

Must Call List

*The attending surgeon is either the attending on call or the attending of record for the patient.

The following must be discussed with and approved by the attending *before they may occur*:

- Admission to hospital
- Transfer on or off service
- Discharge from hospital or ED
- Transfer out of ICU
- Scheduling emergent surgical procedure

For all critical changes in a patient's condition, the attending on call and/or the patient's attending will be notified immediately. These include:

- Admission to hospital
- Transfer to ICU
- Intubation
- Cardiac arrest
- Death
- Hemodynamic instability
- New symptomatic arrhythmias
- Code
- Significant neurologic changes (CVA suspected/seizures/paralysis/altered)
- Development of major wound complication (dehiscence, evisceration)
- Medication or treatment error requiring intervention
- Blood transfusion without direct attending authorization
- Any clinical problem requiring an invasive procedure or operation for treatment
- Discharge AMA

The attending should be contacted at any time if:

- Any trainee feels a situation is more than s/he can manage
- Any trainee wants additional advice or attending support
- Any trainee has concerns about the plan of care or hospital course
- The patient, another physician, or nursing staff requests that the attending be contacted.

Surgery

Surgeons have the rare privilege and responsibility to operate on patients. The bond created with patients lasts a lifetime. The faculty expects you to adopt an attitude of "ownership" of your patients, assuming primary responsibility of the patient's entire well-being from the moment of initial introduction until you leave the program.

- ❖ **YOU ARE EXPECTED TO READ ABOUT EACH PROCEDURE AND TO KNOW THE COMPLETE PATIENT HISTORY.** Assume the staff has no information about the patient. Evidence of incomplete information or lack of

knowledge may relegate the resident to the role of assistant or requested to leave the OR.

- ❖ Residents will be approved by the staff to perform operative procedures in accordance with their skill levels.. Until approved at the appropriate skill level, no resident will perform or supervise an operation without being directly supervised.
- ❖ **OPERATIVE REPORTS MUST BE DICTATED WITHIN 24 HOURS!, preferably right after the case is finished, and certainly before leaving work on the day of surgery.**
- ❖ **Each resident maintains a log of all procedures performed by entering each into the ACGME web-based program.** This will be done in accordance with ACGME guidelines every week. At no time is a resident to fall more than one week behind in entering their cases into the ACGME website. Failure to do so may result in disciplinary measures.
- ❖ The chief resident determines resident assignments for surgery scheduling. All questions, problems or issues about the schedule go through the Chief Resident. The Chief Resident will delegate to the more junior residents administrative duties as indicated.
- ❖ The service admin support team enters the electronic posting into the computer and generates the schedule. The chief resident will review for accuracy at the time of weekly Surgical Indications conference.
- ❖ The resident performing the surgery will see the patient preoperatively and complete the preoperative documentation. If the resident did not preop the patient, he is required to write a Resident Preop Note (RAN) on the chart stating they have reviewed the preoperative history and physical.
- ❖ All cases will be discussed with the attending surgeon prior to the case being done unless there are extenuating circumstances. The resident performing the case will be responsible for the presentation, ensuring all necessary equipment has been requested through the proper channels.

Urology Clinic

- ❖ PGY 2 Urology residents will see clinic with attendings on a monthly rotation. They will also be integrated in Pediatric Urology clinic on a regular basis.
- ❖ All patients seen by the house staff (at any level, medical student through chief resident) must be supervised by a staff member. The staff member's name will be entered into the note of every patient as, "patient seen with", "discussed with", or "sent to Dr. -- for review."
- ❖ All notes will be written or dictated in the EHR for review and signature by the appropriate attending.
- ❖ Procedures must be supervised by a staff member. If a resident is approved to perform a procedure, he may proceed with indirect supervision but after discussing the case and the proposed procedure with the involved faculty.
- ❖ Complete all dictations and required paperwork (ADM sheets, consent forms and GU worksheets) by the completion of the duty work day. Exception for extenuating circumstances. Failure to do so will result in suspension of privileges and inability to take leave or TDY.
- ❖ Residents are not to change scheduled clinics without approval of a Urology attending.
- ❖ Unprofessional conduct will not be tolerated.

- ❖ All clinic add-ons should be cleared with the Urology Head Nurse.

Professional Conduct

- ❖ Personal conduct (behavior, speech and appearance) reveals much about one's character. Ultimately, it is character that determines whether patients and colleagues can trust their physician. This program expects the highest degree of moral character from the residents.
- ❖ Having a teachable attitude is a vitally important character trait.
- ❖ Keep a positive attitude at all times, and be an example to others. Some examples of unprofessional conduct include:
 - Dishonesty or misleading information in any form (verbal, non-verbal, or written)
 - Lack of courtesy to patients, staff, or colleagues.
 - Profanity (especially within earshot of patients).
 - Failure to respond to emergency calls.
 - Exceeding one's level of professional competence by performing acts beyond his/her level of expertise and without staff consultation and/or participation.
 - Late arrival to, or inappropriate absence from, the operating room, the clinic, rounds or scheduled conferences.
 - Failure to be a team player, not assisting fellow residents with patient care, and academic workload.
- ❖ Actions perceived by the staff to represent unprofessional or undesirable conduct will be called to the resident's attention. If the conduct is of sufficient magnitude or frequency, the staff may recommend action such as probation or dismissal from the program.

Urology Residency Performance Evaluations

An evaluation of resident performance and academic progress is completed every six months. This evaluation is reviewed and discussed with the resident by the Program Director and a record of the discussion will be kept on a secure file. The resident must achieve an overall global evaluation of pass or higher to progress in the program. For residents who get overall conditional evaluations, a remedial study program will be initiated and monitored by the Urology faculty. If substandard progress is documented, the resident may be referred to the UVa graduate Medical Education Committee (GMEC) for consideration of formal probation. Prior to a resident being placed on probation or separated from the residency position, a due process policy established by the GMEC and the UVa medical center regulations board will be adhered to. At the end of this probationary period, performance will be reassessed. If no improvement is seen, the resident will not be allowed to progress further in the program.

Resident evaluation is based on progress toward meeting the goals and objectives of the six general competencies listed in the ACGME urology milestones: <https://www.acgme.org/acgmeweb/Portals/0/PDFs/Milestones/UrologyMilestones.pdf>
To this end, several evaluation methods are currently being utilized:

Global Staff Evaluation

Urology faculty will assess each resident every six months using a global evaluation tool that assesses resident performance in the 6 general competencies. The global evaluation tool is a password protected web based program entitled Myevaluations.com (or equivalent). The system requires each faculty member to rate residents separately without input from other faculty members allowing unbiased assessment of resident performance. Faculty evaluations of resident performance are averaged giving each resident a total score for that six-month block. Total and competency specific evaluation scores and comments are accumulated by the so that resident performance can be tracked over the duration of their residency. (See the attached copies of evaluation forms.)

In-service/Written Examination

A written examination will be used every six months to assess resident fund of knowledge. For the first six-month block (July-December), the American Urological Associations (AUA) In-Service examination will serve as the written examination. A second examination consisting of the AUA's Self-Assessment Examination (SASP) will be given at the end of the second six-month block (January-June) to serve a barometer for the resident to identify areas that need improvement prior to the In-service examination. Written examination performance will be considered in the Medical Knowledge score on the resident evaluation every six months.

360° Evaluation

Annually a 360° evaluation and will be given to evaluate resident professionalism and interpersonal skills. The residents are evaluated by nursing staff from each of the areas the residents interact with hospital staff i.e. the Urology Clinic, the Operating Room and the wards. (See attached evaluation form)

Urology Milestones

The milestones are an ACGME requirement and are evaluated by the Clinical Competency Committee (CCC) on a semi-annual basis in December and June of each year. The CCC uses all of the above evaluation methods to determine the appropriate milestones. Milestones are rated from 1-5 , with the expectation that residents will gradually improve over time and should have a goal of level 4 for each milestone by the time of graduation.

Certification of Program Completion

At the end of the Chief Resident year, the Program Director reviews the resident's training file to ensure completion of all training requirements. An end of training evaluation is completed for each Chief Resident at the completion of their residency. A graduation certificate is prepared and signed by the Program Director and the Urology faculty. In addition the Program Director will complete an evaluation of clinical privileges in which the Program Director will certify that the resident has demonstrated patient management abilities appropriate to the discipline of Urology, and his/her competence to perform the various technical skills and procedures as listed on the form. (Please see attached form).

Faculty Evaluations

Every 12 months, the residents are required to evaluate faculty performance in the areas of teaching ability, commitment to the educational program, clinical knowledge and scholarly

activities and research. They are also encouraged enter specific comments about individual faculty members. These evaluations are done anonymously by entering these evaluations and comments from the resident's office using the New Innovations program (or equivalent). The faculty evaluations are presented to and reviewed with the faculty member by the Program Director. These evaluations are also presented and discussed with the faculty during the morning staff meetings that occur daily during morning report. Please see the attached faculty evaluation form.

Program Evaluations

Every 12 months, the residents will be required to provide an assessment and critique of the residency program. Residents are asked to honestly critique the training program with regard to the academic program, surgical experience and quality of rotations at participating institutions. These evaluations are done anonymously by entering these evaluations and comments from the resident's office computer using the Myevaluations.com program. These evaluations are reviewed annually by the program Director and faculty during faculty Meetings. Please see the attached copy of the Program Evaluation form.

After reviewing the program and faculty evaluations, the Program Director and faculty discuss the results and how to make the necessary changes to ensure improvement in the program's educational effectiveness. This is done during the Staff Meetings

Personal Requirements

Each resident is expected to read the Institutional Resident Guidelines Booklet at the beginning of each academic year when they sign their Agreement of Appointment. The booklet will be provided to each resident by the Graduate Medical Education Office and may also be found on the Urology Intranet under "UVA Urology Educational Opportunities "Graduate Medical Education". The following are highlights of resident requirements and institutional policies from the booklet and the resident is referred to the booklet for more details.

Dress Code

Your clothes must display professionalism. During duty hours it is mandatory for you to wear appropriate professional dress to and from work. During weekends, appropriate attire for patient rounds includes shirt with collar, long pants and closed shoes. Shorts and sandals are not permitted when seeing patients.

Surgical scrubs are allowed in the Urology Clinic for procedures. Scrubs must be covered by a fully buttoned coat when outside the designated areas. Scrubs are not allowed outdoors.

Travel Policy

1-Residents will be allotted twenty weekdays/4 weeks of vacation time which includes the non-holiday days taken off around Christmas, New Year's Eve, Thanksgiving, etc. Any

additional time must be requested from chair/PD for vacation leave and only to the extent permitted by ABU requirements for graduation.

2-Residents are allotted 7 weekdays for educational activity travel per year with more allowable for special circumstances. Additional time must be requested from the chair and program director. This is not counted towards vacation time.

3-**Travel stipend:** Residents are allocated \$2500 for educational conference travel. Funding will only be provided when a resident is presenting at a conference. Residents may apply for additional funding for approval from PD team/chair. This approval must be received **before** any travel is booked. Funding is not appropriated for attending a conference only for fellowship interviews.

4-**Booking Procedure:** Senior faculty must review and approve final posters and presentations before booking conference travel. All travel arrangements for conference attendance must be made through the program coordinator. Residents are not permitted to book travel independently and request reimbursement afterward. **Residents who book travel independently will not be reimbursed.**

References:

UVA Policy: Vacation Leave: Trainees must be provided a minimum of 15 business days of vacation time per academic year. 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.

ACGME Common Requirements CommonProgramRequirementsFAQs.pdf (acgme.org) Can residents/fellows be required to use vacation or sick time when attending appointments during scheduled working hours? [Common Program Requirement: VI.C.1.d).(1); One-Year Common Program Requirement: VI.C.1.d).(1)] The requirements do not specify whether residents/fellows will be required to use vacation or sick time for medical, dental, and mental health appointments. Programs should comply with their institution's policies regarding time off for such appointments.

If some of a program's residents/fellows attend a conference that requires travel, how should the hours be counted for clinical and educational work hour compliance? [Common Program Requirement: VI.F.1.; One-Year Common Program Requirement: VI.F.1.] If attendance at the conference is required by the program, or if the resident/fellow is a representative for the program (e.g., presenting a paper or poster), the hours should be included as clinical and educational work hours. Travel time and non-conference hours while away do not meet the definition of "clinical and educational work hours" in the ACGME requirements.

ABU specifications:

Leaves of absence and vacation may be granted to residents at the discretion of the Program Director consistent with local institutional policy and applicable laws. Each program may provide vacation leave and family leave (any leave required to care for a family member) for the resident in accordance with institutional policy. The ABU requires 46 weeks of full-time clinical activity in each of the five years of residency. However, the 46 weeks may be

averaged over the first 3 years of residency, for a total of 138 weeks required in the first 3 years, and over the last 2 years, a total of 92 weeks is required.

Vacation or various other leave may not be accumulated to reduce the total training requirement. Should circumstances occur which keep a resident from working the required 138 weeks the first 3 years and 92 weeks the last 2 years, the Program Director must submit a request to the ABU for a variance of the current policy or a plan outlining how the training deficit will be rectified. In certain cases an extension of the residency training may be required.

This policy is not retroactive and does not apply to leave taken prior to the 2021-2022 academic year.

Ninety-two (92) weeks of training is required for two-year fellowships, without the need to request a variance or submit a plan for making up a training deficit.

Leave for educational/scientific conferences are at the discretion of the Program Director.

GME Policies

Stipend & Salary (No. 01)

The stipends of Graduate Medical Education (GME) Trainees will be based on the appropriate Post Graduate Year (PGY) in the appointed residency/fellowship training program, according to specialty or subspecialty Board requirements for certification.

The following shall not affect the level of payment:

1. **Advanced training** — A GME Trainee enters a training program with more years experience than required according to Board requirements for certification. In the event that a graduate medical trainee changes his/her specialty, he/she will receive credit for only those years which are acceptable to Board requirements for certification in that specialty or subspecialty and will be paid at the level that the certifying Board recognizes. For example, if a Medicine trainee switches to Anesthesia after two years of Internal Medicine training, the trainee will be paid at the PGY level at which the Board of Anesthesiology recognizes the trainee (perhaps the Anesthesiology Board recognizes and accepts one year of Internal Medicine training; the trainee will be paid at the PGY-2 level despite having completed two years of Internal Medicine training).
2. **Dual training** — A GME Trainee enters a training program after completing Board requirements in another specialty. He/she will receive credit for only those years which are acceptable to Board requirements for certification in that specialty which he/she is entering.
3. **Repeat year(s)** — A GME Trainee is requested to repeat a year (or a portion thereof) in the training program due to inadequate performance. He/she will not receive credit for that year (or portion) and will continue to be paid at the same PGY level for the repeated time.
4. **Research year(s)** — A GME Trainee enters research training year(s) while in a UVA training program. Under current policy, positions with less than 75% clinical responsibility are not funded by the Medical Center. Upon returning to full-time clinical training with resumption of Medical Center funding, the GME trainee will

receive credit for a maximum of one year of research, or for the number of research years approved by the program's Board for certification or for the number of research years mandated by the training program.

5. International Medical Graduates – International medical graduates entering an ACGME-accredited training program will be paid at the PGY level that their certifying Board recognizes them, despite any training already completed outside the United States. International medical graduates entering non-ACGME accredited fellowship programs will be paid at the level of the required number of postgraduate years of the core residency of the specialty plus one.
6. In accordance with CMS regulations, the University of Virginia Graduate Medical Education Office does not pay beyond the PGY-8 level (PGY-9 and above).

Stipends will be reviewed annually by the Graduate Medical Education Committee and its subcommittee on Stipends and Benefits. The GMEC will make its recommendation to the CEO and Medical Center Operating Board for final approval.

Chief residency year will receive compensation at PGY level plus one. UVA Chief Residents who continue in UVA fellowship programs will continue to be paid at the PGY level he/she was paid during the Chief Residency year. Chief residency is defined as a designated GME Trainee whose primary role throughout the year includes the provision of substantial administrative or supervisory duties to the program. The final year of residency alone is not enough to constitute chief residency status. If there is a question regarding chief residency status that cannot be resolved by the program and GME Office, the issue will be referred to the Executive Committee of the GMEC for approval by vote. Chief residency status needs to be determined no later than 3 months prior to the start of the academic year and must be included in the annual appointment letter.

For incoming GME Trainees, stipend payments will begin on the first day of the Medical Center Orientation, if they are in attendance. For incoming GME Trainees who do not attend orientation, stipend payments will begin on the first day of their appointment period. GME Trainees who successfully complete a year of training, and are reappointed, shall be advanced to the next PGY level, effective July 1st or the anniversary of their start date. Departments may supplement stipend levels of GME trainees, including chief residents, from reserve funds if they so desire. However, if funds from the department are lost, the stipend will revert to that normally provided by the GME Office.

Resident Recruitment & Selection (No. 02)

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, 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 and operates both affirmative action and equal opportunity programs, consistent with resolutions of the Board of Visitors and with federal and state requirements, including the Governor's Executive Order Number One (2014). (<http://www.virginia.edu/eop/EEOAStatement.html>)

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 graduate medical trainee shall include those who are enrolled 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 training programs must follow any eligibility requirements set forth by their accreditation organization.

Graduate Medical Trainee Selection

1. Each program must ensure that it selects from among eligible applicants on the basis of the 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.
2. In selecting from among qualified applicants, ACGME-accredited residency programs must 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

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. Please refer to the Graduate Medical Education website, <https://med.virginia.edu/gme/credentialing/>, for relevant policies and procedures.

Vacation and Leaves of Absence from Graduate Medical Training (No. 03)

The University of Virginia Health 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.

This GMEC Policy, following all ACGME leave requirements, outlines various types of leave available to Trainees and the rules and policies governing those leaves of absence.

Trainees are provided with a minimum of six paid weeks of approved medical, parental or caregiver leave(s) of absence for qualifying reasons that are consistent with applicable laws, at least once and at any time during an ACGME-accredited program, starting the day the Trainee is required to report. In the academic year in which a Trainee takes those six weeks, they are also able to use one additional paid week of leave outside of the approved six weeks.

Additionally, the Commonwealth of Virginia affords eligible employees, including Trainees, Paid Parental Leave (PPL). Trainees who have been employed for at least 12 months prior to the start of PPL are eligible for up to 8 weeks of consecutive paid leave. Trainees with less than 12 months of employment prior to the start of PPL are eligible for up to 6 weeks of consecutive paid leave. Trainees’ health and disability insurance benefits (for themselves and covered dependents) will be extended for a minimum of six weeks for any approved leave and for eight weeks during parental leave.

The policy contains a worksheet application required for any medical, caregiver or parental leave requests. The purpose of the worksheet is for the Trainee and Program to mutually review and discuss the proposed leave in advance and to understand any impact an extended leave might have on meeting program and board eligibility criteria. This step is required by the ACGME. Trainees must otherwise follow all individual program requirements surrounding leave requests and notifications.

D. Procedures

1. Requests for Leave

- a) Trainees must submit requests in accordance with Program and Medical Center procedures and policies. Trainees should submit leave requests in a timely fashion, especially if rotating on another service and coverage must be arranged.
- b) All leaves of absence must be reported in New Innovations within 30 days of the planned absence.
- c) Leaves of absence resulting from a Disciplinary Action must be coordinated with and reported to the GME Office (GMEO) per GMEC Policy 31.

2. Leaves Available for Trainees

- a) **Bereavement Leave:** GME Trainees may take up to 7 days of paid Bereavement Leave in the event of an Immediate Family Member’s death. Bereavement Leave may also be taken for pregnancy loss:

- A Parent who experiences a pregnancy loss prior to twenty (20) weeks gestation is eligible for 7 days of Paid Parental Leave.
- A Parent who experiences pregnancy loss at twenty (20) weeks gestation or beyond and prior to delivery is eligible for 4 weeks of Bereavement Leave.

Trainees may take additional time for bereavement with the approval of their Program Director by applying sick or vacation time towards that leave.

For the purpose of Bereavement Leave, Immediate Family Member includes a) parents, including step-parents, in-laws and *in loco parentis* (a person who stood in place of parent); b) spouse; c) children, including step-children, foster children, sons-in-law, daughters-in-law; d) siblings, including step-siblings, siblings-in-law; e) grandparents and grandchildren; f) any person living in the trainee's household.

- b) **Caregiver Leave:** Trainees may utilize this category of leave to care for a child, spouse or parent with a Serious Health Condition as outlined in Medical Center Policy HR-600.
- c) **Family and Medical Leave:** Family and Medical Leave, including Military Caregiver Leave and Qualified Exigency Leave, is federally mandated, job-protected leave which is available for Trainees who have been employed by the sponsoring institution for at least 12 months. Please see Medical Center Policy HR-600 for details.
- d) **Medical Leave:** Trainees may utilize this category of leave to take time off due to extended personal illness, medical procedure, disability or other Serious Health Condition as outlined in MC Policy HR-600.
- e) **Paid Parental Leave:** Trainees may utilize this category of leave within 6 months of the event (birth, adoption, or placement).
 - Trainees who have been employed for at least 12 months prior to the start of PPL are eligible for up to 8 weeks of paid leave. Trainees with less than 12 months of employment prior to the start of PPL are eligible for up to 6 weeks of consecutive paid leave.
 - PPL may be taken consecutively or may be taken in two 4 week blocks for those eligible for a total of 8 weeks of PPL, or two 3 week blocks for those eligible for a total of 6 weeks of PPL.
 - PPL must be taken within 6 months of the event
 - PPL can be taken once in a 12-month period and only once per child.
 - PPL is separate from vacation and sick leave (i.e., trainees may take vacation time in addition to approved PPL time).
 - PPL must be requested via the attached form, submitted to Program Director for approval and signature and then to the GMEO and should be requested at least 3 months prior to the birth, adoption, or placement of a child, if possible.

- 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.
 - Trainees who have been employed for 12 months or longer are required by MC policy to also apply for FML which runs concurrently with their PPL (see below).
 - PPL may be used when a Parent loses an infant during birth or whose infant survives for only a short period of time following birth. Both or either parent may take either eight (8) or six (6) weeks of PPL depending on length of employment to date.
- f) **Professional Leave:** Each training program should have its own written professional leave policy to cover attendance at off-site conferences, research time, and other scholarly activities away from the Hospital and in accordance with any Medical Center, GMEC, or ACGME policies.
- g) **Routine Medical Appointment:** Trainees are encouraged to prioritize their own well-being by seeking necessary and proactive care. The ACGME requires that no resident or fellow should have to arrange their own coverage to seek or attend an appointment for medical or mental health. It is an expectation that programs will provide coverage for trainees' routine medical appointments when they are provided reasonable notification. In some instances, medical appointments qualify for FML. Please refer to Medical Center Policy HR-600.
- h) **Sick Leave:** Trainees are provided up to 14 calendar days per academic year of paid sick leave, inclusive of time needed for mental health. This leave type is for unexpected illnesses of short duration. See Medical/Caregiver Leave for additional options.
- i) **Vacation Leave:** Trainees must be provided a minimum of 15 business days of vacation time per academic year. 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.
- j) **Religious Holidays:** When requested, a Trainee should be granted time off to observe a religious holiday consistent with these policies: <https://eocr.virginia.edu/staff-religious-accommodations>.¹ The days taken off will be counted against the trainee's vacation days.

¹ A reasonable workplace accommodation is a modification to an Employee's work or environment to enable the Employee to participate in their religious practice or belief which does not cause an Undue Hardship to UVA operations or activities. UVA is committed to providing accommodations, upon request, to ensure access to employment opportunities, benefits, programs, and services to all employees who have sincerely held religious beliefs. However, reasonable religious accommodations are not required or permitted when such accommodation would cause Undue Hardship, violate other laws, or interfere with the safety and security of UVA or its operations. Undue Hardship is a burden that would result in substantial increased costs in relation to UVA's business. Undue Hardship must be based on an individualized assessment of current circumstances that show that a specific reasonable accommodation would cause such burden or expense.

3. Contingency Plans and Coverage

The Urology Program Director will arrange resident coverage for trainees' during approved leaves of absence. Trainees are not responsible for arranging coverage during leaves of absence.

4. Certification Board Policy on Leave of Absence American Board of Urology :

Leaves of absence and vacation may be granted to residents at the discretion of the Program Director consistent with local institutional policy and applicable laws. Each program may provide vacation leave and family leave (any leave required to care for a family member) for the resident in accordance with institutional policy. The ABU requires 46 weeks of full-time clinical activity in each of the five years of residency. However, the 46 weeks may be averaged over the first 3 years of residency, for a total of 138 weeks required in the first 3 years, and over the last 2 years, a total of 92 weeks is required.

Vacation or various other leave may not be accumulated to reduce the total training requirement. Should circumstances occur which keep a resident from working the required 138 weeks the first 3 years and 92 weeks the last 2 years, the Program Director must submit a request to the ABU for a variance of the current policy or a plan outlining how the training deficit will be rectified. In certain cases an extension of the residency training may be required.

Ninety-two (92) weeks of training is required for two-year fellowships, without the need to request a variance or submit a plan for making up a training deficit. Leave for educational/scientific conferences are at the discretion of the Program Director.

5. Other Considerations

- a) **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 stipend and benefits covered by the GME Office to continue for the extension.
- b) **Unexcused Leave of Absence:** Disciplinary or remedial action resulting from any unexcused leave of absence shall be at the discretion of the Program Director based on individual Department and/or accreditation requirements and regulations, and in consultation with the Designated Institutional Official.
- c) **Timely Notice of Leave Impact:** The program is required to notify the Trainee if any given leave impacts the Trainees' ability to satisfy requirements for program completion or Board eligibility at the initial discussion of leave with the Trainee.

- d) Training program Leave Policy: Every training program in the Medical Center must have its own Leave Policy which must acknowledge compliance with that program's Board requirements.

Non-Renewal of Graduate Medical Trainees' Appointment (No. 04)

The University of Virginia Medical Center and the Graduate Medical Education Committee shall seek to provide all residents and fellows (herein after "graduate medical trainees") with the appropriate procedure and guidelines should their graduate medical trainee agreement not be renewed. This policy is intended to provide oversight. The ultimate decision not to renew a graduate medical trainee's contract remains with the Program Director and/or Chair.

PROCEDURE:

1. When a graduate medical trainee's agreement is not going to be renewed, each program must ensure that it provides the graduate medical trainee(s) with a written notice of intent not to renew a graduate medical trainee's agreement no later than four months prior to the end of the graduate medical trainee's current agreement unless a Remediation Plan has been instituted. In this circumstance, refer to GME Policy #05, Policy on Assessment of Performance, for appropriate timeline. Documentation of non-renewal notification must be kept in the departmental personnel file, communicated to the individual Board Certification Agency, updated in ACGME Web-ADS by the residency or fellowship coordinator, as well as copied and sent to the Graduate Medical Education Office.
2. Upon non-renewal of appointment, the Graduate Medical Education Office must notify the Virginia Board of Medicine that that graduate medical trainee is no longer practicing at the University of Virginia or has switched specialties (if applicable).
3. Should the reason for the non-renewal occur within the four months prior to the end of the agreement, each program must provide the graduate medical trainee with as much written notice of the intent not to renew as the circumstances will reasonably allow, prior to the end of the agreement [I.R. II.D.4.d].
4. Graduate medical trainees must be allowed to implement the University of Virginia Health System's Graduate Medical Education grievance procedure if they have received a written notice of intent not to renew their agreements.
5. The Program Director must submit a final evaluation and summary of the non-renewal of appointment decision within 30 days of date of notification for review of the DIO and the GMEC Executive Committee. This review will remain confidential and is not part of the GME grievance procedure. The minutes of the GME executive committee meeting will serve as the written records for this review.
6. All graduate medical trainees who are not renewed and terminated from employment at the University of Virginia Medical Center, have the right to continue medical benefits at their expense through "Continuation of Benefits" (COBRA). Please visit, <http://www.hr.virginia.edu/hr-for-you/medical-center/mc-benefits/cobra/>

Assessment of Performance (No. 05)

The following Policy and Procedures for the Assessment of Performance of Graduate Medical Trainees (hereinafter “Performance Policy”) shall apply to all graduate medical trainees at the University of Virginia Health System. The Performance Policy governs the qualification of graduate medical 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 at issue.

Definitions

Graduate medical trainee: Any resident or fellow participating in a postgraduate medical, dental, chaplaincy, clinical laboratory, clinical psychology, pharmacy, or radiation physics program.

Deficiency: Inadequate acquisition of or performance in any of the ACGME’s areas of general competencies, including patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, or systems based practice, as expected for the graduate medical trainee’s level of experience and education. If a deficiency is not corrected by providing regular feedback to the trainee, a period of remediation may be imposed. Deficiencies are not reportable events; however, all other events that are not defined as a deficiency are reportable to the Virginia Board of Medicine (e.g., Misconduct, Adverse Action).

Misconduct: A lapse in ethical or moral behavior, irrespective of the graduate medical trainee’s level of experience, ability, or education. Acts of misconduct are addressed with disciplinary action and may be reportable events.

Adverse Action: Administrative leave, suspension, non-renewal, non-promotion, or dismissal of a graduate medical trainee from his or her program. Adverse actions, with the exception of administrative leave, are generally reportable events.

Reportable Events: Those actions the program or institution must disclose to others upon request, including, without limitation, future employers, privileging hospitals, and licensing and specialty boards.

Non-promotion: The decision by a program not to advance a trainee to the next program year or PGY level based on deficits in academic performance. The trainee may be required to repeat a full year or part of a year or the end date (i.e., graduation) of the trainee may be extended, based on requirements from either the program or the certifying board.

Procedures

1. TRAINING PROGRAM ASSESSMENT STRUCTURE AND PLAN

The program director for each training program has primary responsibility for monitoring the competence of the program’s graduate medical trainees, for recommending promotion and board eligibility, and, when necessary, imposing any remedial, adverse or disciplinary actions. Graduate medical trainees shall be evaluated on both the clinical and non-clinical requirements of the ACGME/program RRC and/or the certifying specialty Board.

A Clinical Competency Committee should assist a program director in these functions and meet regularly but no less than every six months. Each program’s assessment structure and plan must be in writing.

2. PERFORMANCE REVIEWS

Each department must provide written summary of performance reviews to graduate medical trainees at regular intervals. The ACGME Residency Review Committee (or

other appropriate accrediting agency) for each specialty may specify the desirable frequency of such reviews; however, at a minimum, they must occur semi-annually. It is recommended that a review of the graduate medical trainee's experience and competence in performing clinical procedures be included in these summaries when appropriate. Summary performance reviews as determined by the program's Clinical Competency Committee for ACGME accredited programs should be based on the Milestones.

For trainees who voluntarily resign prior to completion of a Postgraduate year, an evaluation with amended dates must be completed, included in the trainee's file, and shared with the GME Office.

3. PROMOTION

Those graduate medical trainees judged by a program to have completed satisfactorily the requirements for a specific level of training will be promoted to the next level of responsibility unless the graduate medical trainee specifically 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 graduate medical trainee may remain at the same level of training for more than 24 months, exclusive of leave. A graduate medical trainee whose performance is judged to be satisfactory will advance until the completion of the program/certification requirements.

4. DEFICIENCY or MISCONDUCT

A. Deficiency

- Letter of Deficiency: If, after documenting routine feedback, it is determined that a graduate medical trainee is not performing at an adequate level of competence in any of the general competencies, or otherwise fails to fulfill the responsibilities or meet the level specific goals and objectives of the program in which he or she is enrolled, the graduate medical trainee will be issued a Letter of Deficiency by the program director or program's Clinical Competency Committee. The graduate medical 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 deficiencies or problem behaviors.
 - A plan for remedial action including plans for providing feedback and the timing of that feedback.
 - Criteria by which successful remediation will be judged.
 - The duration of the remedial period in which deficits are expected to be corrected; ordinarily, this period will be at least three months.
 - Written notice that failure to meet the conditions of remedial action could result in additional remediation or training time and/or suspension or dismissal from the program during any point, or at the conclusion of the remedial action period.
 - The Program Director or designee must document that that meeting has occurred and that the trainee was provided this documentation. The Designated Institutional Official (hereinafter "DIO"), and Clinical Competency Committee Chairperson must receive a copy of this documentation.

- If the graduate medical trainee successfully completes the remedial action, written documentation must be included in the graduate medical trainee's file describing the satisfactory completion of all remedial action plans; this documentation must also be submitted to the DIO, and copied to the Clinical Competency Committee Chairperson and trainee.
- If remedial action is extended beyond the initial period, the Clinical Competency Committee must meet to determine further actions. If, at the end of the remedial action period the graduate medical trainee's performance remains unsatisfactory, the graduate medical trainee may be suspended or adverse action may be initiated (see Sections 5C and 5D). The DIO/GME Office must be notified of any such action.

B. Misconduct

- When a graduate medical trainee engages in behavior that is clearly unethical, immoral, or criminal in nature, such as harassment, theft, plagiarism, fighting, dishonesty, breach of the code of conduct, HIPAA violation or abuse of parking privileges, the program director or designee or DIO may choose to impose disciplinary action rather than a period of remedial action. If misconduct is alleged or suspected, the program director or designee should:
 - Discuss allegations with graduate medical trainee and give him or her an opportunity to respond.
 - Consult with the DIO and Clinical Competency Committee, or subset thereof.
 - Dismiss the allegations or impose disciplinary action after consideration of the trainee's response. An example of a non-reportable disciplinary action would be administrative leave without pay. More severe penalties, including suspension or dismissal from the program, would be reportable actions.

5. SUSPENSION AND DISMISSAL

The DIO must be notified prior to enactment of any or all of the following:

• **Suspension of Clinical Activities**

A graduate medical trainee may be suspended from clinical activities by his or her program director, department chair, the medical director of the clinical area to which the graduate medical trainee is assigned, the DIO, and the Chief Medical Officer. This action may be taken in any situation in which continuation of clinical activities by the graduate medical trainee is deemed potentially detrimental or threatening to University of Virginia Health System operations, including but not limited to patient safety or quality of patient care, suspension or loss of licensure, or debarment from participation as a provider of services to Medicare and other federal programs' patients. Unless otherwise directed, a graduate medical trainee suspended from clinical activities may participate in non-clinical program activities. A decision involving suspension of a graduate medical trainee's clinical activities must be reviewed within three (3) calendar days by the department chair (or his or her designee, e.g., Division Chief) to determine whether the graduate medical trainee may return to clinical activities and/or whether further action is warranted (including, but not limited to, counseling, remedial action, fitness

for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of the DIO.

- **Program Suspension**

A graduate medical trainee may be suspended from all program activities and duties by his or her program director, department chair, or any other person listed in Section 5A. Program suspension may be imposed for program-related conduct that is deemed to be grossly unprofessional; incompetent; erratic; potentially criminal; noncompliant with University or Medical Center policies, , federal health care program requirements, (“noncompliance”); or is threatening to the well-being of patients, other graduate medical trainees, faculty, staff, student, or the graduate medical trainee. A decision involving program suspension of a graduate medical trainee must be reviewed within three (3) calendar days by the department chair (or his or her designee) to determine whether the graduate medical trainee may return to some or all program activities and duties and/or whether further action is warranted (including, but not limited to, career or academic advising, remedial action, fitness for duty evaluation, or summary dismissal). Suspension may be with or without pay at the discretion of the DIO.

- **Dismissal During or at the Conclusion of Remedial Action**

A Letter of Deficiency in a training program constitutes notification to the graduate medical trainee that dismissal from the program can occur at any time during or at the conclusion of remedial action. Dismissal prior to the conclusion of a remedial action period may occur if the conduct that gave rise to the Letter of Deficiency is repeated or if grounds for program suspension or summary dismissal exist. Dismissal at the end of a remedial action period may occur if the graduate medical trainee’s performance remains unsatisfactory or for any of the foregoing reasons.

- **Summary Dismissal**

For serious acts of incompetence, impairment, unprofessional behavior, falsifying information, noncompliance, felony conviction, or lying, or if a graduate medical trainee is listed as excluded on the Department of Health and Human Services’ Office of Inspector General’s “List of Excluded Individuals/Entities” or on the General Services Administration’s “List of Parties Excluded from Federal Procurement and Non-Procurement Programs” or is discovered to have been convicted of a crime related to the provision of health care items or services for which one may be excluded under 42 USC 1320a-7(a) (an “excludable crime,” i.e., criminal offenses related to governmentally financed health care programs, including health care fraud; criminal abuse or neglect of patients; and or felony controlled substance convictions related to the provision of health care), a department chair, or any person listed in Section 5A, may immediately suspend a graduate medical trainee from all program activities and duties for a minimum of three (3) calendar days and, concurrently, issue a notice of dismissal effective at the end of the suspension period. The graduate medical trainee does not need to have been issued a Letter of Deficiency nor be at the end of a remedial action period for this action to be taken.

- **Notification of Suspension and Dismissal**

The graduate medical trainee must be notified in person and in writing of the reason for and terms of suspension and dismissal, have an opportunity to respond to the action before the suspension or dismissal is effective, and receive a copy of the GME Appeals Process. The DIO and Department Chair (or designee) must also be notified of such action.

6. GME APPEAL PROCESS

In the event that a graduate medical trainee (i) is not promoted, (ii) is suspended, (iii) is dismissed from a program, (iv) does not have his/her appointment/contract renewed, or (v) has his/her training extended such that the extension adversely affects his/her ability to obtain a subsequent position, the graduate medical trainee may appeal such non-promotion, suspension, dismissal, non-renewal of appointment/contract, extension of training or adverse action as follows. Any questions about appealability shall be directed to the DIO.

- **GMEC Appeal**

A graduate medical trainee may initiate an appeal by submitting a written notice of appeal to the DIO, within thirty (30) calendar days of the date of the appealable action (hereinafter “adverse action”). The DIO will convene an appeal panel consisting of 3 faculty members outside of the trainee’s Department.

The graduate medical trainee may request one of the three members appointed by the DIO be replaced by another physician including a trainee at a same or a higher training level within a GME training program. The GMEC appeal hearing will be held within thirty (30) calendar days following receipt of the notice of appeal. A member of the GME Office must be present during this hearing. The graduate medical trainee may have a faculty advocate appear and participate on the graduate medical trainee’s behalf at the hearing.

Prior to the hearing, the graduate medical trainee and program director must notify the chair of the appeal panel of the number of witnesses (if any) the graduate medical trainee expects to call and whether the graduate medical trainee will be accompanied by a faculty advocate and/or legal counsel. At the appeal hearing, the program director (or designee) will present a statement in support of the adverse action and may present any relevant records, witnesses, or other evidence. The graduate medical trainee will have the right to present evidence, call and question witnesses, and make statements in defense of his or her position.

Legal counsel may be present to provide advice and counsel to the graduate medical trainee, the Program, and the chair of appeal panel but counsel will not be permitted to actively participate in presentation of testimony, examination/cross-examination of witnesses, or oral arguments. A record of the hearing will be kept by the member of the GME Office present for the hearing, or by a professional legal reporter hired by the GME Office for this

purpose. After presentation of evidence and arguments by both sides, the appeal panel will meet in closed session to consider the adverse action.

In its deliberations, the panel must accord deference to the recommendations of the Clinical Competency Committee. The panel's review shall be limited to: (a) compliance with applicable GME policies and procedures, and (b) whether there is sufficient evidence to support the recommendation of the program director or the Clinical Competency Committee.

The panel may uphold or reject the adverse action or may impose alternative actions, which may be more or less severe than the initial action. However, before rejecting the adverse action or imposing any alternative action, the panel must conclude that: (a) there was a failure to follow GME policies and that failure negatively affected the program's recommendation, and/or (b) that there is not substantial evidence to support the recommendation. The panel's decision must be submitted to the graduate medical trainee, the program director, chair of the department, and chair of the Clinical Competency Committee within ten (10) calendar days of the close of the hearing and copied to the DIO and the GME Office.

- **Appeal to the DIO**

Either party may appeal the panel's decision to the DIO. The graduate medical trainee or program director must deliver a written appeal to the DIO within ten (10) calendar days of receipt of the notification of the action of the appeal panel. Either party must state as clearly and as fully as possible the reasons for seeking modification of the decision. The DIO will review the graduate medical trainee's training file, evidence presented during the appeal hearing, and any other relevant materials. The DIO will review the record submitted during the course of the appeal and may consider any other written material or oral testimony he or she deems relevant. The DIO's responsibilities are to:

- ❖ Determine whether applicable University, department, and/or Medical Center policies were fairly and appropriately applied, and
- ❖ Determine whether there is sufficient evidence to support the decision of the appeal panel. The DIO may uphold or reject the adverse action, may uphold or reject the decision of the appeal panel. The decision of the DIO will be submitted to the graduate medical trainee, the program director, Clinical Competency Committee Chair and the department chair within thirty (30) calendar days of the notice of appeal to the DIO. The decision of the DIO will be final within the University of Virginia.

7. OTHER CONSIDERATIONS

Documentation of the entire appeal will be maintained by the GME Office and becomes a part of the graduate medical trainee's permanent record.

External rules, regulations, or law governs mandatory reporting of problematic behavior or performance to licensing agencies or professional boards. The fact that such a report is made is not a matter which may give rise to the appeal process; only

the adverse action as specified by this section is appealable. The reporting of an Adverse Action shall not be made the subject of an appeal. Graduate medical trainees should be aware that participation in the GME appeal process does not preclude investigation or action on the part of external entities.

Grievance Policy (No. 06)

This policy is established to provide a mechanism for resolving disputes and complaints that may arise between a graduate medical trainee and his or her program director or other persons involved with the administration of the educational program.

There shall be a process for adjudicating graduate medical trainee complaints and grievances related to the work environment or non-academic issues related to individual residency programs or faculty.

Definition of Terms

Complaint - A written or verbal expression of dissatisfaction with the work environment, individual residency programs or the faculty.

Grievable Complaints (“Grievance”) - A grievable complaint is a concern or issue that a graduate medical 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 ACGME and the program.

Grievable Complaints Include

- ❖ A program’s consistently exceeding the ACGME Duty Hour regulations without regard to the graduate medical trainee’s well-being.
- ❖ Complaints related to a graduate medical trainee feeling unsafe and/or unprotected due to lack of security provided by the program or Medical Center.
- ❖ Complaints related to a disciplinary action brought forth by the Program Director as a result of trainee misconduct.
- ❖ Complaints related to inappropriate behavior, including mistreatment, by any member of the Medical Center or School of Medicine as defined in Medical Center Policy 262.

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

- ❖ Decisions regarding and/or documentation of areas of deficiencies in academic performance or remedial actions (*see Policy on Assessment of Performance of Graduate Medical Trainees*).
- ❖ Establishment and revision of salaries, position classifications, or general benefits;
- ❖ Work activity accepted by the graduate medical trainee as a condition of employment or work activity that may be reasonably expected to constitute a part of the job;
- ❖ The content of policies, procedures and other rules applicable to graduate medical trainees
- ❖ Work and duty assignments with the Medical Center.
- ❖ Discrimination on the basis of race, national origin, religion, sex, age, handicap, or sexual orientation. These complaints are handled in the manner specified in the University of Virginia Office of Equal Opportunity Programs.

Procedures

- ❖ Step 1: (If Grievance is with Program Director, skip to Step 2.) The graduate medical 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 graduate medical trainee shall, within 30 calendar days of the event or action giving rise to the grievance, 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 graduate medical trainee and attempt to reach a solution along with a third party (e.g. Vice Chair of Education of department, member of GME Office). Within 5 calendar days of this discussion, the program director shall inform the graduate medical 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 resolution shall be provided to the appropriate Department Chair and to the Designated Institutional Official (herein after "DIO") and Associate Dean of Graduate Medical Education.
- ❖ Step 2: If the program director's written resolution is not acceptable to the graduate medical trainee, the graduate medical 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 resolution. This notification shall include a copy of the program director's resolution and all other information supportive of the graduate medical trainee's grievance. Within 7 calendar days of receipt of the grievance, the Department Chair shall meet with the graduate medical trainee to discuss the grievance and attempt to reach a solution with third party present. Within 5 business days of this meeting, the Department Chair shall send to the graduate medical 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 graduate medical trainee disagrees with the decision of the Department Chair or the Program Director is the Department Chair, the graduate medical trainee shall present a written statement to the DIO within 15 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 fifteen 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. Within 10 calendar days of receipt of the graduate medical trainee's statement, the DIO shall provide to the graduate medical trainee a written decision on the grievance. This decision shall be final.
- ❖ The DIO 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.

Passing USMLE (No. 07)

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 STEP by June of their intern year (PGY-1) and pass Step 3 of the USMLE prior to March of their PGY-2 year. Failure to pass USMLE Step 3 by March of the PGY-2 year may result in non-renewal of their appointment. (Department Policy/Modification)

Department policy change (2023): USMLE Step 3: R1 Residents are expected to take USMLE Step 3 prior to June 30th of the R1 year. Residents are expected to pass USMLE Step 3 prior to December 31 of their R2 year.

Residents should register for the USMLE or COMLEX Step 3 examination (or its equivalent) with enough time to allow for scheduling, grading, and notification of results prior to December 1st.

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.

Conditions of Employment (No. 08)

The University of Virginia Health System and the Office of Graduate Medical Education hereby establish as a condition of appointment for graduate medical trainees, the following provisions regarding both an initial appointment and reappointments.

Initial Appointment

- 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)
- The Sponsoring Institution and the program directors must assure that 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).

Appointment Renewal

- Trainees will be reappointed based on successful completion of level-appropriate program requirements as determined by the Program Director and program faculty.
- All programs must submit the appropriate reappointment documents as regulated by the GME Office.
- All graduate medical trainees being reappointed must complete the appropriate reappointment paperwork and contract, NetLearning Modules, and obtain TB Testing (by the end of their birth month).
- Instances of trainee non-renewal are governed by GMEC Policy No.04.
- Additionally, all trainees must abide by Medical Center Policy No.0283- Behavioral Code of Conduct and HR Policies 701-Employee Standards of Performance and 104-Conditions of Employment.
- All appointments and reappointments must be in compliance with GME Policy #7, passing USMLE Steps 1, 2, 3.
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The Graduate Medical Education Office and the Graduate Medical Education Committee will review and revise this policy contingent upon any revisions to the Medical Center Policies and/or the Accreditation Council for Graduate Medical Education (ACGME).

Breaches of Confidentiality (No. 09)

The University of Virginia Health System and the Office of Graduate Medical Education shall adapt Medical Center Human Resources Policy No. 707 with respect to all issues of patient confidentiality. All graduate medical trainees must be knowledgeable on the subject of MC-HR Policy No. 707

specifically as it pertains to:

- Confidential Information
- Violations of Confidentiality
- Protected Health Information
- Methods for Reporting Violations of Confidentiality
- Levels of Violations of Confidentiality
- Corrective Action

The Graduate Medical Education Office and the Graduate Medical Education Committee will review and revise this policy contingent upon any revisions to the MC-HR Policy 707 and/or the Accreditation Council for Graduate Medical Education (ACGME).

ACGME Duty Hours Regulations and Procedure (No. 10)

The Office of Graduate Medical Education shall require all ACGME and non-ACGME residency and fellowship programs to participate in the documentation of duty hours in New Innovations, to ensure graduate medical trainees are not being placed at risk for fatigue, and to document compliance with each program's individual Residency Review Committee

(RRC) and the Accreditation Council for Graduate Medical Education (ACGME) regulations.

Definition:

Duty hours are defined as all clinical and academic activities required for the residency program; i.e., patient care (direct patient care: both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care; time spent in-house during call activities, and scheduled activities such as required conferences. Duty hours do not include reading and preparation time spent away from the duty site. Duty hours restrictions are based upon the ACGME Duty Hour rules as found in the Common Program Requirements on the ACGME website: <https://www.acgme.org>

PROCEDURE:

- Faculty and residents must be educated to recognize the signs of fatigue and sleep deprivation and must adopt and apply policies to prevent and counteract its potential negative effects on patient care and learning.
- The Institution mandates that all graduate medical programs comply with their individual RRC regulations regarding duty hours restrictions.
- The Institution mandates that all non-ACGME accredited programs comply with the ACGME Duty Hour rules as found in the Common Program Requirements on the ACGME website:
<https://www.acgme.org/acgmeweb/tabid/429/ProgramandInstitutionalAccreditation/CommonProgramRequirements.aspx> (7/01/2015) 4. The Institution does not allow exceptions to the 80 hour weekly limit on duty hours.
- The GMEC has established a Subcommittee on Duty Hours Compliance. Review of duty hour compliance is within the scope of review of the GMEC CLER Subcommittee.. It will be the responsibility of this Subcommittee to review the tracking reports and determine sufficient programmatic compliance. The Subcommittee, with assistance from the Graduate Medical Education Office (GMEO), will compile and track additional information related to duty hours for each program (including RRC surveys, internal reviews, annual program reviews, routine New Innovations (NI) logging audits, and off-service trainees' violations, etc.) in order to establish an initial baseline of duty hours violations for each program from which to gauge individual progress toward eliminating violations. Subcommittee will further be responsible for investigating any duty hours concerns, complaints or reports that arise from faculty, staff, or trainees. The DIO and the Subcommittee may request from any program documentation or clarification regarding any concern. In instances where a concern is found to be significant or has not been resolved in a reasonable period of time, the Subcommittee will make recommendations to the full GMEC, including the possibility of activating the internal review process.

Duty Hour Logging and Monitoring

- Per RRC Common Program Requirements, the program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas.
- The program director must:

1. implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, and, to that end, must monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements;
2. ensure that residents can freely report duty hour violations without fear of consequences
3. adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and,
4. if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue.
5. Because of the intricacies of New Innovations (NI) and individual RRC mandates regarding duty hours, it will be the responsibility of the Program Directors and his/her staff to determine which exceptions reported in New Innovations represent true violations and to follow up on those accordingly. It is the expectation that programs will monitor duty hours, and collect data on trends and systems- based causes on a schedule sufficient to ensure compliance.
6. Program Directors will complete and submit a duty hours tracking report to the GMEC Subcommittee on Duty Hours Compliance on the following schedule:
 - Programs at high risk for violations will complete one survey for each of the months in the 2nd and 4th academic quarters. (October 1 – December 31 and April 1 – June 30). The forms for October – December will be due to the GMEO by the second Friday in January. The forms for April – June will be due to the GMEO the second Friday in July. High risk is defined as having any risk for duty hour violations, or the presence of any of the following: true duty hour violations recorded in New Innovations, including those of off-service residents, an RRC citation or concern, an Internal Review concern, or any ACGME/RRC Anonymous Survey generating non-compliance responses on duty hour related questions, GME Office exit survey, or call to the Residency Advocacy Hotline.
 - Programs at low risk for violations will complete one survey for the one month period of their choosing and will submit to the GMEO the second Friday after the end of that rotation. Low risk is having no risk of true duty hour violations and absence of any of the additional measures noted above to designate high risk.
7. While Programs may initially select their own reporting status per above, determinations about a program’s classification into either high or low risk status will ultimately rest with the GMEC CLER Subcommittee. Any of the aforementioned qualifying events (RRC citation, Internal Review concern, anonymous incident tip reporting line, ACGME survey results, etc.) will result in Subcommittee review and possible change in reporting status.
8. The CLER Subcommittee will report any recommended action or follow up to the full GME Committee. A Program Director may be asked to provide

additional information and/or clarification. If programs cannot achieve compliance easily by schedule alteration, a more detailed compliance plan may be requested.

9. In the event of failure to comply with either tracking, monitoring or proposing solutions to violations, the Program Director and/or Department Chair may be asked to present to either the Subcommittee or full GME Committee.
10. Additionally, programs must ensure the following:
 - Graduate Medical Trainees must be responsible for recording their own hours in New Innovations.
 - Any graduate medical trainee who rotates to another service (host program) must be in compliance with the host program's RRC duty hours requirements. Programs must be responsible for providing sufficient orientation on any program-specific duty hours requirements to all off-service residents. Both the home program and the host program must monitor that trainee's duty hours for compliance.
 - Any trainee participating in any required away rotation must log all duty hours for those rotations.
 - Trainees engaged in any moonlighting activities must log ALL duty hours for the primary rotation they are on during that time period in addition to logging the hours they spend moonlighting (See also Policy on Moonlighting Activities, No. 11). Time spent by trainees in any form of moonlighting must be counted towards the 80 hr maximum weekly duty hour limit. Trainees who are enrolled in non-accredited, non-clinical years are required to log hours spent moonlighting.
 - Any graduate medical trainee wishing to discuss a duty hour concern may do so confidentially with their program director, chief resident, GMEO staff or the DIO. Trainees are encouraged to utilize the anonymous incident reporting line at (434) 806-9521.

Supervision of Graduate Medical Trainees (No. 12)

This policy outlines the University of Virginia Graduate Medical Education 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 policies, procedures and standards of accreditation.

The Clinical Staff of the University of Virginia Health System has overall responsibility for the quality of professional services provided to patients, including patients under the care of trainees. It is the responsibility of the clinical staff to assure that each trainee is supervised in his/her patient care responsibilities by a member of the clinical staff who has been granted clinical privileges.

Supervision of Trainees

In the clinical learning environment, each patient must have an identifiable attending physician who is ultimately responsible for that patient's care (CPR VI.D.1).

- The name of the attending physician of record shall be available to trainees, faculty members and patients.
- In certain situations, the attending physician may delegate supervisory responsibility to another caregiver (e.g., senior level resident) in accordance with individual RRC requirements. Ultimately, supervision rests with the attending physician.
- Trainees shall inform patients of their respective roles in each patient's care (CPR VI.D.1.b).

Levels of Supervision

- Each training program must demonstrate that the appropriate level of supervision is in place for all trainees who care for patients (CPR VI.D.2).
- To ensure oversight of resident supervision and graded authority and responsibility, each program must use the following classification of supervision (CPR VI.D.3):
 - Direct Supervision – the supervising physician is physically present with the trainee and patient (CPR VI.D.3.a).
 - 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 (CPR VI.D.3.b).(1).
 - Indirect 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 (CPR VI.D.3.b).
 - Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered (CPR VI.D.3.c).

Clinical Responsibilities

- The clinical responsibilities for each trainee must be based on PGY-level, patient safety, trainee education, severity and complexity of patient illness/condition, and available support services (CPR.VI.E).
- Progressive authority and responsibility, conditional independence, and level of supervision must be assigned by the program director and faculty members (CPR.VI.D.4) in accordance with individual RRC and Certifying Board requirements.
- While no procedure or clinical scenario always requires the presence of supervising physician, until competency has been determined by the clinical competency committee, the presence of a supervising physician may be required for some procedures'.

Escalation of Care

Notwithstanding the general categories of supervision set out above, a trainee shall 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:

- 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., 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.

Department policy change (2023):

R1/R2 residents: R1/R2 residents are expected to discuss all patients and management plans with the chief resident prior to contacting faculty. It is strongly encouraged that R3 residents, discuss plans with the chief resident prior to reviewing with faculty.

Individual departments may have additional events or more urgent time restrictions that qualify for notifying the responsible Attending Physician.

Protocol for Implementation

A teacher/trainee relationship founded on respect and professionalism is fundamental to GME training. Much of the learning process and the development of progressive responsibility are based on teaching by example under supervision. Supervision and close observation provide the ability of the mentor/program director to ascertain when a GME trainee (herein after “trainee”) is ready and able to assume progressive responsibility. This readiness should be reflected in the evaluation process with timely faculty evaluations that address the achievement of core and specialist competencies commensurate with the level of training, the specific nature of the training program, and the responsibilities involved. Patient safety and continued quality improvement in patient care are the central goals of any system of progressive responsibility.

Detailed descriptions (e.g., Goals and Objectives) of the trainees’ responsibilities and patient care activities of each specialty program shall be maintained by the Program Directors. These descriptions and any revisions must be provided to the Graduate Medical Education Office through the internal review process. Each Program Director must document a trainee’s progressive involvement and independence in patient care activities by an evaluation process

stratified by year of training.

Clinical Department Chairs, working in consultation with Program Directors shall be responsible for compliance with the Supervision Policy and this Protocol. Compliance will be monitored through the Graduate Medical Education Office's annual review process and assessed by documentation of evaluations, and the anonymous ACGME survey of trainees. Audits of compliance may be carried out by the Graduate Medical Education Committee (GMEC) in the event of expressed concerns of trainees, LIPs, staff, patients, accrediting agencies, or other appropriate authorities.

Failure to comply with the Supervision Policy or this Protocol or any concern raised within a program regarding the adequacy of supervision could result in a letter from the GME Office to the Program Director, a required appearance before the full GMEC to address the concerns and describe plans for remediation, and/or a progress report outlining the remediation of any problems identified with supervision requirements.

Responsibilities of Attending Physicians

1. Attending physicians are the physicians of record and ultimately responsible, within the scope of their clinical privileges, for the care and treatment of each patient they admit to the University of Virginia Medical Center (See Medical Center Policy No. 0304 "Responsibilities of Attending Physicians on Inpatient Services" and 0324 "Clinical Communication and Escalation of Care/Inpatient Services").
2. If the attending physician delegates to trainees, in whole or in part, the medical management plan, the attending physician remains responsible for ensuring the trainees have appropriate training, experience and competence to undertake such management.
3. The attending physician must communicate clearly to each trainee involved in the care of the patient when that attending expects to be contacted by the trainee. At a minimum, the trainees must be told to notify that attending of significant changes in the patient's condition regardless of the time of day or day of week. See also Factors that require resident to notify the Attending Physician within 90 minutes in Section 4 of the Supervision Policy. Attending physicians shall behave in a professional manner in regard to trainee supervision and shall encourage each trainee to seek guidance from the attending physician at any time the trainee believes it to be helpful in the care of the patient. The attending physician is to make clear to each trainee that it is only the failure to seek guidance that will be considered problematic.
4. The attending physician shall review inpatient progress notes, sign outpatient progress notes, procedural and operative notes, and discharge summaries for cases in which a trainee has been involved.
5. The attending physician shall provide trainees with constructive feedback when appropriate.
6. The attending physician will serve as a role model to trainees in the provision of patient care that demonstrates professionalism and good communication skills.
7. The attending physician will provide direct supervision or indirect supervision with direct supervision immediately available of trainees in the ambulatory setting.
8. In the inpatient setting, an attending physician is expected to provide daily direct (in person) teaching and supervision to the team. If the attending physician is out of

- town or unavailable, coverage of his/her patients must be communicated clearly with the covering attending and with the team on that service.
9. The attending physician will adhere to program specific levels of responsibility and teach trainees according to the level that is commensurate with training, education, and demonstrated skill. It is the responsibility of the program director and/or Chair to develop and communicate program specific levels of responsibility.
 10. The attending physician will adhere to Institutional , and GMEC policies with special attention to Patient Safety Guidelines for Attending Physician Oversight of In-Patient Care and Responses to Changes in Patient Condition (approved by Clinical Staff Executive Committee 2/16/10).
 11. The attending physician should be educated to recognize the signs of fatigue and sleep deprivation, and support trainees in preventing and counteracting the negative effects that can impact patient care and learning (See GME Policy 26 “Fitness for Duty”).

Responsibilities of Trainees

1. All patient care responsibilities of the trainee will be under the supervision of an attending physician who has full appropriate appointment and privileges at the University of Virginia Medical Center or affiliated institution granted through the medical staff credentialing process. The attending physician will monitor patient care services provided by trainees to assure provision of quality patient care and sign trainees’ notes and orders as appropriate to hospital and program policy.
2. Trainees must be aware of and follow his/her program’s supervision plans.
3. Licensed trainees at all levels of training may write orders. All orders shall include the date signed by the trainee. These orders are written under the supervision of an attending physician as noted in 1 above. 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.
4. 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 skill level of the trainee.
5. 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.
6. In all specialties and subspecialties, progressive responsibility for trainees is provided in accordance with ACGME Common Program Requirements policies on achievement of general and specific competencies, including the six General Competencies, as promulgated by the ACGME and endorsed and implemented by the University of Virginia GME Office and the University of Virginia School of Medicine. Documentation of the trainees’ achievement of these competencies is provided through Faculty evaluations of the trainees and evaluations and reviews provided by the Program Director. The GMEC, GME Office, and the Designated Institutional Official provide institutional oversight of this process.

Responsibilities of the Program

1. The program will develop and maintain a trainee supervision plan that provides for safe and effective patient care, educational needs of trainees, and progressive responsibility that is appropriate to the trainee's level of education, competence, and experience. The supervision plan must include but is not limited to the following:
 - A definition of the clinical responsibilities and level of supervision required for each, for trainees at each level of training.
 - A mechanism of providing feedback and program notification if either a member of the faculty or a trainee identifies a problem with supervision.
 - Action to be taken in emergency situations where a trainee is beyond his/her level of experience or competence.
 - Action to be taken if the supervising attending physician is unavailable, does not respond to attempts at communication, or does not provide adequate supervision.
2. The program will develop and maintain a system for documenting supervision in the resident rotation schedules and the attending on-call schedules. On-call schedules for attending physicians shall provide for supervision that is readily available to a trainee on duty 24 hours per day, 7 days per week.
3. Any significant changes to the Institutional or program Supervision Policy or plan for supervision must be communicated to all faculty and trainees.

Definitions:

Direct Supervision: the supervising physician is physically present with the fellow during the key portions of the patient interaction; or, the supervising physician and/or patient is not physically present with the fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.

Indirect Supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but is immediately available to the fellow for guidance and is available to provide appropriate direct supervision.

Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

Presence of Other Learners (No. 13)

The presence of other UVA Medical Center learners (including, but not limited to, trainees from other specialties, trainees from other institutions, medical students, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed trainees' education. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. [CPR III.D.]

The presence of outside, non-UVA learners is addressed in the Policy #28 on Observers, Visitors, and Externs.

Any sustained (more than 31 days) increase in the number of other learners must be reported to the GMEC. The ratio of faculty to all graduate medical trainees should be in accordance with any individual RRC Requirements. Individual programs may opt to promote a more restrictive policy on the presence of other learners.

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.

PROCEDURE:

All visiting residents must be appropriately credentialed through the GME Office and Credentialing Committee, including obtaining a Virginia Medical License. Full applications should be submitted 60 days prior to the start date. Any visiting resident not fully credentialed will not be permitted to have direct (“hands-on”) patient contact.

Graduate Medical Trainees Rotating to Other Institutional Services (No. 15)

Definitions:

- Primary Program – Residency Program in which graduate medical trainee is based.
- Hosting Program – Residency Program in which graduate medical trainee from another UVA program rotates.
- Off Service Rotator – Graduate medical trainee within the UVA system rotating to another clinical service other than his/her primary/home program.

PROCEDURE:

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

1. If any post-graduate training requires a rotation to another Department other than the graduate medical 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 rotator and the primary program’s Program Director along with any other educational materials.
3. A rotation schedule must be made in advance allowing the two services involved to make the needed adjustments to ACGME/RRC 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 hosting program is no longer able to accommodate graduate medical 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 on its rotations and will be communicated between Program Directors. Ideally, off service rotators 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 rotator to the Chief Resident or other individual who is responsible for that program's scheduling.
6. In programs where off-service rotators are scheduled on a regular basis and/or where the presence of those trainees is required to meet the patient care needs of the hosting 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 and coverage.
 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 duty hour requirements of the host program.

Administrative Support in the Event of a Disaster (No. 16)

All residents and fellows (herein after "graduate medical trainees") shall be provided by the University of Virginia Health System and the Office of Graduate Medical Education the administrative resources necessary and required by the Accreditation Council for Graduate Medical Education (ACGME) to ensure their graduate medical education training is sustained during the event of a disaster or interruption in patient care.

PROCEDURE:

It is the responsibility of the individual graduate medical education training program to keep current address/contact information on file of all its graduate medical trainees and to include any alternate email addresses. Any changes in address/contact information must be communicated promptly to the Office of Graduate Medical Education who will maintain graduate medical trainees' current information in New Innovations.

Upon declaration of a disaster or interruption in patient care, which is communicated by the Dean of the School of Medicine and/or Chief Executive Officer of the University of Virginia Health System, the Designated Institutional Official (DIO) for Graduate Medical Education will inform all appropriate personnel of such events.

The Office of Graduate Medical Education, working under the direct supervision of the DIO, will assess what steps need to be taken to assist all graduate medical trainees of the University of Virginia Health System who are facing a potential disruption in their graduate medical education training. Working collaboratively with both local and national academic centers, every effort will be made to place all graduate medical trainees in a graduate medical

education program acceptable to all parties (the graduate medical trainee, the program director, the DIO, ACGME, and the certifying specialty Board).

Any necessary paperwork will be a collaborative effort between the Office of Graduate Medical Education and the graduate medical education training program. The appropriate agencies must be notified upon transfer (i.e., Virginia Board of Medicine, ACGME, certifying specialty Board).

Every effort will be made to restore each displaced graduate medical trainee to his/her position in his/her University of Virginia graduate medical training program. In the event that time away involved PGY advancement, the University of Virginia Health System will honor the advancement upon verification from the program director of the temporary ACGME-accredited program that the graduate medical trainee had successfully advanced. Such documentation must be kept in the personnel file maintained by the graduate medical education training program and a copy must be sent to the Office of Graduate Medical Education.

Reduction in Size/Closure of GME Training Programs (No. 18)

The University of Virginia Health System shall seek to provide its graduate medical trainees with fair and equitable treatment when those trainees are affected by institutional decision to close or reduce the number of graduate medical trainees in a GME program sponsored by the University of Virginia Health System.

PURPOSE

Circumstances and considerations that may lead to closure or reduction in the size of a training program include, but are not limited to:

1. Failure of the training program to correct concerns and/or comply with recommendations of the GME Committee based on the Internal Review of the program;
2. Failure of the training program to correct citations of the program's Residency Review Committee (RRC) of the Accreditation Council for Graduate Medical Education (ACGME);
3. Decreased financial or educational resources to support the training program;
4. Reallocation of positions among the postgraduate programs;
5. The Program Director of a program that has not had graduate medical trainees enrolled within four years shall initiate procedures to close the program.

PROCEDURE

The following procedure will be followed in the event that the health system and/or a training program director decide to reduce the number of positions in or close a training program:

1. Graduate medical trainees, the GMEC, and the DIO will be notified by UVA Health System as soon as possible when it intends to reduce the size or close one or more programs, or when UVA Health System intends to close.
2. Every attempt will be made to reduce the number of positions over a period of time and/or by reducing entry level positions through decreased recruitment and

enrollment so that currently enrolled graduate medical trainees can complete their training.

3. If completing the program is not possible, the program director and the Graduate Medical Education Office will assist displaced graduate medical trainee(s) in securing an appointment to another training program in which they can continue their education/training.
4. If necessary, the Medical Center will continue salary and benefits until the end of the current appointment term or until the graduate medical trainee begins in a new program, whichever comes first.
5. The institution will protect remaining graduate medical trainees from inappropriate duty hours and service obligations resulting from closures/reductions.

INSTITUTIONAL and/or AFFILIATES

Should the University of Virginia Medical Center or any affiliated institution close or reduce their funding of graduate medical trainee slots during a residency training program, the University of Virginia Medical center shall attempt to locate funds for completion of the academic year and shall strive to replace those training slots within other programs at the Medical Center or at other affiliated institutions.

Clinical Duties of Graduate Medical Trainees During Extreme Emergent Situations (No. 19)

The University of Virginia Health System takes responsibility for clinical duties of trainees during extreme emergent situations and has developed this policy 1) to define an extreme emergent situation, 2) to assign and recognize resident duties and responsibilities during extreme emergent situations, and 3) to report such an event and its impact on resident education and training by the DIO to the ACGME..

DEFINITION:

An extreme emergent situation is defined as an event localized to a single sponsoring institution, a participating institution, or other clinical setting (e.g., a hospital-declared epidemic) that affects resident education or the work environment. This situation does not rise to the level of a disaster as declared by the University of Virginia Health System or an ACGME-declared disaster, considered to be extraordinary disasters which impact an entire community or region for an extended period of time (in accordance with ACGME Policies and Procedures, II.H.2.).

The Graduate Medical Education Office, Designated Institutional Official (DIO), and Program Directors will collectively determine if a current localized event is to be designated as an extreme emergent situation.

PROCEDURE

Resident Responsibilities

The University of Virginia Institutional disaster plan addresses clinical duties of trainees

during extreme emergent situations.

Designated Institutional Officials (DIOs) will attempt to ensure that all ACGME Institutional, Common, and specialty-specific Program Requirements apply in extreme emergent situations for clinical assignments within a training program and the institution.

Trainees are, first and foremost, physicians, whether they are acting under normal circumstances or in extreme emergent situations. Trainees must be expected to perform according to society's expectations of physicians as professionals and leaders in health care delivery, taking into account their degree of competence, their specialty training, and the context of the specific situation. Many trainees at an advanced level of training may even be fully licensed in their state, and, therefore, they may be able to provide patient care independent of supervision.

Trainees are students. Trainees should not be first-line responders without appropriate supervision given the clinical situation at hand and their level of training and competence. If a resident is working under a training license from a state licensing board, they must work under supervision. Resident performance in extreme emergent situations should not exceed expectations for their scope of competence as judged by program directors and other supervisors. Trainees should not be expected to perform beyond the limits of their own abilities. In addition, a resident must not be expected to perform in any situations outside of the scope of their individual license.

Decisions regarding a resident's involvement in local extreme emergent situations must take into account the following aspects of his/her multiple roles as a student, a physician, and an institutional employee:

1. the nature of the health care and clinical work that a resident will be expected to deliver;
2. resident's level of post-graduate education specifically regarding specialty preparedness;
3. resident safety, considering their level of post-graduate training, associated professional judgment capacity, and the nature of the disaster at hand;
4. board certification eligibility during or after a prolonged extreme emergent situation;
5. reasonable expectations for duration of engagement in the extreme emergent situation; and,
6. self-limitations according to the resident's maturity to act under significant stress or even duress

DIO Responsibilities

The DIO will work with the Medical Center Hospital Command Center to determine the nature and extent of the event. Once an event has been determined to be extremely emergent and likely to cause extended disruption to resident assignments, educational infrastructure, or clinical operations; and therefore, having the potential to cause non-compliance with ACGME or RRC standards, the DIO will report the event to the Executive Director for the Institutional Review Committee (ED-IRC).

Program directors will be expected to follow the GMEC Institutional Policy on

Administrative Support in the Event of a Disaster or Interruption in Patient Care for communication processes.

Upon resolution of the extreme emergent situation, the DIO will notify the ED-IRC.

Post-Graduate Clinical Externships (No. 20)

Externships in Graduate Medical Education may be offered by any member of the School of Medicine Faculty with the approval of that Department to a physician graduate of a US or foreign medical school who is not in a residency program. An externship may be offered under either of these circumstances:

1. to provide the faculty with an opportunity to more fully evaluate the physician for his or her potential as a candidate for residency; the offering department is responsible for providing the appropriate supervision;
2. to permit a graduate physician to obtain limited training in the area of expertise of the faculty that is not available at his/her home institution, nor available through a standard residency or fellowship program.

Definition

This graduate externship would be different from an observership as the applicants will be allowed to perform some aspects of patient care under the direct supervision of faculty, fellows, and resident staff. The externship is for the benefit of the faculty at the University of Virginia. Potential applicants shall be informed that **no certificate of completion of the externship will be awarded, nor will any documentation of completed clinical activities be given to externs who visit the University of Virginia. The externship will not count in any way towards board eligibility in a specialty.** Moreover, there will be no degree awarded from the University of Virginia for the temporary externship. **Completing or granting an externship does not guarantee an interview and in no way implies a commitment.**

Requirements for Externships

1. All temporary externships must be approved in advance by the Graduate Medical Education Committee (GMEC). Externships will be limited in time from 1 – 3 months unless an extension of this time period has been pre-approved by the GMEC.
2. The applicant's externship must not interfere with the education of UVa residents, fellows, or medical students.
3. The rationale for the externship with goals and objectives for each defined rotation must be clearly stated. This rationale must be presented to the GMEC at the time pre-approval is sought.
4. All applicants for Clinical externships must have a sponsor from the active Clinical Staff of the Medical Center.
5. A performance evaluation of the applicant by faculty will be required after each rotation.
6. No payment, including in the form of salary or benefits will be made to the applicant for the externship. All expenses, including but not limited to those incurred for transportation, housing, parking, and white coats are the responsibility of the applicant. Once approved by the GMEC, the applicant will have malpractice insurance through UVA paid for by Graduate Medical Education Office.

7. The extern applicant may perform or participate in only the following during the rotation:
 - History and Physical Examination under direct supervision of an attending physician and/or faculty, or graduate medical trainee staff
 - Assist Faculty and graduate medical trainees in inpatient and outpatient care including assisting in surgery and the emergency room. The applicant must be under the direct supervision of the faculty (See GME Policy 12- Resident Supervision, in 2-b) Levels of Supervision) and the graduate medical trainee.
 - Departmental and Divisional educational conferences
8. All applicants approved for a Clinical Externship at the University of Virginia Medical Center must obtain a Commonwealth of Virginia Temporary Medical License, at the expense of the applicant, the sponsoring faculty member, or the faculty member's department.

PROCEDURE

Review of Applications for Externship: Before an applicant can be considered for an externship the following information must be submitted by the applicant:

1. Education: Transcript and diploma from applicant's medical university;
2. Updated C.V.;
3. If applicable, certificate from the Educational Commission of Foreign Medical Graduates (ECFMG);
4. Documentation showing USMLE Step 1 and Step 2 (CK and CS) have been taken and passed; and
5. Letter of support from the hosting program director of the externship and two letters of support from the reference.

This information will be evaluated by the program director in the department of the externship, and the Chair of the Department must approve. If the program director and Chairman of the department wish to invite the applicant for an externship then the applicant's information and a cover letter to make the request will be sent to the GMEDC for approval.

Emergency/Back-up Call for Off Service Trainees (No. 22)

Definition:

Primary Program – Residency Program in which Graduate Medical Trainee is based.

Hosting Program – Residency Program in which Graduate Medical Trainee from another UVA program rotates.

Off Service Rotator/Trainee – Graduate Medical Trainee within the UVA system rotating to another clinical service other than their primary/home program.

PROCEDURE:

Graduate medical trainee training may occur in programs other than the graduate medical trainees' primary program. Contingency plans when graduate medical trainees are absent for

illness, family emergency, or other personal or professional issues will be dealt with in the following manner:

1. For absences up to three days coverage falls to the host program.
2. For absences greater than three days coverage is agreed upon by the two programs.
3. Graduate medical trainees with planned extended leave (e.g., maternity/paternity leave) will not be scheduled for rotations outside their primary program at the time of their anticipated leave.

New Innovations (No. 23)

The University of Virginia Medical Center and the Graduate Medical Education Committee provides all Accredited Graduate Medical Training Programs with the New Innovations Residency Management Suite as the required tool to accurately record and monitor duty hours and complete evaluations. In addition, New Innovations is the primary source of financial accountability in Medicare Cost Reporting for the Institution through its maintenance of block schedules.

All ACGME and Non-ACGME Programs must use New Innovations for, at least, evaluations, maintenance of block schedules and duty hours in accordance with the GMEC Institutional Policy on Duty Hours. To enter block schedules, each program must demonstrate competence in completing and maintaining current block schedules. The GME Office is available to assist in maintaining block schedules.

Programs are encouraged to use all additional available modules as a means of enhancing program management.

Learner Mistreatment (No. 25)

The University of Virginia Medical Center is committed to maintaining an optimal clinical learning environment to achieve safe and high quality patient care and requires the highest standards of behavior from all those who are involved in clinical learning environment, including faculty members, Trainees, staff, and all other health care Practitioners.

The University Medical Center maintains its commitment to preventing learner mistreatment by providing a procedure for reporting instances of learner mistreatment, by providing support for learners subjected to mistreatment, and by responding with corrective action.

This policy is intended to ensure an optimal clinical learning environment in which all learners may raise and resolve issues without fear of intimidation or retaliation.

This policy should be considered as supplemental to [Medical Center policy #0262, Standards for Professional Behavior](#).

STANDARDS

Trainee mistreatment will not be tolerated in the clinical learning environment. Examples of inappropriate behavior or situations that would be unacceptable include the following, but are not limited to:

1. Threatening or abusive language, profanity or language that is perceived by others to be demeaning, berating, rude, loud or offensive, and/or
2. Actual or threatened inappropriate physical contact that is unrelated to the provision of healthcare (Assault), and/or

3. Other forms of behavior that are perceived as intimidation or harassment by learners or others working within the Medical Center, and/or
4. Derogatory comments and jokes pertaining to race, age, color, disability, national or ethnic origin, political affiliation, religion, sex (including pregnancy), sexual orientation, or veteran status. stereotypic or ethnic connotation, and/or
5. Inappropriate or unprofessional criticism intended to belittle, embarrass, or humiliate a Trainee or others, and/or
6. Requiring a trainee to perform menial tasks intended to humiliate, control, or intimidate the Trainee, and/or
7. Unreasonable requests for a trainee to perform personal services, and/or
8. Grading or assigning tasks used to punish a Trainee rather than to evaluate or improve performance, and/or
9. Purposeful neglect or exclusion from learning opportunities as means of punishment, and/or
10. Sexual misconduct (refer to University Policy #HRM-040), and/or
11. Discrimination, harassment, and/or retaliation (refer also to University Policy #HRM-009), and/or
12. Disregard for Trainee safety.

While constructive criticism is appropriate in certain circumstances in the clinical learning environment, it should be handled in such a way as to promote learning, avoiding purposeful humiliation. Feedback that has negative elements is generally more useful when delivered in a private setting that fosters discussion and behavior modification. All feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

COMMUNICATION OF COMPLAINTS BY TRAINEES

Communication of the Complaint: When reports of learner mistreatment and a negative learning environment involving Trainee(s) or witnessed by Trainee(s), multiple avenues must be provided for both direct and anonymous reporting given the sensitive nature of complaints and the perceived power differential in lodging complaints. Reports of mistreatment or unacceptable behavior are handled confidentially to the extent possible given the obligation to investigate the report.

In addition to the process outlined in the Medical Center policy #0262, the following include avenues of reporting instances of learner mistreatment or a negative learning environment:

- Trainee meets with Chief Resident or Housestaff Council President
- Trainee meets with Program Director
- Trainee meets with other member of faculty
- Trainee meets with Chairman
- Trainee meets with DIO or member of GMEC
- Trainee uses confidential GME hotline (434-806-9521)
- Trainee makes comment during Annual Program Evaluation
- Trainee makes comment during anonymous faculty evaluation

Information about complaints of learner mistreatment or a negative learning environment will be shared only with individuals essential to achieve resolution. Trainees must feel free to bring complaints without fear of retaliation, and those receiving complaints must not retaliate. Medical students experiencing mistreatment by a trainee in a teaching role should

refer to School of Medicine Policy 4.2000. Trainees experiencing mistreatment by a member of the Medical Center staff or a member of the Clinical Staff shall refer to Medical Center Policy 0262.

RESOLUTION PROCEDURES FOR TRAINEES

Resolution procedures will follow Medical Center Policy 0262, Standards for Professional Behavior.

Fitness for Duty (No. 26)

The University of Virginia Medical Center strives to build a healthy, safe, and supportive environment for all members of its community. To promote this goal, each trainee is required to report to work physically and mentally capable of safely performing the functions of his/her job, and in an alcohol and drug free condition.

This policy outlines the responsibilities for action when a trainee's Fitness for Duty is in question, the steps to be taken to assess such fitness, the necessary follow-up, and the steps to be taken before a trainee can return to duty. The conditions by which a trainee may be deemed unfit for duty include physical, mental, and alcohol or chemical impairment. This policy outlines the responsibilities for action under each of these conditions.

This policy applies to all GME trainees of the Medical Center in any capacity including observers, visitors, and externs.

All graduate medical trainees also fall under Medical Center policy, and the relevant Medical Center policies will be cross-referenced with the current policy.

DEFINITIONS:

Fit for Duty; Fitness for Duty – The trainee is physically and mentally capable of safely performing the functions of his/her job. Fitness for Duty includes being free of alcohol and drugs that have not been legitimately prescribed and being free from impairment that affects job functioning due to a) use of prescription or nonprescription drugs, and/or b) medical or emotional problems while enrolled in a UVA graduate medical training program.

Coordinating Party – The appropriate party/office (based on the specific situation) responsible for coordinating and facilitating the Fitness for Duty evaluation. For GME trainees, this includes, but is not limited to, the Program Director, Chairman of the Department, Designated Institutional Officer (DIO), or Graduate Medical Education Office; the representative from the Faculty and Employee Assistance Program (FEAP) or Physician Wellness Program (PWP).

PROCEDURE

Physical Impairment (See also Medical Center Policy No. 0091 “Infection Prevention and Control”)

1. If a trainee is found to have an infectious/communicable disease, he/she will be evaluated for infectious processes and/or referred to his/her medical

provider for further evaluation. If indicated, the trainee will be placed off duty until cleared to return to work by Employee Health.

2. If a trainee suffers a physical impairment including, but not limited to, injury, illness, or fatigue that precludes effective patient care or the ability to perform his/her job, the trainee will be placed on medical (“sick”) leave until able to return to work as determined by his/her medical provider. For details on sick leave, see Graduate Medical Education Policy No. 3, Absence from Graduate Medical Training, “Sick Leave.”

Mental Impairment and/or Impairment related to use of alcohol or drugs (See also Medical Center Policy No. 702 “Fitness for Duty”)

1. No trainee may unlawfully manufacture, distribute, dispense, use, possess, sell, or be under the influence of alcohol, illegal drugs or any medications that impair performance while on Medical Center premises and while conducting business- related activities off Medical Center premises.
2. The following applies when addressing concerns with trainees whose performance and/or behavior brings into question their fitness for duty, necessary follow up, and return to duty.
 - Trainees must comply with all aspects of the Fitness for Duty evaluation (which may include drug and alcohol testing) or be subject to disciplinary action, up to and including termination. Trainees must also comply with all treatment recommendations resulting from a Fitness for Duty evaluation in order to be cleared to return to work.
 - The trainee’s work performance is the basis for continued employment. When a program suspects impairment, whether due to emotional difficulty and/or drug/alcohol impairment, as the underlying cause for a trainee’s poor performance, referral must be made immediately to the Faculty and Employee Assistance Program (FEAP) and the Physician Wellness Program (PWP). Participation in a treatment or rehabilitation program does not guarantee continued employment and will not necessarily prevent disciplinary action for violation of the GME and Medical Center policies.
 - Trainees taking prescription medications or over-the-counter medications that impair their ability to work safely are subject to the conditions of this policy.
 - Trainees who have the responsibility for on-call shifts must meet the Fitness for Duty standard during the entire on-call period.
3. When there is concern that the trainee is not Fit for Duty, the trainee’s supervisor, Program Director, Chairman, or the administrative representative on duty must document the encounter (the Initial Observation Report Form is a suggested means of documentation; see form at the end of this policy) and follow the recommended steps outlined below:
 - Note observations; check all behavioral examples that apply and either complete the Initial Observation Form in its entirety or document the encounter.

- Obtain a witness for a private interaction with the trainee, if possible.
 - Consult with a representative of FEAP at 924-0000. Discuss any concerns about safety and ensure a plan is in place to provide support for the trainee.
 - Meet with the trainee and perform the following actions:
 - ❖ Remove the trainee from direct job duties and inform the trainee that he/she is relieved from duty at this time.
 - ❖ In private, state your concerns for the safety and well-being of the trainee.
 - ❖ Ask the trainee to explain any signs of possible impairment and document his/her response.
 - Arrange for removal of the trainee from the worksite. Trainees who are required to go to FEAP or Employee Health as directed by FEAP must be escorted by the trainee's supervisor, Program Director, or representative to the destination, and must remain for disposition. The trainee must be informed that failure to comply with this directive shall result in suspension and disciplinary action.
 - Identify means for transporting the trainee safely home. Should the trainee become uncooperative, contact Security or University Police as appropriate.
4. The results of Fitness for Duty evaluations performed by qualified, licensed health care professionals shall be presumed to be valid. Results of the evaluation will be received by FEAP and PWP. The trainee shall be notified of the results of the evaluation by the evaluator and/or FEAP/PWP. Only necessary information shall be shared with the Coordinating Party. After an evaluation, information given to the Program Director, Chairman, GME Office, shall be limited to whether the trainee may:
- return to full duty;
 - not return to full duty, pending required follow-up action; or
 - return to modified duty that meets the evaluator's recommendations.
5. Continued employment will be contingent upon compliance with conditions established by FEAP and or PWP such as periodic testing, participation in professional counseling and treatment programs, re-assignment of duties for a specific period of time and/or continued performance of specified functions under more immediate supervision. Failure to comply may result in disciplinary action up to and including termination from employment. FEAP and or PWP will coordinate with the Program Director and GME Office regarding return to work status.
6. Acts or Threats of Violence and the Threat Assessment Team:
The University has established a Threat Assessment Team ("TAT") with responsibility for implementing the University's assessment, intervention and action protocol in cases suggesting a potential risk of violence. All acts of violence, threats of violence or other seriously disruptive behaviors must be reported immediately to University Police and/or to the TAT.

7. Confidentiality/Privacy of Fitness for Duty Evaluations:
Under the Health Insurance Portability and Accountability Act (HIPAA), any document containing medical information about a trainee is considered a medical record and is regarded as confidential. Records of fitness for duty evaluations shall be treated as confidential medical records and maintained by FEAP, PWP or Employee Health, as appropriate. This information may be shared only when necessary to support treatment, business operations, and upon the execution of appropriate release by the individual trainee or as otherwise permitted or required by law. Trainees may obtain a copy of the medical report upon written request to FEAP or Employee Health.
8. Suspension of Clinical Duties:
The trainee's assignment of clinical duties may be suspended for suspicion of any impairment as outlined in this policy or for the following: refusal to undergo an evaluation, failure or refusal to stop practice after a recommendation has been made for treatment, refusal to comply with treatment recommendations, or non-compliance with required monitoring.

Responsibilities:

1. A trainee is responsible for:
 - Coming to work Fit for Duty and performing job responsibilities in a safe, secure, productive, and effective manner during the entire time at work;
 - Notifying the Program Director or attending physician when not Fit for Duty;
 - Notifying the Program Director or attending physician when a co-worker is observed acting in a manner that indicates the co-worker may not be Fit for Duty;
 - Informing the Chairman or Designated Institutional Officer for further guidance, if the supervisor's behavior is the focus of concern. Threats or acts of violence should be reported immediately to the University Police Department by calling 911;
2. A supervisor, Program Director, or attending physician is responsible for:
 - Monitoring the attendance, performance, and behavior of the trainees under his/her supervision;
 - Notifying FEAP and the Graduate Medical Education Office (or DIO) when a trainee is exhibiting behavior that suggests he/she may not be Fit for Duty;
 - Following this policy's procedures for documentation or completing an Initial Observation Report form when presented with circumstances or knowledge that indicate that a trainee may be unfit for duty;
 - In consultation with FEAP, arranging for the trainee to be removed or escorted from the worksite if the trainee is deemed unfit for duty (unless he/she poses an immediate safety threat in which case the supervisor should call 911) and calling the trainee's emergency contact or a taxi service to transport the trainee home. The supervisor or other staff members should not personally drive the trainee home.

- Maintaining the confidentiality of a trainee’s medical record. (See Section 2.g above)

Extramural Activities (No. 27)

The University of Virginia Graduate Medical Education program takes responsibility for clinical duties of graduate medical trainees (“trainees”) performing medical activities and patient care within their training programs.

Activities arise where trainees perform voluntary, uncompensated patient-related activities outside the physical boundaries of the Medical Center, its Clinics, and affiliated institutions. Voluntary, compensated patient care activities fall under the guidelines of the Moonlighting Policy. The Graduate Medical Education Committee oversees the enforcement of this policy to provide some guidance and oversight to these activities.

DEFINITION:

Residents may sometimes wish or be asked to deliver patient care in the community both with and without direct supervision. Specifically, voluntary, uncompensated activities that involve patient care may include, but are not limited to, healthcare screenings that occur outside the Medical Center, school well visits or physical examinations, health screenings and/or treatment of sports injuries at athletic events, and others when such activities are NOT part of a Trainee’s training program, school well visits or physical examination. This policy outlines the requirements of trainees to participate in these extramural activities.

PROCEDURES:

Graduate medical trainees hold temporary licenses to practice medicine and surgery within their GME training programs and do not have legal authority to practice outside their training programs. The training license and the malpractice coverage provided to trainees by the Board of Medicine and the Commonwealth of Virginia do not extend to extramural activities as defined above.

In order to participate in voluntary, uncompensated patient-related activities outside the physical boundaries of the Medical Center, its Clinics, and affiliated institutions, a Trainee must either:

1. Establish his/her own legal authority by holding a permanent, independent medical license in the Commonwealth of Virginia or other state and securing his/her own medical malpractice coverage,

OR

2. The activity must fall within the educational program of the individual Department where the following procedures are mandated:
 - The Department must include the activity in its curriculum for training graduate medical trainees
 - Goals and Objectives for the activity must be stated and given to the trainee.
 - The trainee must be under the supervision of an identified LIP who agrees to supervise in accordance with the individual Department’s Supervision policy

- The trainee’s performance must be evaluated within the activity
- The trainee must be given feedback on his/her performance

Visitors, Observers & Externs (No. 28)

POLICY STATEMENT:

This policy sets forth a standardized process for the onboarding and management of non-UVA GME Trainees who seek the use of Medical Center resources for observation and participating in the delivery of patient care.

For information on the management of non-GME Trainee observers, please refer to Medical Center Policy 0315.

For information on the management of Student Preceptorships, refer to Medical Center Policy 0316.

For information on visiting attending physicians, contact Clinical Staff Office at 434-243-5896.

DEFINITIONS:

1. “Observer” shall refer to any non-UVA trainee currently enrolled in a GME training program elsewhere who seeks the use of the Medical Center facilities, programs, and services for observing patient care. Observers are not allowed to participate in the delivery of patient care.
2. “Visitor” shall refer to any non-UVA trainee currently enrolled in a GME training program elsewhere who seeks the use of the Medical Center facilities, programs, and services while directly participating in the training and delivery of patient care.
3. “Extern” shall refer to any eligible physician as defined by GME Policy 20.
4. “Sponsor” shall refer to the Medical Center faculty member responsible for the direct supervision of any GME Observer, Visitor, or Extern.

POLICY:

Non-UVA GME Trainees shall comply at all times with Medical Center, University and GME policies and procedures, including, but not limited to those related to patient privacy and confidentiality.

1. Sponsors shall appropriately supervise at all times Observers, Visitors, or Externs during observation, patient care, and other services or programs as part of their experience.
2. Visiting experiences shall only be provided to individuals covered under an approved contract or agreement.
3. The GME Office shall be responsible for approval and credentialing of the Observer’s, Visitor’s, or Extern’s experience. The GME Office or Sponsoring Program reserves the right to deny an applicant such experience on the basis of incomplete documentation, noncompliance with these requirements, unprofessional

behavior, or any other matter the GME Office regards as inconsistent with the mission of the Medical Center and graduate medical training.

4. The following criteria shall be considered prior to accepting/scheduling any Observers, Visitors, or Externs:
 - Adequate supervision at all times
 - Ability to maintain patient privacy and confidentiality
 - Ability to provide training experience in a safe environment
 - Sensitivity to any teacher/learner ratio requirement

POLICY REGARDING VISITING GME TRAINEES:

Definition

- Rotations for Observers will not exceed 30 consecutive days.
- Rotations for Visitors will not exceed 30 consecutive days unless an extension of this time period has been approved by the GME Education subcommittee and full GMEC.
- Rotations for Externs will comply with GMEC Policy No.20.

Contracts and Agreements

- GME Observers must complete the Observer Agreement (addendum).
- For GME Visitors, a Letter of Agreement must be completed between the Sponsoring program and the Visitor's home program prior to the beginning of the rotation. This agreement is available through the GME Office and must be signed by UVA's Designated Institutional Official (DIO).
- GME Externs must comply with requirements in GMEC Policy No. 20.

Credentialing and Orientation

- The GME Office, in conjunction with the Sponsoring Department, will manage all credentialing and orientation requirements for GME Observers, Visitors, and Externs. Involvement in the educational experience may not commence prior to completing all requirements.
- Standard Precautions/Infection Control: Observers, Visitors, or Externs must complete University of Virginia Standard Precaution/Infection Control Guidelines and any required Computer Base Learning Module prior to working or observing in clinical areas.
- Compliance and Electronic Medical Record Training: Visitors and Externs must complete Medical Center Compliance CBLs and any required EMR Training prior to commencing the educational experience.
- Additional orientation to department or area specific policies may be required as determined by the Sponsoring department/area specific manager involved in the Visiting Trainee's rotation.

Infectious Disease Requirements

- To ensure a safe training environment, all Observers, Visitors, and Externs shall be required to meet specific infectious disease requirements based on the nature of their educational experiences. The University of Virginia Student Health and Hospital

Epidemiology, in collaboration with the School Of Medicine, shall be responsible for establishing infectious disease requirements for Observers, Visitors, and Externs. Medical Center Employee Health and Hospital Epidemiology, in collaboration with Medical Center Contracts Management, shall provide guidelines for infectious disease requirements for all Visitors. The specifics of these requirements are outlined in Medical Center Policies 315 and 316.

- Additional questions regarding infectious disease requirements may be directed to Medical Center Employee Health, University of Virginia Student Health, or Hospital Epidemiology.

Respiratory Fit Testing:

Visiting Trainees, Observers and Externs will be assigned the PAPR Computer Based Learning Module that addresses airborne precaution requirements.

Criminal Background History

Visiting Trainees and Externs must provide disclosure of criminal background history from their current institution certifying no criminal history. Human Resources will determine the need for a background check prior to beginning the rotation.

Identification Badge

On the first day of the experience, the Sponsoring Department must take Visitors, Observers and Externs to ID Badge Services (434-982- 4009) and acquire an identification badge. Visitors are subject to Medical Center Policy, No. 0004, “Medical Center Identification”. The badge must be worn at all times while on Medical Center premises.

Parking

Non-UVA GME Trainees who wish to request parking at a Medical Center site are responsible for contacting University Parking and Transportation prior to their first day. A temporary parking pass is available for purchase. Additional questions regarding parking information may be directed to Parking and Transportation Services (434-924-7231).

Use of Recording Devices (No. 29)

A GME trainee may not record by any electronic medium conversations or interactions with faculty, other trainees, or staff without prior disclosure of the intent to do so, and with the express permission of those persons being recorded.

Video – or audiotaping of patients may only be done in compliance with Medical Center Policy 0030, ‘The Use of Cameras and other Electronic Devices and Media’.

Industry Funding (No. 30)

This policy is designed to complement University of Virginia Medical Center policies 0008, Gifts and Gratuities, and 0013, Interactions with Vendors, Sales, and Service Representatives. This policy applies to both Graduate Medical Education Trainees and Members of the Clinical Staff, within or for the benefit of the Medical Center, regardless of employer. Employees of the Medical Center and the University are subject to the State and

Local Governmental Conflict of Interests Act and the Ethics in Public Contracting Section of the Virginia Public Procurement Act of the Code of Virginia. This policy incorporates the requirements of these Acts, and in some instances imposes more stringent requirements. To the extent that this policy exceeds the requirements of state law or other codes of conduct, this policy shall control.

The GME Committee acknowledges that financial support from industry vendors or representatives provided to GME trainees or their supervising faculty members can influence patient care decisions. Therefore, the following standards must be applied.

STANDARDS:

Graduate Medical Education Trainees shall not directly accept from any industry vendor, sales or service representatives any of the following:

- food or beverage, of any kind and regardless of value, from any representative on the grounds of the Medical Center or on University grounds, even if it is provided in the context of an educational activity;
- funds to support travel to and registration for an educational activity, either held on grounds or away from grounds; or
- educational material in the form of textbooks, electronic devices and their applications, or materials or devices for simulated training of medical care.

THE GMEC Committee would prefer that industry representatives and vendors provide funding for such materials or activities in the form of an unrestricted gift to the Development Office of the University of Virginia Health Foundation.

Industry representatives or vendors may provide support to the Department Chair of the GME Trainee's program for the stipend and benefits of a GME Trainee and/or travel or registration for a GME trainee to attend an educational conference under the following conditions:

- The funding cannot be linked to the training of an individual trainee, nor should any trainee have knowledge that funding is being accepted on behalf of the trainee for his or her education and training
- Applications for the funding by industry of educational activities must be reviewed and approved in advance by the GMEC Subcommittee on Stipend and Benefits
- Applications for the funding by industry for the stipend and benefits of a GME Trainee must be approved in advance by the Graduate Medical Education Committee, in addition to following any and all necessary requirements of the School of Medicine Office on Grants and Contracts. If approved and subsequently funded, a PTAO must be provided to the GME Office so that such funds can be tracked.
- Any application for funding by industry for either stipend and benefits or educational activities for a GME Trainee(s) must name the Department Chair as the recipient; the Chair must acknowledge that he or she may be publicly reported for accepting such funds under the Sunshine Act

- All programs should participate in educational activities pertaining to conflict of interest and relationships with industry.

Industry support for the purpose of education may also be given to the Chair and must comply with all of the following provisions.

- The Department, Division, or program selects the trainee.
- The Department, Division, or program has determined that the funded conference or program has educational merit.
- The recipient is not subject to any implicit or explicit expectation of providing something in return for the support, i.e., a “quid pro quo.”
- Applications for the funding by industry of educational activities must be reviewed and approved in advance by the GMEC Subcommittee on Stipend and Benefits.

Faculty and Employee Assistance

The Faculty and Employee Assistance Program has been providing comprehensive, onsite Employee Assistance services to employee and their families since 1991. The mission is to assist organizations to maximize employee productivity and to help employees identify and resolve personal concerns that may affect job performance. This is offered as an individualized, confidential assessment based on clinically-sound standards, brief counseling, and appropriate community referrals when necessary. For general information or to schedule an appointment, please call (434) 243.2643 or visit the website at <http://www.healthsystem.virginia.edu/pub/feap/general-information/request.html>.