Dartmouth Hitchcock Medical Center

Urology Residency Program Policy and Procedure Manual 2022-2023

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- **Purpose** - Urology at DHMC is committed to the provision of a high-quality resident training environment, balancing time for educational experiences with patient care responsibilities. We supervise and promote resident physicians' health and well-being while they learn to deliver safe, effective patient care. We support limits on resident work hours, while assuming responsibility for addressing the impact of compliance with the ACGME Duty Hours requirements on our delivery of care and our resident physicians' educational experience.
- **Definition**- Providing residents with a sound academic and clinical education must be carefully planned and balanced with concerns for patient safety and resident well-being. The learning objectives of our urology program will not be compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education has priority in the allotment of our residents' time and energies. Duty hour assignments shall recognize that faculty and residents have collective responsibility for the safety and welfare of patients. Residents will adhere to the resident duty hour rules as defined by the ACGME and the DHMC GME policy.

GME Policy Statement

A. **Clinical Experience and Education Work Hours:**

All residency and fellowship programs will adhere to the following work hour requirements mandated by the ACGME, specialty-specific Review Committee (RC), and D-H as defined below.

1. **Clinical and Educational Work Activities:**

Residents must report the following work activities:

- **Patient care:**
  - Inpatient and outpatient care occurring at the hospital or while at home
  - Administrative duties related to patient care occurring at the hospital or while at home
  - Electronic Medical Record (EMR) note writing, preparation of discharge summaries, phone calls related to patient care, while at home or at the hospital
  - The provision for transfer of patient care / sign-outs
  - Time spent in-house during call activities

- **Education/Academic:**
  - Scheduled academic activities such as conferences or unique educational events
  - Research

- Time spent at regional/national conferences/meetings when attendance at the meeting is required by the program, or when the Resident is acting as a representative of the program (i.e. presenting a paper or poster). Only actual CME-designated meeting time counts towards work hours.
- Hours spent on activities that are required by the accreditation standards, such as membership on a hospital committee, or that are accepted practice in residency programs, such as Residents' participation in interviewing residency candidates.

- **The following activities are excluded from work hour reporting:**
  - Academic preparation time, such as time spent preparing for presentations or journal club, board review, or other reading and study time.
  - Travel and non-conference time when at a regional/national conference/meeting.

2. **Maximum Hours of Clinical and Educational Work per Week:**
   - Clinical and educational work must be limited to no more than 80 hours per week, averaged over 28 days or the length of the rotation block, whichever is shorter.
   - When vacation is taken during a block, the remainder of the block must be compliant with all clinical and educational work hour rules.

3. **Mandatory Time Free of Clinical Work and Education:**
   - The program must design an effective program structure that is configured to provide Residents with educational opportunities as well as reasonable opportunities for rest and personal well-being.
   - Resident should have eight hours off between scheduled clinical work and education periods.
     - Residents may choose to stay to care for patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements.
   - Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call.
   - Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks).
     - At-home call cannot be assigned on these free days.
     - It is not permissible to have the day off regularly or frequently scheduled on a Resident's post-call day but in smaller programs it may occasionally be necessary to have the day off fall on the post-call day.

4. **Maximum Clinical Work and Education Period Length:**
   - Clinical and educational work periods for Residents must not exceed 24 hours of continuous scheduled clinical assignments.
   - Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or Resident education.

- Additional patient care responsibilities must not be assigned to a Resident during this time.

5. **Clinical and Educational Work Hour Exceptions:**
   - In rare circumstances, after handing off other responsibilities, a Resident, on the Resident's initiative, may elect to remain or return to the clinical site in the following circumstances:
     - To continue to provide care to a single severely ill or unstable patient
     - To provide humanistic attention to the needs of a patient or family, or;
     - To attend unique educational events.
   - These additional hours of care or education will be counted toward the 80-hour weekly limit.

6. **Moonlighting:** Please see the GME Moonlighting Policy

1. Dartmouth-Hitchcock Medical Center neither encourages nor discourages moonlighting. House staff are not required to moonlight.
2. The resident must have a permanent license to practice medicine in each state where he/she moonlights. A permanent license is different from a training license. It is the sole responsibility of the resident to apply for and obtain a permanent license.
3. The resident must complete a moonlighting request form within the MedHub system and have both Program Director and Graduate Medical Education approval prior to starting.
4. The resident's Program Director will monitor and ensure moonlighting or *locum tenens* work does not interfere with the ability of the resident to meet the goals, objectives, assigned duties and responsibilities of the program and ensure resident reporting of and compliance with duty hour requirements. All moonlighting work hours done within DHMC must be reported by the resident as regular duty hours. These duty hours will be calculated and become part of the residents' total hours worked and are subject to all ACGME duty hour regulations.
5. The resident's Program Director must sign off on the moonlighting request form identifying moonlighting assignments and may restrict moonlighting based upon training program considerations. The Program Director may withdraw permission to moonlight if it is seen as producing adverse effects on the resident's training experience.
6. Residents pursuing *locum tenens* or who moonlight outside of DHMC are not covered by DHMC liability or malpractice insurance.

DHMC Urology Moonlighting Policy

- a. Because residency education is a full-time endeavor, moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

- b. In Urology the program director will not allow any RESIDENT to moonlight unless the resident has achieved a score of >50th percentile ON THE AUA IN-SERVICE EXAM. If a resident has been moonlighting but then scores less than the 50th percentile the resident will be asked to stop moonlighting within 2 months of when the in-service scores are released in early January.

7. **In-House Night Float:** Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements.

8. **In-House Call:** Residents must not be scheduled for in-house call more frequently than every third night (when averaged over a four-week period).

9. **At-Home Call:** At-home call (pager call) is call taken from outside the assigned institution. While scheduled for at-home call a Resident may return to the hospital to provide direct patient care for new or established patients. Home call is only appropriate if the service intensity and frequency of being called in is low.
   - **Frequency:** The frequency of at-home call is not subject to the every third night limitation.
     - At-home call must not be so frequent as to preclude rest and reasonable personal time for each Resident.
     - Residents taking at-home call must be provided with one-day-in-seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
   - **Reporting of Hours:** Residents must report time spent on patient care activities while at home, including pages, phone calls and EMR documentation as well as time spent in the hospital providing direct care for new or established patients. These hours count toward the 80-hour work limit.

   For information on how to log "Complete Work Hours", please refer to the 'MedHub Quickstart Guide-Residents/Fellows' on the MedHub portal https://dh.medhub.com ➔Resources/Documents➔MedHub Training Documentation.

   - The Program Director and the faculty must monitor the demands of at-home call in the program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.

DHMC Urology Call Rules

a. Residents will leave the hospital after working 30 consecutive hours.

- please tell us if you have been up all night or are about to break one of these rules
- violations will be dealt with immediately
- if you are asked to go home – LEAVE

b. You must consider these rules when you change the call schedule.
c. It is your responsibility to see that you are in beeper range. Long range beepers are available. You should be able to get to the hospital within 30 minutes. An on call room is available if you are concerned about bad weather, etc.
d. Meal allowance will be provided based on the hours that you are at the DH. (see revised policy)
e. If you are at work and are too tired or if you are sick and you cannot work effectively or if you have worked too many hours and will break the duty hour rules you have an obligation to stop working. You should let the Chief resident know and the attending that you are assigned to work with know that you need to rest.

You may choose to go home (please consider taking a taxi or Uber) and return when rested or

You may use a call room for a nap

- **Education & Orientation**

a. The Institution sends a clear message to all DHMC faculty and residents regarding the critical importance of adhering to the Institutional and Program Requirements for resident duty hours. **Honesty in reporting is expected.**
b. At general GME orientation the institutional expectations of compliance with duty hour regulations as well as duty hours reporting compliance were reviewed as was didactic material about the effects of sleeplessness and fatigue on physical health, cognitive development, and mental well-being. The section and institutional expectations are reviewed yearly at Urology orientation by the Program Director at the start of every academic year. A written copy is provided to all residents and the policy is posted on the GME and Urology websites.

- **Reporting Procedures**

a. DHMC has a standard system for use by all residents to document duty hours. Currently this standard system is a part of the MedHub resident management system. To ensure accuracy and timeliness of the data:

- Each resident is responsible for direct entry of their own duty hour information into the MedHub System.
- Residents are expected to log their hours weekly. Repeated failure to log hours, greater than 3times in a 6 month time period, will be noted on the resident's end of year evaluation as a failure of expected professional behavior. This will also be reflected on the resident's Milestone report and possibly on their final credentialing paperwork.

- Residents are able to log Duty Hours for the current week and the week prior. Lockout occurs every Sunday at 12:01am.
- By design, there is no resident unlock for Duty Hours. Program Coordinators will have to log Duty Hours for residents who get locked out. Residents are expected to use the global set of duty hour labels available to all programs to ensure reported data is consistent across programs.

b. The program Coordinator and or Program Director may randomly check duty hour calendars for compliance. Residents' whose hours appear to be inaccurate or that are not up to date will be sent an email notice that they need to log their hours within 24 hours. A resident who fails to log their hours will not go to the OR until their duty hour report is up to date.

c. The standard definition of "reporting compliance" for the institution is that within seven days of a month's end, each resident completes 80% of that month's calendar.

d. The program Coordinator will have a seven day window, immediately following the seven days provided to residents, to internally audit and confirm duty hours as reported by our residents before the reports are finalized. No changes to the monthly duty hour report should be entered beyond the specified audit window.

e. The GME Office utilizes a standard reporting form across all programs to track data relating to both reporting compliance and duty hour violations. All required data is derived from the MedHub system and may be acquired by GME staff independent of the training program.

f. In order to increase transparency, as well as foster improved compliance, the standard GME-generated data set will be made widely available to all residents, faculty, and administrative members of the DHMC community on a quarterly basis.

- **Reporting Non-Compliance & Administrative Action**

a. A standard threshold for "administrative action" in response to reporting non-compliance exists across all DHMC programs with the following thresholds and administrative actions:
    - Three months of zero compliance in any given academic year will generate a Letter of Concern from the Director of GME to be placed in the resident's QA file citing a pattern of reporting non-compliance that reflects negatively on the resident physician's professionalism.
    - Continued reporting non-compliance following receipt of a Letter of Concern will trigger a review by the GME Duty Hours Subcommittee and may result in disciplinary action up to and including dismissal.

b. There are two systems for confidential reporting: GME Confidential is available for confidential reporting or guidance regarding duty hours, and a confidential telephone hotline is also available. Both systems forward all reports to the designated resident representative on the Duty Hours

Subcommittee. Residents should be educated about confidential reporting by both GME and their own programs.

- **Urology Call Schedule**

  - The Chief Resident is responsible for the resident call schedule. This is posted on Qgenda.
  - The resident who is on call on a weekend should be free from call during the week prior to and week following their weekend.
  - The resident covers both hospitals (MHMH and VA) with attending backup. Rounds are made with an attending on the weekend days. The resident should round in the afternoon at both hospitals.
  - If residents switch call they are responsible to make the changes in Qgenda and notify the Coordinator.
  - If a resident leaves the hospital during the day or is unable to come to work, the attending that you are working with, the Residency Coordinator and the Chief Resident should be notified. Notify Dr. Pais or Dr. Gormley if the Coordinator is unavailable.
  - **It is the responsibility of the Chief Resident to post EACH day, on the call board; the name of the on call resident for that day. This is the person with the urology on call beeper and who will be responsible for urgent/emergent calls. The secretaries and nurses must know who is on call. The on call resident should be the person who has the least surgical responsibilities for the day.** If the on call person is in the OR the attending needs to release them to deal with the emergency.

- **Meal Money**

  Individuals who are scheduled for In-House Overnight Call or **Home Call – Called In** will receive an email from GME with the amount of funding dispersed to the Cafeteria

  - and/or Cravin's for the timeframe of July 1- December 31, 2022. You will receive a like email in late December covering the second half of the academic year. In order for time to be counted towards meal funding (>3 hours duration called in) , it must be logged as **"called in"**

  - **As a special reminder for those scheduled to take Home Call**: It is essential that you log all Home Call-Called In hours in MedHub, utilizing the Home Call - Called In designation, to meet the obligations of your Agreement of Appointment (GME Contract). Also, failure to log these hours appropriately effects your junior colleagues' meal funding for the following year (i.e.: PGY4 logging this in academic year 2021-2022, impacts meal funding for the PGY4 in the same program in academic year 2022-2023).

2. Resident Responsibilities

- **Purpose**

During the time of residency training, residents have many professional responsibilities including, but not limited to, the clinical care of patients, improving their own educational preparation, and teaching those with whom they work. In addition, graduate medical education is based on the principle progressively increasing levels of responsibility in caring for patients under the supervision of qualified faculty. The responsibilities for each year of Urology training, including goals and objectives, are in the Resident Curriculum. The general description of resident activities as they progress through training as described in the GME policy is also adhered to.

- **Definition**

Clinical Care

Residents are expected to provide competent and compassionate patient care, and to work effectively as a member of the health care team. This implies professional demeanor and conduct both in direct patient care and in communication with family members, other health care professionals, and support staff. The highest level of professionalism is expected at all times. Residents are directly responsible to the faculty attending to whom they have been assigned for all matters related to the professional care of patients. Under the supervision of attending physicians, general responsibilities of the resident physician may include:

- perform initial and ongoing assessment of patient's medical, physical, and psychosocial status
- perform history and physical
- develop assessment and treatment plan
- perform rounds
- record progress notes
- order tests, examinations, medications, and therapies
- interpret results of tests
- arrange for discharge and after care
- write or dictate admission notes, progress notes, procedure notes, and discharge summaries
- provide patient education and counseling regarding test results, disease processes, and discharge planning
- perform procedures
- assist in surgery and/or perform surgical procedures with appropriate supervision.

Residents at all levels should have a strong commitment to patient safety and professionalism. It is a physician's responsibility to appear for duty appropriately rested and fit to provide the services required by their patients. Physicians must recognize that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. Urology residents must participate in clinical quality improvement and patient safety programs throughout their training. A resident may come up with a project on their own or it may be suggested by a faculty member. The resident may do this work as part of

a research elective or a residents may be called upon to do this as part of the morbidity and mortality review process or in response to action items developed at the annual program evaluation.

Call schedules will be organized to minimize the number of transitions in patient care. Residents must be competent in communicating with team members in the hand-over process.

Learning and Education

Residents are recognized as adult learners and ultimately the acquisition of knowledge, skills, and professional attitudes is the responsibility of each individual. The Urology Residency Program will provide an ample selection of educational offerings. The expectation is that residents will attend educational conferences as required. The conference programs are designed to provide an interactive didactic forum to augment the resident's reading and clinical experience.

An essential component of learning is the development of life-long learning skills; all physicians must practice disciplined ongoing acquisition of medical knowledge. The resident is expected to develop a personal program of reading. Besides the general reading in the specialty, the resident should do directed daily reading relating to problems that they encounter in the care of patients. The resident is responsible for reading prior to performing or assisting in procedures that they have not yet had the opportunity to see.

The ACGME (www.acgme.org) has defined the following six areas as General Competencies and stipulates that programs require their residents to develop them to the level of a new practitioner by the completion of training:

1. Patient Care
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Residents are referred to the DHMC urology residency curricula, their global evaluation form and the ACGME website:
http://www.acgme.org/acWebsite/downloads/RRC_progReq/480_urology_07012009.pdf
for further description of the competencies.

Residents should familiarize themselves with the ACGME Milestones 2.0 for Urology. Each resident will be evaluated using the Milestones twice per year by the Clinical Competency Committee.

Discipline-Specific Education

A primary responsibility of graduate medical trainees is to meet the educational goals of their specific programs. In Urology, as in all MHMH-sponsored GME programs, the Residency Program Director is responsible for the organization and implementation of discipline-specific educational objectives. The resident is expected to manifest active involvement in learning, and has responsibility for the following:

- familiarity with the program's educational objectives and residency curriculum
- development of competence in the six areas listed above
- development of a personal growth program of learning to foster continued professional growth
- experience with quality assurance/performance improvement

All residents must provide data on their educational experience to their program director and GME office as requested. The provision of regular feedback on faculty, program and overall educational experiences via confidential written or electronic evaluations, is an essential part of the continuous improvement of the educational programs within our institution and is required by the ACGME.

Active participation in departmental and hospital committees provide an opportunity for residents to become familiar with administrative aspects of health care and involvement with such experiences is strongly encouraged.

Teaching Others

Residents are also expected to teach and mentor junior residents, medical students, and other learners with whom they interact. Collaborative learning is an important part of graduate medical education and residents' involvement with the education of other members of the health care team is vitally important.

Graduated Levels of Responsibility

Graduate medical education is based on the principle of progressively increasing levels of responsibility in caring for patients under the supervision of the faculty. The overriding consideration must be the safe and effective care of the patient that is the responsibility of the faculty attending. The faculty is responsible for evaluating the progress of each resident in acquiring the skills necessary for the resident to progress to the next level of training. Factors considered in this evaluation include the resident's clinical experience, judgment, professionalism, cognitive knowledge, and technical skills. At each level of training, there is a set of competencies that the resident is expected to master. Our residents are expected to have retained those competencies that they accomplished in the preceding years. Each resident is responsible for knowing the limits of their scope of authority and the circumstances under which they are permitted to act with conditional independence.

General Responsibilities of Urology Residents

- All patient care must be supervised by qualified faculty.
- On-call and clinical assignment schedules must be available at all clinical service locations so that residents, nursing staff and ancillary personnel can easily identify the assigned resident and their faculty supervisor.
- PGY-1 level residents, during the day, must be supervised either directly or indirectly, with direct supervision immediately available.
- At night, when a PGY-1 level resident is not assigned to our service the on-call urology resident may, in an emergent situation, ask the PGY-1 level resident on call for General Surgery to assess a patient while the urology resident travels to the hospital.

- In recognition of their responsibility to the institution and commitment to adhere to the highest standards of patient care, resident physicians shall routinely notify the responsible attending physician based on the guidelines noted below under Supervision.

General Responsibilities of Urology Faculty

- Routinely review resident physician documentation in the medical record.
- Be attentive to compliance with institutional requirements such as problem lists, medication reconciliation, and additional field defined document priorities.
- Provide resident physicians with constructive feedback as appropriate.
- Serve as a role model to resident physicians in the provision of patient care that demonstrates professionalism and exemplary communication skills.

Responsibilities by Resident Year

PGY 1- The Intern is expected to participate in direct patient care with the team, evaluate patients, attend clinic and participate in cases in the operating room. The Intern on the Urology service is expected to ask for help and to ask questions. The Intern should always be able to find answers to their questions.

The Intern is expected to know what is happening with our patients, day or night. This includes working with and learning from the Physician Assistant on the team. We view patient care as a team effort, with all of us working together and learning from each other.

The Intern is expected to come to Urology clinic. The Chief will assign the Intern to the clinics of various urology attending clinics to encompass both general and subspecialty urology. When the Intern is unassigned and finished their work on the floor they should feel free to join anybody in clinic. Interns will also be assigned to particular ORs but again they should feel free to come to any of the urology faculty's cases when they are not assigned.

The PGY-1 must complete USMLE Step 3 prior to the end of their intern year. The intern should schedule their exam at a time when they are not scheduled to be on call or they must make arrangements to make up missed call

PGY 2- Junior urology residents should be capable of managing patients with virtually any routine or complicated condition and of supervising a PGY 1 or a mid-level provider in their daily activities. The resident is responsible for coordinating the care of multiple patients on the team assigned. Individuals in the second post graduate year will perform additional diagnostic and therapeutic procedures (primarily cystoscopy and difficult catheterization) with indirect supervision once competency has been documented. The PGY 2 can perform progressively more complex procedures under the direct supervision of the faculty. In addition to serving as the junior resident on the DH adult urology service, the PGY2 resident will also serve as the pediatric urology resident for a 3 month rotation in the first half and second half of the year. Progressive autonomy will be provided over the 2 pediatric urology rotations.

PGY-3 - The PGY-3 should begin to have an understanding of the role of practitioner in an integrated health care delivery system and to be aware of the issues in health care management

facing patients and physicians. PGY-3's assume an increased level of responsibility. The third year of urology begins transition to leadership and the resident should be able to assume responsibility organizing the service at the Veteran's Affairs Medical Center in White River Junction, VT (VAMC). The resident should have mastery of the information contained in standard tests and be facile in using the literature to solve specific problems. The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis.

PGY 4 - The PGY-4 will participate and perform increasingly complex procedures and provides further opportunity for leadership growth. In the first half of the academic year, the PGY4 will be assigned to the VAMC, at which they will be responsible for medical and surgical care of urology patients and manage the urology service under the supervision of attending physicians. They will also spend 3 months in Concord to participate in a wide variety of urologic cases and assist in the management of the urology service. In the second half of the academic year they will return for a second rotation at Concord hospital, and finally will assume the role of DH Senior, performing more complex cases and assuming primary management and coordination of the urology consult service.

The resident will be responsible for presentations at conferences and for teaching junior residents and students on a routine basis.

PGY 5 - The PGY 5 resident takes responsibility for the management of the urology service, under the supervision of the faculty. The PGY 5 can perform most complex and high risk procedures expected of a physician with the supervision of the attending physician. The attending physician should be comfortable allowing the PGY 5 resident to manage all common problems expected to be encountered during independent practice. During the final year of training the resident should have the opportunity to demonstrate the mature ethical, judgmental and clinical skills needed for independent practice. The PGY 5 will give or will have given as a PGY 4, a formal presentation at a regional or national meeting and will assume a leadership role in teaching on the service. The mores and values of the profession should be highly developed, including the expected selfless dedication to patient care, a habit of lifelong study and commitment to continuous improvement of self and the practice of medicine.
The PGY-5 assigned to the Administrative Chief position will have additional responsibilities for managing the entire urology service, under the supervision of the faculty. The Chief resident will be responsible for assigning cases and clinic coverage on a weekly basis. The PGY-5 residents will be responsible for making and administering the call schedule. The two PGY-5 residents, together with the program director, will make and administer the conference schedule.

Responsibilities by Site

DHMC
Under in-direct supervision, residents are potentially responsible for total patient care of all urological patients at Dartmouth-Hitchcock Medical Center. Residents cover the emergency room on a prearranged schedule. On each clinical rotation on the Lebanon campus, residents are

teamed with 2-3 faculty; they spend 2-3 days in the operating room and 2-3 days in the out-patient clinic with one of these supervising faculty. Residents are responsible for all urology in-patients in the medical center.

In the emergency room, the patients are seen by the resident who evaluates, diagnoses and selects the initial course of management which may include hospital admission. The supervising urologist is notified of the admission, the patient's history and examination and other evaluations are reviewed. When deemed necessary the supervising urologist will personally assess the patient. The management plan is finalized in concert with the supervising urologist. If surgery is indicated, the resident will operate under direct faculty supervision. The resident will be responsible for the follow-up care of each patient in the hospital or in the out-patient clinic.

For patients to be admitted from the ED, new guidance has been provided:

The EMERGENCY DEPARTMENT providers will place the admit order and bed request. This means that as SOON as you make the decision to admit, please close the loop by communicating with the ED team the decision to admit, the level of care required, and the admitting attending name. This new work policy is intended to improve flow of patients out of the ED and ensure better patient safety. The unintended positive consequence will be improved communication between consultants and the ED.

The surgical team will still need to "Assign team" once they have time and write full admission orders. The ED provider is JUST placing the bed request and order to admit to facilitate patients getting more timely bed assignments

In the Dartmouth-Hitchcock Clinic, males and females of all ages, including pediatrics are seen. All patients booking in the clinic are booked under a staff urologist. When possible, new patients are first seen by a resident. The resident performs the initial evaluation and formulates a diagnosis before presenting the case to the urologist. Together they examine the patient, review any tests, select further investigations and plan management. Those patients seen solely by the staff urologist who require surgery and/or admission are discussed with the responsible resident. Other cases which have particular educational pertinence are presented at the weekly uroradiology conference for resident education.

Post-operative follow-up patients may be seen by the responsible resident in conjunction with the operating urologist to facilitate continuity of care.

In Mary Hitchcock Memorial Hospital, all patients are the responsibility of the resident under the indirect supervision of the admitting attending. The adult urology service is in one geographic area; pediatric urology patients are admitted to the pediatric surgical ward. Each patient is utilized for teaching and the residents are allowed progressive responsibility by the attending relative to the individual residents experience and ability. Generally the residents are responsible for the day-to-day decisions on the wards. Ideally each in-patient is seen by an attending urologist every day.

Residents are involved in all urological surgery performed in the operating rooms at Mary Hitchcock Memorial Hospital or in the Outpatient Surgical Center, usually as the operating

surgeon. The responsible attending urologist is always scrubbed or present in the operating room or for certain minor cases readily available in the building. Residents are responsible for the post-operative care and management of complications on all patients under appropriate graded attending supervision.

The resident performs consultations at the request of other services and may recommend medical or surgical procedures after appropriate examinations and consultation with the supervising urology faculty. The residents have a close association with residents of other programs and at times they participate in conferences and teaching experiences of those services. They are particularly concerned with the teaching of the interns who may be assigned to the urology service at night and with the surgical and medical residents in the emergency room.

VA

At the VA the resident has complete responsibility for all patients with indirect supervision.

At the Veterans Affairs Medical Center, the vast majority of patients are adult males. The urology resident is responsible for the total patient care in the out-patient clinic, emergency room and the in-patient ward service. The resident is the operating surgeon on virtually all urology cases with direct supervision. At the VA, the resident covers the emergency room during daytime hours; out-patient clinic and operating room schedules do not conflict. Attendings are physically present or immediately available in the clinic and operating room. Long-term care is provided by the resident through the out-patient clinic.

New London

At the discretion of the Chief Resident and Program Director, DH-assigned resident will be assigned to participate in the surgical care of men's health urology patients at New London Hospital with Drs. Gross and Grant.

At New London Hospital, the majority of patients are adult males, with a focus on surgery for BPH and ED. The urology resident is responsible for pre and immediate postoperative patient care. The resident will participate and operate on all urology cases with direct supervision. They are not responsible for on site, after hour's care, which will be directed to the responsible attending. Attendings are physically present in the operating room.

Concord Urology

While rotating at Concord the resident's responsibility under supervision for total patient care is the same as at DHMC except that the resident may see only a portion of the patients. The Concord resident under indirect supervision is potentially responsible for total patient care of all urological in-patients. The resident operates with direct supervision usually 5 days per week and is in clinic when not operating.

The resident covers the emergency room on a prearranged schedule. The resident evaluates, diagnoses and selects the initial course of management which may include hospital admission. The supervising urologist is notified of the admission, the patient's history and examination and other evaluations are reviewed. When deemed necessary the supervising urologist will personally assess the patient. The management plan is finalized in concert with the supervising urologist. If surgery is indicated, the resident will operate under direct faculty supervision.

At Concord Urology males and females of all ages, including pediatrics are seen. All patients booked in the clinic are booked under a staff urologist. When the resident is in clinic they will see any new patients. The resident performs the initial evaluation and formulates a diagnosis before presenting the case to the urologist. Together they examine the patient, review any tests, select further investigations and plan management. Post-operative follow-up patients are seen by the responsible resident when possible in conjunction with the attending urologist.

At Concord Hospital all patients are the responsibility of the resident under indirect supervision of the admitting attending. The resident is allowed progressive responsibility by the attending relative to the individual residents experience and ability. Generally the residents are responsible for the day-to-day decisions on the wards.

As there is only one urology resident in Concord the resident is not involved in all urological surgery performed in the operating rooms but when they are involved it is usually as the operating surgeon. The responsible attending urologist is always scrubbed or present in the operating room. The resident is responsible for the post-operative care and management of complications on all patients under appropriate graded attending supervision.

The resident performs consultations at the request of other services and may recommend medical or surgical procedures after appropriate examinations and consultation with the supervising urology faculty.

Night/Weekend Duty
DHMC and VA
Night and weekend duty is assigned to residents on a prearranged schedule. The residents share a 1 in 7 call schedule. Call is usually taken from home. The resident covers both hospitals (DHMC and the VA) with attending backup on immediate call. In addition, rounds are made at both facilities with an attending on the weekend days. The faculty share a 1-in-8 call schedule covering both hospitals. .

Concord Urology
Night and weekend duty is assigned to the resident on a prearranged schedule. The resident does no more than one in three nights and is assigned one weekend per month. Call is taken from the resident's apartment in Concord. There is attending backup on immediate call. Rounds are made with an attending on both weekend days.

3. Resident Supervision

DHMC urology residents are assigned responsibility commensurate with their experience with the goal that the resident will be the operating surgeon in every case possible.

At DHMC, we consider that Urology Interns or PG 1s are the most junior team members. PG 2 and PG 3 urology residents are considered to be at an intermediate level of training and that PG 4 and PG5 (chief) residents are considered to be in the final years of education.

a. Purpose
The section of Urology will abide by the Graduate Medical Education Committee (GMEC) guidelines regarding the levels of supervision required for all graduate medical trainees.

b. Definition
Levels of Supervision
To ensure appropriate oversight of resident supervision, we will use the following classification of supervision:

1. Direct Supervision – The supervising physician is physically present with the resident and patient.

2. Indirect Supervision:
    a. with direct supervision immediately available – The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision.
    b. with direct supervision available – The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via phone, and is available to provide Direct Supervision.

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

Progressive Authority and Responsibility
The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident will be assigned by the program director and faculty members.

With the exception of the intern, faculty supervision assignments are all at least 3 months in length which are of sufficient duration to assess the knowledge and skills of each resident and delegate to them the appropriate level of patient care authority and responsibility. We have developed descriptions of the level of responsibility accorded to each resident by rotation and PGY level. The resident's supervisor(s) and Program Director make decisions about each resident's progressive involvement and independence in specific patient care activities.

In particular:

- The Program Director will evaluate each resident's abilities based on specific criteria established by the faculty. These criteria will be guided by national standards-based criteria when such are available;
- Supervising faculty members will delegate patient care activities to residents based on the needs of the patient and the demonstrated abilities of the resident;
- Senior residents may serve in a supervisory role of junior residents with appropriate patients, provided their demonstrated progress in the training program justifies this role;
- **All residents,** regardless of level of training and experience, must **verbally communicate** with appropriate supervising faculty during certain circumstances. These circumstances will include:
    - **any admission to the hospital from the ER, clinic or same day area;**
    - **consultation for urgent condition;**
    - **transfer of patient to a higher level of care;**
    - **Code Blue Team activation;**
    - **change in DNR status;**
    - **patient or family dissatisfaction**;
    - **patient requesting discharge AMA;**
    - **patient death, or:**
    - **need for urgent or emergent procedure by our service or another service**

Supervision by Site

DHMC

It is a policy of the Section of Urology that in-patients are seen daily by the attending of record. The attending ideally writes or cosigns a note daily and prior to any surgical intervention on an in-patient or emergency patient.

All surgical procedures are directly supervised by an attending faculty. An exception to this is certain minor procedures such as cystoscopy and stent placement performed/supervised by a senior resident. The faculty decide when senior residents are given privileges. An attending must always provide indirect supervision and be immediately available.

In the urology clinic each patient is assigned to an attending. If the patient is seen by a resident the attending and resident review the case and pertinent tests. The attending reviews the resident's note, adds to the note if necessary, documents that they participated in the encounter and signs off on the billing that they were the supervising physician.

The residents are asked to evaluate the faculties' supervision on their annual evaluation.

VA

Each patient is admitted to the urology service under the direction of the resident supervised by the Chief of Urology or other urology faculty. In-patient notes, consults and out-patient notes are co-signed by the attending of record.

All surgical procedures are directly supervised by attending faculty.

The faculties' supervision is evaluated at the time of their annual evaluation.

Concord Urology
Each patient is admitted to the urology service by an attending. All surgical procedures are directly supervised by an attending faculty.

In the urology clinic each patient is assigned to an attending who directly supervises the resident's care of the patient.

4. Grievance/Fair Hearing Policy

- As per the GME policy – see the Grievance Policy on the GME Website under Policies and Procedures.

5. Paid Parental Leave Policy

A. **Parental Leave Entitlement**
D-H will provide up to six (6) consecutive weeks of Parental Leave for all Eligible Employees following the birth or adoption of a child. This policy shall only apply to births or adoptions that occur on or after July 1, 2022.

Parental Leave shall be paid based upon the Eligible Employee's base salary determined by the employee's regularly scheduled work hours.

B. **Eligibility Requirements**
Eligible Employees may only utilize this benefit after thirty (30) days of employment.

In the event that both parents/partners of a child are Eligible Employees, both parents/partners are eligible to receive Parental Leave under the terms of this policy.

Timing of Leave and Amount of Leave
Eligible Employees must take Parental Leave during the first twelve (12) months following the birth or adoption of a child.

Eligible Employees may utilize one term of Parental Leave per birth or adoption event. For purposes of this policy, an event is defined as a delivery or adoption of a child (ren). For example, if an Eligible Employee has a delivery of multiple newborns or adopts multiple children at the same time, the employee would be eligible for one term of Parental Leave for that event.

6. Resident Well-Being Policy

IV. Policy Statement

Residents' physical, psychological and emotional Well-being is of paramount importance to D-H and our ACGME-accredited training programs. Residents are encouraged to lead healthy lives and make healthy choices that support them in their personal and professional growth. To that end, we provide the following strategies to support trainee health, Well-being and Resilience:

▪ Institutional Support ◦Live Well/Work Well (LWWW) provides D-H employees and their families with resources and services that motivate, encourage, and promote healthy lifestyles and foster Resilience. Services include:

▪ Health Improvement and Employee Wellness: including Health Risk and Wellness Assessment, Mind Strength mindfulness training, health and lifestyle coaching, diet and nutrition resources, fitness rooms, onsite fitness classes and others.

▪ Employee Assistance Program (EAP): Confidential and free counseling services which include up to six in-person visits/year and 24/7 telephonic counseling. All new incoming residents will have an introductory appointment scheduled, from which they may opt out. All residents are encouraged to set up an introductory meeting.

▪ Occurrence Reporting: Patient and employee safety reporting for actual events and near misses.

▪ Residents have access to healthy food and beverage options at the D-H cafeteria and from other on-campus food purveyors.

▪ All Residents participate in a half-day Safety Behaviors for Error Prevention course during training.

▪ Graduate Medical Education Support ◦The Office of GME is a safe place where Residents can ask for and receive help with various needs including academic counseling, coaching, and mentoring.

▪ The Office of GME sponsors an annual Resident and Fellow Appreciation Week where Residents have the opportunity to participate in daily wellness activities and shared meals. During the week, D-H community members write notes of appreciation to trainees and individual programs sponsor wellness activities for their Residents.

▪ The D-Hx seminar series provides Residents with an opportunity to learn and ask questions about topics of interest to their professional lives and future.

▪ Residents may become members of, or participate in, the Associated Resident Council (ARC), its subcommittees, and sponsored events. The ARC membership is composed of a group of peer-elected representatives from each of the core residency programs which comes together to discuss issues affecting Resident life. The ARC seeks to promote harmonious and collaborative relationships amongst Residents, faculty and staff and enhance the Resident community through advocacy, volunteer, and social activities.

▪ The Office of GME delivers coffee, fruit and snacks to the Resident call room and provides dinner on Saturday evenings for on-call Residents, free of charge. Meal funding support is also provided to Residents taking overnight in-house call and for Residents who must return to the hospital to provide care when scheduled to home call.

▪ Residents may take advantage of free taxi service to and from the hospital in the event that they are too fatigued to drive home after a clinical shift.

▪ All Residents and core faculty complete an annual learning module on sleep alertness and fatigue mitigation.

▪ Program Support ◦There are circumstances in which Residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program has policies and procedures in place to ensure coverage of patient care in the event that a Resident may be unable to perform their patient care responsibilities. These polices will be implemented without fear of negative consequences for the Resident whom is unable to provide the clinical work.

(As stated elsewhere in this manual, residents are to notify the chief resident, the attending they are assigned to work with and the coordinator, that they are unable to work. Residents are encouraged to take a taxi or an Uber home)

▪ Residents have the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their work hours. Residents must follow the program's procedures for scheduling and notification of these appointments.

(As stated elsewhere in this manual, residents are to notify the chief resident, the attending they are assigned to work with and the coordinator that they need to leave work to attend an appointment. In the case of recurring appointments residents are encouraged to make those appointments, if possible, during times that are least disruptive to the functioning of the resident team.)

▪ Residents are encouraged to alert the Program Director, a faculty mentor or Chief Resident when they have concern for themselves, a Resident colleague or a faculty member

displaying signs of Burnout, depression, substance abuse, suicidal ideation or potential for violence.

(The Section of Urology will arrange at least 2 team-building, resident only events, held during the work day that all residents are expected to attend. A team dinner held at a location chosen by the residents follows the event. These events are chosen and arranged by the residents and paid for the Section. The chief resident will submit a short summary of the event, including date, time, approximate cost (<$500 typically) and an explanation of how it will promote team building. Ideally all should be planned at least 60 days A faculty member will carry the resident on-call pager during this time. The resident who is on call that evening is expected to return to DH between 5 pm and 6 pm and assume call. It is expected that faculty and residents will rotate call coverage during these events.)

II. Urology Section Policies

1. Clinic

As a resident you may be seeing a patient in an attending clinic **or alternatively you may be seeing a patient who has been booked to be seen by a resident with attending back-up.** Patients' most frequent complaint is that they were made to wait. Every attempt to facilitate an efficient visit should be made. Other factors to be considered in the clinics:

- Timeliness
- Check the schedule to see if the patient has arrived – **do not wait for a nurse to call you**
- Professional attire
- Confidentiality – consider where and when you discuss patient issues and consider the need to know when looking up medical records
  - Clinic notes. In an attending clinic you may be asked to write a note. This note may be edited or appended and should be cosigned by an attending, stating their level of involvement. You may need to finish your note after clinic in order to keep on time.
  - Follow-up. Notify the appropriate secretary via the eD-H work list of any follow-ups, including the appropriate testing/labs to be arranged. Include all pertinent information, i.e. diagnosis. Order all appropriate testing or include all the information so that the test can be ordered.

  All patients booked into clinic must have an attending back-up which you must identify. Ensure that you or somebody else has the time to see the patient.
- Attempt to maintain continuity – same resident/same attending.
- A cysto in the clinic, ward or OR cannot be billed to Medicare unless the attending is present for the entire procedure.
- Billing should reflect what you did. The attending must sign it. You must fill out the Level of Service in eD-H.
- The Chief Resident is responsible to introduce interns and medical students to the section. The Chief Resident shall notify Megan, Surgical Coordinator, of any upcoming vacation plans of the intern while on the Urology rotation.

2. Consents/ Pre-op Checks

- Check the attending's notes and the OR booking prior to consenting the patient. **If you are not sure about the consent – ask! Consents are not valid without a side as well as a date AND time of the signature.** Please ensure that you are using a valid consent form. Avoid jargon or abbreviations. The resident who will operate on the patient should see the patient preoperatively to assure that the appropriate work-up is completed and the antibiotics/ DVT prophylaxis and site marking is completed.
- The resident assigned to the case is responsible for completing the preoperative orders the day before (or prior). This is particularly important for the OSC.

3. Dress Code

- Professional attire* is essential when in contact with patients, etc. or if you are representing DHMC Urology. * See appendix.
- Scrubs are not to be worn from home or to home.
- Lab coats – up to 2 per year by GME. We pay for these so don't order them if you don't wear them.

4. Educational Conferences

- Residents are required to attend the weekly GU Conferences on Monday and Friday and the Thurs Radiology Conference. The Concord resident will attend Friday morning conferences and should make an effort to call in on Monday or Thursday. All residents are expected to have read the AUA core curriculum relevant to the Monday conference in advance and be prepared to discuss. Senior residents are expected to have reviewed the core curriculum and supplemented this with further reading from Campbell's Urology. If a resident chooses to stay in Concord for Friday they will be responsible to notify the administrative chief who will then insure that the phone / WebEx is set up for the conference. **All conferences will start on time.**

- **Radiology** –held weekly

This conference is for the benefit of the residents and the emphasis should be on the radiologic findings. The Chief resident at Hitchcock is responsible to assure that an adequate list of cases is delivered to Radiology. All residents should keep a list of x-rays suitable for presentation. A mix of cases can be presented and can be presented to the intern, junior radiology residents, med students, etc.

The 1st Thurs of the month is the Pedi radiology conference. The resident on the Pedi service is responsible to present the cases. All residents can contribute cases to be presented.

- **M&M**- held monthly.

Residents will keep a list of M&Ms for all sites

All M&M's for the prior month are sent to Dr. Seigne who will determine which cases will be presented.

Ideally the resident involved with the case should present the case and a brief discussion of how the M&M could be avoided.

An M&M sheet will be filled out for each patient prior to the conference. For those cases chosen to be presented the conclusion will be filled in during or after the conference.

The chief resident is responsible for maintaining the M&M sheets.
These should be delivered to the Residency Coordinator when they are completed.

- **Urodynamic** - held 4-5x/year.

- **Tumor Board** – held weekly - 4:30 Thursday

The resident on the A team is required to attend.
All clinical residents should attend.

- **Pathology** – held as part of the regular GU conference.

- **Journal Club**-held monthly. Dr. Schroeck is the facilitator.

The Chief Resident should insure that the appropriate assignments are made.
Articles should be submitted to the Residency Coordinator 7-14 days in advance so she can circulate the articles received 1 week prior to the conference.
You are responsible for distributing your article if you miss the deadline.
Residents should have reviewed all articles

- **Combined UroGyn/Uro** – held 4 times per year (5th Friday of the month).

A resident will be assigned to present. This is usually the B team resident. Please discuss your presentation with Dr. Gormley at least 1 week prior to the conference.

5. Evaluations

- Resident evaluation is an on-going process. Residents are in contact with faculty on a daily basis. Formal evaluations occur every 3-6 months. Standardized residency evaluation forms are completed by each faculty member, every 3-6 months. Faculty must evaluate residents. After a 2 week period of time and numerous reminders from MedHub a faculty member is warned that they have 24 hours left to finish their evaluation(s). Incomplete evaluations result in the faculty member working without a resident except in the OR.
- An evaluation is performed by the support staff every 6 - 12 months and is used to evaluate professionalism and communication skills.
- Operative evaluations of each resident may be performed for standard urologic cases by faculty members.
- Patient survey results are used when available. The data accumulated on these forms serves as a basis for discussion.
- A new patient evaluation form is being developed.
- A resident is expected to meet average standards in his/her professional, technical and ethical performance. The Clinical Competency Review Committee (CCRC) meets twice per year to review evaluations and to evaluate residents' progress through the Milestones making certain that each resident has appropriate professional growth and skills to proceed to the next year. The Program Director discusses resident performance with each individual at least every 6 months following the meeting of the CCRC. During the last review for the year the operative log is reviewed and signed off. To enter the Chief Resident year a resident must have obtained an appropriate level of performance in the opinion of the majority of faculty members. Items evaluated in the resident evaluation

form include patient care, medical knowledge, practice based learning and improvement, interpersonal & communication skills, professionalism and system based practice.

- A final written evaluation that summarizes the resident's performance in the program and a completed operative log is reviewed with the Chief resident during their final evaluation. A mock credentialing form is also filled out on all finishing residents. All evaluations will be kept on file in the resident's personnel file with the final evaluation form, the final log and the mock credentialing form being used to fill out subsequent credentialing forms.
- All residents, including the Intern are required to sit the AUA In-Service Examination yearly and the results of this test are incorporated into the evaluation. All residents are expected to improve the percentage correct each year. Chief residents should aim to achieve a minimum of 70 percent correct. Failure to perform at this level may result in a focus of concern. Performance on the In-Service as well as the American Board of Urology Qualifying (Part I) is compared to overall national achievement and these data are reviewed at a Faculty Meeting as well as at the Program Review in order to direct attention to areas of apparent weakness. Faculty are encouraged to sit the In-Service to better understand what is on the exam. Resident scores on the in-service are maintained in the resident's personnel file. The AUA Self-Assessment Exam is available to all residents and faculty.
- Faculty members are evaluated annually. Residents must evaluate faculty. Failure to do so will result in not being allowed into the OR. Residents will be given a warning when they have 1 week and then 24 hours left to complete their evaluations. Residents anonymously complete a faculty assessment form which addresses characteristics and attributes that include teaching ability, availability and role modeling. The Residency Coordinator compiles a blinded, summary evaluation for each faculty member which is given to the Chairman. Each faculty member meets with the Chief of Urology biannually and their resident evaluations are discussed during these reviews.
- The Urology Section performs a yearly internal program review with faculty and residents to assess the teaching program. Residents and Faculty complete a program evaluation form annually which addresses the extent to which the resident's educational goals and objectives are fulfilled with special concern regarding the balance between the educational and service components of the program.
- The Program Director and faculty review the National Log Data to compare the experience available to the Dartmouth resident with the national experience

6. Funding

- External funds may only be requested from drug or equipment companies as an unrestricted grant and should be done in conjunction with a faulty member. The only time that monies from a company may be ear marked for a specific resident is if it is an award. See Vendor sponsorship policy also.
- **Residents should not submit abstracts to meetings without first checking that the meeting is appropriate with both their research mentor and either the Program Director or the Section Chief**.

7. In-house and Same Day Surgery Patients

- History and Physical examinations: performed by the intern, resident or faculty.

- Discharge Summaries: Although the discharge summaries may be done by the intern or the Inpatient PA it **is the responsibility of the resident to ensure that all discharge summaries are accurately completed.**
- Discharge Orders: It is the responsibility of the **resident** to insure that the appropriate orders and instructions are written for the discharge. The resident shall notify the appropriate secretary of all post-discharge follow-ups via eD-H work-list with all pertinent information.
- Rounding: The Urology Residents round in the a.m. hours as a team. All members of the team should be familiar with all patients, including consults. The chief residents should maintain primary responsibility for management of the consult service under the supervision of the appropriate attending physician. A note will be written on all inpatients and all consults with active issues. Resident assigned to a specific attending may be asked to round with that attending in the p.m. hours. If you need to leave prior to evening rounds please let the attending that you are assigned to know that you will not be there.
- It is the attending's responsibility to sign out the patients to the attending on call. Residents should also sign out to the on call resident. The resident on call should be familiar with all in-house patients and consults.
- Consultations: The resident on-call will be paged for any consults. In-house consultations, are performed by the on-call resident. Pedi consults are performed by the resident assigned to Pedi. The Chief (1st 6 months) and DH Senior (2nd 6 months) will be responsible for managing the consult service and formulating/carrying out plans with the responsible attending physician
- Emergency room consults go directly to the resident on-call.
- **After consults have been seen, they should be discussed with a chief or senior resident and then the on-call faculty. <u>Unless emergent, consults do not take precedence over clinic patients.</u>**
- Telephone documentation – **Outside telephone conversations with patients and other providers regarding patient management should be documented and incorporated into the medical record. Residents are not expected to take calls from the transfer center except in exceptional circumstances.**
- Appointments following discharge (either Same Day Surgery or in-house) or emergency room consult: the responsible resident must communicate with the appropriate attending what the follow-up plans are. The resident will then communicate with the appropriate secretary follow-up appointments. On-line surgical booking forms, X-ray orders and laboratory orders must accompany this request.

8. Laboratory and X-ray Results

- The Resident requesting laboratory or x-ray testing should document on the on-line requisition their name and the name of the responsible attending. When the resident follows up on the results with the patient it must be documented in eD-H.

9. Lockers

- OR Lockers are assigned to all new residents. These lockers are assigned for the length of residency.

10. Logs –Surgical Log ACGME Web Site

The residents will be responsible to input all of their surgical experiences into the ACGME website accurately and in a timely manner. Insure you log all the portions of a case (e.g. cystectomy, nodes, diversion, hysterectomy; e.g. percutaneous renal access / nephrolithotomy and ureterostomy)

- Avoid coding miscellaneous cases – use the codes on the web site
- Residents will log all cases from the week by Sunday evening.
- The Program Coordinator or Program Director may randomly check logs for compliance. Residents whose logs appear to be inaccurate or that are not up to date will be sent an email notice that they have 24 hours to update their log. A resident who fails to log cases will not go to the OR until their log is up to date. Repeated infractions, greater than 3 in 6 months, will be noted on the resident's evaluation, the Milestones and credentialing paperwork as a failure of expected professional behavior.
- Log cystoscopy, biopsy, urodynamics, injections, RUGS, fluoroscopy for UDS etc.
- At your end of year evaluation your log must be up-to date. Your log will be reviewed, signed and filed with plans made on surgical goals for the next year.
- The Chief Resident's surgical log must be complete prior to their departure. The residency is not considered completed until this is done. Failure to complete this will impact on future credentialing and may impact your ability to sit for Part II of the ABU exam.

11. Memberships

- The Section of Urology and the New England Section of the AUA pays membership dues to the American Urological Association, which includes the Journal of Urology. The Residency Coordinator or Practice Manager will process this payment.

12. Office Resources and Personnel

- Computers are located in the "Residents' Office for resident use. The residents are assigned 10 lap top computers, 1 lap top with kiosk only and 4 desktop computers. There are also 2 computers in the clinic work room. You will be assigned a laptop. You will be charged if you do not return it. IT will determine what reasonable wear and tear is.
- Support personnel are available to assist residents and faculty. The DHMC Urology Surgical Coordinator is available to assist with pre-op, surgical bookings and precertification.

13. Operating Room

- Brief OP notes must be completed before the patient leaves the room.
- Operative Note Dictation: Discussed and assigned in the Operating Room. **Op notes should be dictated the day the case is done**. Cases are logged into the ACGME operative log web site.

14. Physician Orders

- History and Physicals (Pre-op) done by the resident or intern. A preoperative H&P is entered into eD-H and the consent is done*. (See Consent) See Megan the OR scheduler, before seeing the patient to obtain the surgical date and check what procedure is to be done. Megan may also have information about what tests need to

be done. After the H&P has been completed direct the patient to Pre-admission Testing if appropriate.

- Order pre-op antibiotics/ DVT prophylaxis on all pre-op patients – at least 24 hr. prior to case
  - Base antibiotics on culture results and best practice guidelines.
- Urine Results: Urine results anticipated to come in on the weekend will be the responsibility of the resident on-call. The nurses inform the resident on-call on Friday which patients have outstanding results to be addressed on Saturday or Sunday. **Treatments will be documented in eD-H – both on the patient's drug list and as a phone note. We treat patients not cultures! Please refer to the patients clinic and phone notes.**

15. Recruitment

- **Residents**
  - attendance at all the interview days (and the evening social event when reinstituted) is mandatory
  - feedback is appreciated
- **Faculty**
  - you may be required to attend a lecture
  - generally you will meet with prospective candidates over lunch
  - feedback is appreciated

16. Resident Curriculum

Urology Curriculum

Goals and Objectives by Year- Abbreviated version
See Goals and Objectives for each rotation, by year

PGY 1 Year

During the first year, the Intern year, the intern will spend time doing General Surgery Rotations and Urology Rotations. The ACGME requirements are that the Intern will do at least 3 months of General Surgery which may include general surgery, acute care, colorectal, surgical oncology, transplant and at least 3 months of additional non-urological surgical training which may include vascular, pediatric surgery, transplant, critical care and plastics. At DHMC in 2019-2020 the rotations will include a VA rotation, colorectal, night emergency trauma, trauma and acute care, and surgical oncology. Non-urologic surgical training will include 2 ICU rotations, plastics and we have permission to use thoracic surgery as a non-urologic rotation.
When the Intern rotates in Urology they are expected to participate in direct patient care with the team, evaluate patients, attend clinic and participate in cases in the operating room. The Intern on the Urology service is expected to ask for help and to ask questions. The Intern should always be able to find answers to their questions.
The Intern is expected to know what is happening with our patients, day or night. This includes working with and learning from the Physician Assistant on the team. We view patient care as a team effort, with all of us working together and learning from each other.

The Intern is expected to come to Urology clinic. The Chief will assign the Intern to the clinics of various urology attending clinics to encompass both general and subspecialty urology. When the Intern is unassigned and finished their work on the floor they should feel free to join anybody in clinic. Interns will also be assigned to particular ORs but again they should feel free to come to any of the urology faculty's cases when they are not assigned
Interns are expected to log all of their cases in the ACGME system under Urology in a timely manner. The Program Director will review the Intern's case log quarterly.
Interns are expected to be reading in preparation for cases and for didactic conferences. The Urology Intern should establish a reading program based on the AUA Core Curriculum and Campbell's Urology. Prior to coming to the OR the Intern should also read an operative text.
Urology Interns are expected to take the AUA In-Service Exam in November.
When rotating on Urology, interns are expected to attend General Surgery Grand Rounds that the Urology group is attending. On other Fridays the Intern may "pick and choose" which conferences to attend. If the Intern's General Surgery conference is on a topic that is pertinent to covering patients on intern call then the Intern should attend that conference. When the Intern is on Urology we expect that the Intern will attend all other non-Friday Urology conferences.

General Goals:
The Intern during their Urology rotations will
a) Gain experience in urology disease evaluation and management.
b) Gain experience in office urology, endoscopy, and minor surgery, open and laparoscopic/robotic cases.
c) Refine the basic urologic work up of the urologic patient and gain further experience in surgery, post-operative management and management of complications of common urologic procedures.
d) Expand depth and scope of knowledge of urologic disease.
e) Develop problem solving skills for diagnosis of urologic conditions.
f) Refine interpersonal skills with patients, health care professional colleagues and mentors, and support personnel.
g) **Take and Pass USMLE Step III exam.**

General Objectives:
a) Demonstrate knowledge of fundamental principles of urologic disease and pathophysiology through didactic lectures and self-study.
b) Evaluate fund of basic urologic knowledge through the in-service exam. A performance above the 50th percentile of the national average for PGY is considered to be ideal.
c) Discuss some cases at Radiology rounds, M&M conference and Tumor Board.
d) Work effectively with support personnel in urology.

PGY 2 Year
The second year Urology residents rotate at DHMC with 6 months on Pediatrics and Transplant and 6 months as the DHMC junior resident.

As the junior resident the first year will primarily spend time in clinic learning office cysto, urodynamics and prostate biopsy and will be assigned to the OR for cases that are appropriate such as cystos, stents, SWL and scrotal cases. The resident will often carry the pager and will do many of the adult consults. As appropriate they will participate in the work-up and treatment of those patients that they see as a consult. The junior resident will be the "go to person" for the nurses and secretaries. Initially it is expected that the junior resident will need to consult often with more senior residents and the faculty.

The resident will attend the elevated PSA clinic that is held 3- 5 mornings per month where they assess new patients and perform transrectal ultrasounds and prostate biopsies with direct supervision or indirect supervision with the supervising physician in the same clinic.

The resident will learn how to perform and interpret urodynamics by participating in an adequate number of urodynamic studies with direct supervision or indirect supervision with the supervising physician in the same clinic.

During the pediatric/transplant rotation the resident is assigned to both services. The resident will attend Transplant Clinic and/or Dr. Gormley' s clinic to participate in pretransplant evaluation at least once per week. In the OR the resident will participate in donor nephrectomy and in transplantation, particularly the neocystotomy, all with direct supervision. The resident also spends a half day per week going to Transplant Clinic where they are involved in the work-up of new patients and the follow-up of patients that they have operated on. On Pediatrics the resident will attend clinic and will go to the OR with Pediatric urology faculty. Senior residents may be assigned to do more complex cases. The resident on Pediatrics should be very familiar with all of the pediatric patients including the consults.

Goals:

a) Obtain foundation of knowledge in urologic disease, including basics of renal physiology, adrenal physiology, neurourology and urodynamics, infertility, embryology, pediatric urology, female urology, stone disease, general male urology, and oncology with emphasis on office urology and diagnostic procedures.
b) Gain experience in pediatric urology disease evaluation and management.
c) Learn basics skills of endoscopy of the lower urinary tract.
d) Gain initial experience in open and laparoscopic including robotically assisted cases in the pelvis, abdominal and flank.
e) Participate in diversions, particularly the bowel anastomosis.
g) Gain initial experience in percutaneous endourologic procedures.
g) Develop teaching skills to assist in the education of medical students and interns.
h) Initiate study of clinical research principles.
i) Refine interpersonal skills with support personnel.

Transplantation Specific Goals:

a) Become familiar with the biology of histocompatibility.
b) Learn the process of donor and recipient selection, renal perfusion and preservation.

Radiology Specific Goals:

a) Understand the role, techniques and complications of transrectal ultrasonography of the prostate and prostate biopsy.

Objectives:

a) Demonstrate knowledge of fundamental principles of urologic disease and pathophysiology through didactic lectures and self-study.
b) Perform cystoscopy, bladder biopsies and ureteral catheter insertion with direct supervision.
-cystoscopy for insertion of a difficult catheter may be performed with supervision available once the resident has logged at least three office or OR cystoscopy cases and the supervising physician attests that the resident is capable of performing the procedure without direct supervision.
c) Perform urethral dilation and direct vision urethrotomies with direct supervision.
d) Perform more complex lower urinary tract endoscopic procedures, such as TUR biopsies of the bladder with direct supervision.
e) Gain experience with ureteroscopy and laser lithotripsy with direct supervision.
f) Obtain experience and technical expertise in scrotal, inguinal, vaginal and other minor urologic surgery with direct supervision. Perform abdominal and flank wound opening and closing and bowel anastomosis and as the year progresses perform an increasing amount of the case in major abdominal or flank cases all with direct supervision.
g) Develop basic laparoscopic surgical skills such as instrument handling and knot tying with the use of simulators without supervision.
h) Develop basic robotic skills by being the bedside assistant on 10 robotic cases with direct supervision prior to transitioning to working at the consul.
i) Gain experience in pediatric urology with particular emphasis on procedures such as circumcision, orchiopexy and hernia repair with direct supervision.
b) Gain experience in donor nephrectomy and ureteroneocystotomy under the direct supervision of the transplant surgeon.
j) Provide pre and postoperative care for pediatric and adult urology patients with direct supervision available.
k) Obtain skill in urologic trauma care including the evaluation, monitoring, surgical care and postoperative care of acute trauma with direct supervision available.
l) Identify, plan and initiate a clinical research project with oversight.
m) Evaluate progress of urologic knowledge through in-service examination with expected performance that exceeds the performance from the Intern year.
n) Present at least one lecture at Urology conference.
o) Present and discuss cases at Radiology rounds, M&M conference and Tumor Board.
p) Work effectively with support personnel in urology.

Transplantation Specific Objectives:

a) Obtain exposure to pre and post-transplant patients in Transplant Clinic with direct supervision.

Radiology Specific Objectives:

a) Perform transrectal ultrasonography and prostate biopsies under the direct supervision of attending staff. After a reasonable number of procedures the attending staff may deem

that the resident can do the procedure with indirect supervision with the staff present in the same clinic.

PGY 3 Year

During the third year the resident spends 9 months on clinical rotations; 3 months on each adult service at DHMC, 3 months at the VA, and 3 months doing an elective.
While assigned to a particular team residents attend clinic and operate with the team's attendings. Care is taken to insure that continuity of care occurs by having the resident attend clinics in addition to operating. Continuity of care occurs by seeing new patients in clinic, operating on and caring for the same patient post op and then seeing patients return to clinic for follow-up.

In the third year the resident has increased responsibility assigned to them as compared to the responsibilities in the PGY2 year, most notably managing the VAMC urology service for 3 months in the second half of the academic year. While assigned to a particular team, residents attend clinic and operate with the attendings. Continuity of care occurs by seeing new patients in clinic or in the Emergency room, operating on patients and caring for them post op and then seeing patients return to clinic for follow-up. The resident is the operating surgeon under direct supervision on all cases. Continuity of care occurs by seeing new patients in clinic, operating on patients and caring for them post op and then seeing patients in follow-up in clinic. All activities are directly or indirectly supervised by the attending who is personally present in the hospital.

Electives may consist of the following: colorectal surgery, interventional radiology, body imaging, nephrology, urogynecology, pathology, research, radiation oncology or medical oncology. Other electives may be considered following discussion with the Program Director. Electives will be planned in the second year.

General Goals:

Learning in the second year will focus on
a) Expand depth and scope of knowledge of urologic disease.
b) Develop problem solving skills for diagnosis of urologic conditions.
c) Refine interpersonal skills with support personnel.
d) Learn issues related to private practice of urology and managed care.
e) Gain additional expertise in a private practice setting in both inpatient and outpatient care.
f) Gain additional expertise in managing both inpatient and outpatient care at the VAMC.

General Objectives:

a) Demonstrate knowledge of fundamental principles of urologic disease and pathophysiology through didactic lectures and self-study.
b) Evaluate fund of basic urologic knowledge through the in-service exam with continued improvement in the percentage correct.
c) Present a minimum of one lecture at Urology conference.
d) Present and discuss cases at Radiology rounds, M&M conference and Tumor Board.
e) Work effectively with support personnel in urology.

Research Specific Goals:

Research will be ongoing throughout the urology residency. By the completion of the 3rd year the resident will:

a) Interpret, initiate, and complete basic urologic research.
b) Expand understanding of clinical research, including trial design, biostatistics, epidemiology and outcomes research.

Research Specific Objectives:
a) Interpret, initiate and complete a basic research project in urology either based on laboratory research or outcomes research with a scientific mentor in Urology or another Dartmouth researcher with special expertise.
b) Learn basic principles of study design and biostatistics through initiation of basic and or clinical research.
c) Work effectively with research graduate and post graduate students, laboratory technicians, managers and research colleagues.
d) Submit abstract to a regional and a national meeting.
e) Submit manuscripts for publication on at least one research topic.

PGY 4 Year
The fourth year residents usually rotate for 3 months as DH senior resident, 6 months in Concord and 3 months at the VA. As in the third year the resident has increased responsibility assigned to them each time they rotate on a service.

While assigned to a particular team residents attend clinic and operate with the attendings. Continuity of care occurs by seeing new patients in clinic, operating on patients and caring for them post op and then seeing patients return to clinic for follow-up. The resident at the VA oversees the in-patient and outpatient urology service at the VA. The resident is the operating surgeon under direct supervision on all cases. Continuity of care occurs by seeing new patients in clinic, operating on patients and caring for them post op and then seeing patients in follow-up in clinic. Non-OR activities are indirectly supervised with the attending available in the hospital.

As DH senior, the resident will additionally be in charge of the DH consult service. They are expected to supervise and coordinate care and follow up for consult patients, under the supervision of and communicating daily with the responsible consultant urologist.

Goals:
a) Expand depth and scope of knowledge of urologic diseases.
b) Develop problem solving skills for diagnosis of urologic conditions.
c) Gain experience in complex reconstructive surgery including pediatrics.
d) Expand surgical experience in oncology and laparoscopy.
e) Refine interpersonal skills with support personnel.
f) Learn issues related to private practice of urology and managed care.
g) Gain additional expertise in a private practice setting in both inpatient and outpatient care at Concord Urology and Concord Hospital.
h) Supervise inpatient and outpatient care at the VA as chief of the service with faculty supervision.
i) Compare academic practice at a multi-specialty clinic to a Veterans Medical Center.

Objectives:

a) Demonstrate knowledge of fundamental principles of urologic disease and pathophysiology through didactic lectures and self-study.
b) Refine endoscopic, open and laparoscopic surgical skills.
c) Supervise inpatient and outpatient care at the VA as chief of the service with faculty supervision.
d) Compare academic practice at a multi-specialty clinic to a Veterans Medical Center.
e) Evaluate fund of basic urologic knowledge through the in-service exam with continued improvement in the percentage correct.
f) Present a lecture at Urology conference.
g) Present and discuss cases at Radiology rounds, M& M conference and Tumor Board.
h) Work effectively with support personnel in urology.
i) Supervise and coordinate care for the consult urology service while rotating as DH senior

PGY 5 Year – Senior/Chief Resident

The Fifth year residents rotate at DHMC for 12 months. They serve as the Administrative Chief Resident for 6 months. For the additional 6 months they are assigned to the adult services at DHMC as a senior/Chief. The Administrative Chief resident oversees all three clinical services with indirect supervision. The Chief resident is given increased responsibility by the attending in caring for in patients and is ideally the operating surgeon under direct supervision on the most complex cases. Continuity of care occurs by seeing new patients in clinic, operating on patients and caring for them post op and then seeing patients return to clinic for follow-up.

Goals:

a) Obtain proficiency in entire spectrum of pathophysiology of urologic disease.
b) Mature in surgical expertise as primary surgeon.
c) Demonstrate administrative skills and responsibility in organization of the service.
d) Refine interpersonal skills with support personnel.
e) Supervision of entire resident team.
f) Refine teaching skills as a lecturer.
g) Refine interpersonal skills with support personnel.
h) The Chief Resident is responsible for the entire service. Although residents are assigned to teams during certain rotations, the chief resident will oversee the assignment of cases to insure that cases are assigned to an appropriate level resident while still allowing junior residents to have some participation in complex cases.

Objectives:

a) Master sophisticated aspects of urologic disease physiology, diagnosis and decision making in preparation for the qualifying exam (Part 1) of the Urology Boards.
b) Organize teaching conferences within the Section in conjunction with the Program Director. Administer the conferences including; publicizing the conference on a weekly basis, assigning presenters for M&M and radiology conference, submitting a list weekly to radiology of cases to be presented at Radiology conference, completing the records for all conferences and the completion of the case sheets for M&M conference and delivering them to the Residency Coordinator.
c) Develop resident call schedule and insure that the schedule is maintained to that all residents are in compliance with the ACGME rules.
d) Supervise inpatient care at DHMC as the chief of the service with indirect faculty supervision.

e) Delegate responsibilities to junior residents as appropriate.
f) Submit at least one manuscript or chapter for publication on a clinical or basis science research topic.
g) Present a minimum of 1 lecture at Urology conference.
h) Present and discuss cases at Radiology rounds, M&M conference and Tumor Board.
i) Refine surgical skills in most complex cases with a particular emphasis on oncology and laparoscopy including robotics (including radical prostatectomy – open and lap, cystectomy with cutaneous and continent diversion, partial nephrectomy, IVC thrombectomy, retroperitoneal lymph node dissection, reconstructive pediatrics).
j) Evaluate progress of urologic knowledge through in-service examination by achieving a minimum score of 70 percent.
k) Work effectively with support personnel in urology.

B) **Goals and objectives for each resident assignment – provided in detail separately**

17. Resident Rotations – see separate handout

Hitchcock A - Cancer – Drs. Seigne, Sverrisson, Schroeck, Dagrosa
Hitchcock B - Benign – Drs. Bihrle, Gormley, Grant, Gross, Moses, Pais
Pediatric Urology and Transplantation – Drs. Chavez, Morhardt and Drs. Daley and Zimmerman
VA – Drs. Schroeck, , Moses, Bettencourt and Pais + additional coverage as needed
Concord – all Concord faculty

18. Selection Process for Residency/ Eligibility/Appointment/Promotion
Selection/Eligibility

The Section of Urology adheres to the eligibility and selection policies of Dartmouth-Hitchcock Graduate Medical Education (GME) Program as outlined under their Policy and Procedures – under Eligibility Requirements.

1. Applications, along with required supporting documentation, are received via the Electronic Residency Application Service. (ERAS)
2. Applications are reviewed by Dr. Pais with assistance from other faculty, who confirms eligibility requirements, and selects applicants who are then invited for a personal interview. Interview days include interviews with faculty and house staff, program orientations, tours of the medical center, etc.
3. All DHMC/VA Urology Faculty and the Program Director of the Concord site may interview invited candidates, along with interested residents. Each interviewer then rank the candidates.
4. Criteria for evaluating and ranking candidates may include:
    a. Performance on standardized medical knowledge tests.
    b. Personal Statement, Interview and interpersonal skills.
    c. Letters of recommendation from faculty.
    d. Dean's letter.
    e. Medical school transcript and AOA membership.
    f. Extracurricular activities and accomplishments.

    At a special meeting of faculty the final ranking for the match is done by consensus. Residents are asked for input on the candidates.

19. Appointment

1. When the AUA match is announced the residents are sent a formal agreement of appointment which they are required to sign and return.

20. Promotion

1. For all residents promotion is dependent upon satisfactory evaluations and fulfillment of program and institutional requirements and as informed by the clinical competency committee.

21. Surgery Bookings

- To book an emergency case:
    a. call the OR control desk at ext. 33100. *
    b. call the Anesthesiologist on call—pager 2509
    c. call the Same Day Surgical Unit
    d. give the booking secretary, a booking sheet with the CPT code or fill out an online booking sheet in eD-H so she can book the admission reservation in the computer.
    e. do an H&P and record it in eD-H, consent the patient and send them to Pre-Admission Testing and/or Same Day.

- CPT codes are necessary to book a case, especially after hours. They are on the list of procedures on Megan's desk, in the CPT code book, in the smart sets in eD-H or on the ACGME web site

- To book an urgent case for the Operating Room for the next day:

    If before 11:30 a.m. fill out a booking sheet or fill out an appropriate online booking and notify the OR booking secretary

    If after 11:30 a.m.
        a. call OR Control Desk at X33100
        b. call the Anesthesiologist on call—pager 2509
        c. call the Same Day Surgical Unit
        d. give the OR booking secretary a booking sheet with the CPT code or fill out an appropriate online booking so she can book the admission reservation in the computer
        e. perform H&P and record it in eD-H and send patient to Pre-Admission Testing and/or Same Day.
- To book an emergency admission from the ER or clinic call the Admitting Office for availability of a room.
- **To transfer a patient to our service from another service at DHMC talk to the responsible attending.**
- **You should not get calls from outside physicians or the Transfer Center regarding transfers but if you do, do not accept a patient until you have discussed with the responsible attending.**

22. TDX

- Residents are assigned a TDX (long distance telephone access code) upon employment at DHMC. This is to be used for DHMC business. Use is monitored by GME.

23. Trips and Meetings

- Conference and meeting attendance is at the discretion of the Program Director and Section Chief. Permission should be obtained prior to submitting abstracts or registering.
- If you are presenting at a meeting the time away will not count against vacation time.
- Residents will be allowed up to $1,500 to attend/or complete online the AUA review course. These funds may not be used for other expenses. The resident will be responsible for costs greater than $1,500. Residents will not be given more than 2 days off to attend an in person review course.
  The program director or Chair may mandate that a resident use the funds in the year prior to their Chief year.
- If you are attending a meeting and not presenting, or if you are attending a course other than a review course, the amount of time that may count as vacation vs. conference time is at the discretion of the faculty.
- Attendance at residency preceptorships [SUFU, SMS or other institutions] is at the discretion of the faculty. Expense not covered by the host will be paid for at the discretion of the faculty.
- When you are attending a meeting or course you are expected to be in attendance at the meeting and you are expected to abide by DHMC policies.
- When you are requesting time away for meetings/courses check the calendar to see if others have requested time off, fill out an away request in MedHub, which will get sent to the Chief resident for approval. The Chief resident must sign off on it and assign a resident to cover you before submitting it to the Residency Coordinator for approval by the Program Director.
- Generally only 1 resident is allowed to be away from each hospital at one time.

24. Department of Surgery Resident Business Travel Policy

I. PURPOSE and SCOPE

▪ Provide guidelines for Department of Surgery Residents for travel expenses related to presentation of original scientific work originating from Dartmouth-Hitchcock and supervised by Dartmouth-Hitchcock Surgical Faculty or teaching faculty (including adjunct surgical faculty at approved ACGME rotation sites) at regional or national professional society meetings ("business-related travel"). This includes podium presentations or selected poster presentations. This policy specifically applies to Department of Surgery funds and may or may not reflect the use of Section-specific funds.
▪ Clarify that travel for scientific work performed by Department of Surgery residents when the research is based at institutions other than Dartmouth-Hitchcock and its affiliates is not generally

eligible for support from the Department of Surgery and will be considered on a case-by-case basis.

- Provide guidelines which residents will use in order to receive reimbursement for approved travel expenses that meet IRS and Dartmouth-Hitchcock requirements.

The primary responsibility for compliance with these policies rests with the residency Program Directors who are authorizing time for travel and with the individual resident as a representative of Dartmouth-Hitchcock. Residents requesting reimbursement should also keep in mind that government agencies and other observers may perceive certain expenditures as being either excessive or inappropriate.

It is the intent that this policy comply with all relevant regulatory requirements.

II. POLICY OVERVIEW

Each academic year, the Department of Surgery will budget a set amount per semester (Summer/Fall and Winter/Spring) to reimburse reasonable expenses for residents presenting original scientific research via a **podium or selected poster presentation at a regional or national meeting within the continental United States**. Reasonable expenses over the set amounts will be considered for reimbursement on a case by case basis depending on the availability of funds in the overall budget. Additional reimbursement should be discussed with the individual resident's research mentor and covered by individual program/section academic enhancement funds or mentors/senior authors. Special requests may be made to the Chair of Surgery and allowances may depend on availability of funds.

To be eligible for reimbursement, residents must be the presenting author. Work on which you are the second author or non-presenting author is not eligible for reimbursement. Only one person can be reimbursed per abstract presentation, usually the first author or the author who is presenting the abstract at the meeting. **All podium presentations are eligible. For poster presentations, preference will be given to moderated poster presentations (e.g., poster grand rounds, poster discussions).**

Pre-authorization: Only the resident invited to make the presentation is eligible for funding. Intent to travel and request for funds should happen as soon as possible after notification of an abstract's acceptance and approval by their residency Program Director to attend the meeting. Reservation requests are made by notifying the STRIVE Research Director and Program Coordinator who will review requests and reserve funds for approved presentations. The details of each request, the amount requested and reimbursed, will be tracked by the STRIVE Research Director.

A resident **MUST** submit all requests in advance through their Program Director to the Department of Surgery for their approval.

The following information is required:

- Invitation to present and/or notification of abstract acceptance from regional or national professional society
- Verification of approval from residency Program Director
- Title of presentation and authors, including designation of the presenter (for each title, specify whether it is a podium presentation or a poster)
- Name of faculty mentor or PI
- Conference name, location and dates

- Travel dates, and number of days to attend the meeting
- Proposed/estimated budget, not to exceed the amounts set forth in the Reimbursement Schedule above unless other funding exists. Justification must be provided if requesting reimbursement beyond the minimum number of days needed to deliver presentation)
- Receipt of travel award or travel grant (which should be applied fully before use of Department of Surgery funds)

- Source of overage funding (e.g., senior author, mentor, section funds, and grants)

Requests may be denied if expenditures are inappropriate or due to lack of funds.
The resident should pay for these expenses with personal funds and request reimbursement following the meeting. When planning for travel, the resident is responsible for requesting authorization by the residency Program Director to attend the meeting and for requesting pre-authorization of funds as above. After incurring the allowable expenses, reimbursement requests include proper documentation (per DH policy) and appropriate receipts which need to be submitted through Concur (via the designated residency coordinator, working with the Department of Surgery designated approver). **Itemized receipts must be submitted to receive reimbursement.**
Within reason, there is no limit to the number of meetings a resident may attend. However, the overall budget for resident travel is limited. Residents are encouraged to economize on the number of total days at a meeting and budget appropriately in order to ensure availability of funds throughout the year. **Reimbursement for expenses incurred for attendance beyond the minimum days necessary for delivering a presentation will be considered on a case by case basis provided reasonable justification is given in the request.**

Reimbursement Schedule for Resident Travel:

Location	**Selected Poster Presentation** (includes $150 limit for printing)	**Podium Presentation**
Regional Meetings (New England or within a 5 hour drive from Lebanon)	Up to $900	Up to $1,000
National Meetings (within the continental United States)*	Up to $1,350	Up to $1,500

*No international travel or travel to Hawaii or Alaska is permitted except with special approval.

Notation is made that external funding sources (e.g., grant funding, travel award) should be applied and exhausted prior to use of Department of Surgery funds. Consultation with research mentors is expected in order to use academic funds efficiently.

III. DEFINITIONS

Reimbursable Expenses: pre-authorized business-related travel and meals and poster printing will be paid by the Department of Surgery (up to the amount in the Reimbursement Schedule) if they are reasonable expenditures accompanied by appropriately itemized receipts, which may include:

- Coach Class airfare
- Ground transportation (taxis and buses only, no limos or car services; no rental cars unless separately approved)
- Standard lodging accommodations (non-luxury, modestly priced hotels unless there is a specified hotel for the conference and then the room should be booked at the lowest conference rate)
- Meals – maximum 3 per day and during time allotted for travel. Food purchased when there is a provided meal during the meeting is not eligible for reimbursement. Maximum allowable reimbursement amounts are subject to standard DH policies.
- Personal mileage (per DH guidelines)
- Parking/tolls
- Registration fees for event/conference (resident or trainee rate when possible, not to include late or onsite registration costs)
- Printing for scientific poster (as printing prices tend to vary, quotes should be sought from multiple vendors, including those with special rates for conference attendees. See reimbursement schedule for suggested price limit.)

See "Non-reimbursable Expenses" below for those travel expenses that are specifically identified by the Department of Surgery policy as ineligible for reimbursement. **Expenses for alcohol are not reimbursable.** ***A resident will be responsible for all non-reimbursable expenses incurred while traveling***.

Non-reimbursable Expenses: ***Residents will be responsible for all non-reimbursable expenses incurred while traveling***. The Department of Surgery Policy specifies that the following items are considered non-reimbursable travel related expenses (additional restrictions may apply depending on funding source):
- Airline seating upgrades or preferred boarding status
- Inflight Wi-Fi
- Alcohol
- Hotel recreational activities not covered by the base room rate (e.g. spas, health club, athletic facilities, resort fees, etc.)
- Hotel room incidentals
- Expenses related to vacation or personal days taken before, during, or after a trip
- Expenditures of any personal nature
- Expenditures for family members
- Any expense that has been or will be reimbursed from any internal or external sources

IV. PROCEDURES

Before Incurring any Business Expense

Prior to incurring any professional development travel expenses, a resident must receive approval from the sectional Residency Program Director.

To Reserve Funds

A resident **MUST** submit a request in advance through their Program Director to the Department of Surgery for approval. Once the approval is received from the Program Director, resident will

submit a detailed budget and copy of letter of invitation/confirmation of presentation to the Department of Surgery for their approval. Once the submission has been approved, the Department of Surgery will notify the resident, Program Director, and Program Coordinator of approval.

Booking Travel
All employees must use the Milne Travel platform for booking. Travel can be booked through the self-service online portal at https://www.concursolutions.com/home.asp or by working with a travel agent via phone at (603) 298-6644.

Mileage Rate Reimbursement
When the use of a personal automobile is necessary, reimbursement for its use will be made using the Federal government mileage rate per mile and within IRS guidelines. The reimbursement rate is announced annually (generally in January) and covers the resident's use of their vehicle and gasoline. ***The most current rate is indicated on the current Reimbursement Request Form***. It is the responsibility of the resident to carry adequate insurance.

Only actual miles in excess of the resident's normal commute are eligible for reimbursement. Mileage from the resident's home to normal office site is commuting cost, and not reimbursable.

In addition to the mileage rate reimbursement, a resident may be reimbursed for tolls and parking.

A resident will **not** be reimbursed for the following, even if these costs are incurred during business travel:

- Car repair
- Rental car costs during repair of personal car
- Towing charges
- Tickets, fines, or traffic violations
- Gasoline or vehicle maintenance

Receipts and Documentation
Receipts must be **original** and include the vendor name, location, date, and expense detail. Any foreign currency expense amounts should be converted to US Dollars.

It is the resident's responsibility to retain and submit **original** receipts for all expenditures regardless of amount.

Acceptable Documentation includes:
**Original Receipt

Photocopies of credit card charge slips or billing statements are not sufficient documentation, nor are tear-off stubs for meals. Meal requests must be itemized details, the credit card signature page without details will not be accepted. In the case of airfare, residents must submit their boarding pass (es). Travel itineraries do not constitute receipts for reimbursement purposes.

How to Be Reimbursed

Gather Documentation

Once the expense has been incurred, it is the resident's responsibility to retain and submit **original and itemized** receipts (faxes are not accepted) at the completion of their trip to the meeting. (Reimbursement will not be processed prior to the completion of travel)

Submit all expenses to the Residency Coordinator who will submit the e-Travel request to the Department of Surgery for approval.

It is the resident's responsibility to process all expense reimbursements **within 30-days** in order to receive reimbursement for business related expenses.

Inaccurate or incomplete reimbursements will be returned to the resident.

25. Meetings:

I. New Hampshire Urologic Society – Dinner will be provided.

- Up to twice a year in Manchester. Residents are welcome to attend. Please discuss cases suitable for presentation with one of the attending.

II. Annual American Urological Association/New England Section American Urological Association, /Others

- Residents are encouraged to submit abstracts. Generally residents are given permission to attend if an abstract is accepted. Prior to submitting abstracts for meetings outside of New England check with the Program Director/Section Chief. Approximate costs for clinic trips/meetings must be submitted with time away request.
- There are limits to what will be spent on resident travel.
  - Registration will be paid for if your abstract is accepted.
  - Economy airfare purchased 3 months prior to the trip or at the time that the abstract is accepted.
  - ½ the price of the average hotel cost for the meeting. Residents may choose to find a cheaper room elsewhere or consider sharing a room.
  - If a meal is provided as part of the meeting we will not reimburse for that meal if the resident chooses not to eat at the conference.
  - Receipts MUST accompany reimbursement request. (Expenses incurred without receipts will not be reimbursed.)
  - We will not reimburse penalties for late registration, alcohol, movies, telephone calls, athletic events, valet parking, other personal expenses or expenses incurred by anyone other than yourself.
  - Residents are to pay all expenses upfront. DHMC will reimburse them once they have submitted all receipts to the Residency Coordinator.

- **Mileage to and from Concord is not reimbursed. Concord is responsible to provide you with housing for each of the 3 month rotations.**

26. Vacation/Time Away

- Residents are allowed three weeks of vacation consisting of 15 business days and 6 weekend days.
- Prior to requesting time away in MedHub, residents must confirm with the administrative chief that no other time off has already been granted.
- Residents must spread their vacation days throughout the year. Ideally one week should be taken every 4 month block. Residents should also be mindful of how much vacation they take on one rotation.
- By July 31, 2022 all residents must put in a vacation request for at least 5 consecutive vacation days that will be taken prior to Dec 31, 2022.
- By Jan 29, 2023 all residents must put in a vacation request for at least 5 consecutive vacation days that will be taken prior to June 14, 2023.
- The remaining 5 days may be requested throughout the year by submitting a vacation request form with the MedHub system at least 30 days in advance in order to address clinic schedules. Only one resident's request will be approved at a time, unless extenuating circumstances exist. Preference will be given to residents who submit early and who request consecutive days off. Residents will discuss the request with the administrative chief resident before submitting the request. When a resident at the VA puts in for time away the chief resident will assign another resident to cover that service and this will be noted on the time away request.
- It is the expectation that all residents (including Chief Residents) will work up to July 1st at their present PGY level, unless they have requested and have been preapproved for vacation. Residents who elect to take time off that is not preapproved will do so without compensation.
- Vacation requests for the 1st two weeks of July or the last 2 weeks of June – **may not** be granted particularly if no faculty are away.
- The faculty **may** elect to give residents additional time off between Christmas and New Year. This is typically decided in November.
  - The same number of days will be granted to the Concord Resident.
- Time off for interviews for fellowships/jobs is given at the discretion of the faculty. These may not occur during the last 3 weeks of June or the first 2 weeks of July
  - To ensure that this is logged correctly in MedHub email your request to the chief resident and PD and copy the PC. Once approved, the PC will then add it to the schedule using the "alternate activity" functionality.

27. Flex time / Sick / Personal Days

- Flex Time is intended to assist Residents in dealing with brief and unexpected life and personal issues (such as health or family emergencies).
- Flex Time is not intended to extend approved vacation time or holidays, to substitute for unapproved vacation time or holiday requests, to avoid work assignments (such as case coverage, night or weekend shifts), or to replace the use of any other leave covered in this policy for which the Resident is eligible.
- All Residents are eligible to use up to five (5) paid Flex Time days per year.
- Flex Time cannot be used in increments of less than one full day. Unused Flex Time does not carry over to the following year.

- A Resident who wishes to use Flex Time must submit a written request to the Program Director or designee and notify the chief resident and the attending they are scheduled to work with (if applicable). If the unexpected nature of the need for the Flex Time prevents the Resident from submitting a written request in advance, the Resident must submit a written request to designate the time missed as Flex Time as soon after the event as possible.
- Each program will outline the process for Flex Time requests in the program's specific Time Away Policy.
- A Resident is not required to reveal why the Resident wishes to use Flex Time; however, a Resident may voluntarily choose to share why the Resident wishes to use the Flex Time, and the Program Director or designee can factor this voluntarily self-disclosed information into the decision whether or not to approve use of Flex Time.
- Generally speaking, Program Directors or designees will approve in writing all requests for the use of Flex Time unless a request is not consistent with the intended purposes of Flex Time (see above) or the program cannot accommodate the time away due to patient care needs. If a Program Director or designee denies a Resident's request to use Flex Time, the Program Director or designee will notify the Resident in writing of the reason for the denial and will courtesy copy the GME office on that communication.

ABU Leave of Absence Policy

Leaves of absence: Each program may provide sick leave and vacation leave for the resident in accordance with the institutional policy. The leave of absence policy of the Board for a given candidate will be what the policy is or guidelines are at his/her institution. Each program may provide sick leave and vacation leave for the resident in accordance with institutional policy. However, a resident must work forty-six (46) weeks each year of residency. 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, for a total of 92 weeks required. One year of credit must include at least forty-six weeks of full-time urologic education. Vacation or leave time may not be accumulated to reduce the total training requirement.

If a circumstance occurs in which a resident does not work the required forty-six weeks, the Program Director must submit a plan to the ABU for approval on how the training will be made up, which may require an extension of the residency.

Leave for educational/scientific conferences are at the discretion of the program director.

28. Visiting Professors

The Section of Urology traditionally hosts 1- 2 Visiting Professors each year. The Urology Residents are expected to prepare and present cases of interest. Cases must be discussed with the appropriate attending prior to presentation. The Urology Residents are expected to attend dinner with the Visiting Professor on one evening during his/her visit.

29. Vendor Sponsored Meals and Gifts

Purpose and Scope

This policy establishes practice regarding:

- The provision of food/meals by the pharmaceutical, medical device industry or any other vendors to employees of Dartmouth-Hitchcock Clinic or Mary Hitchcock Memorial Hospital
- The acceptance of gifts, regardless of value, by any Dartmouth-Hitchcock Clinic or Mary Hitchcock Memorial Hospital employee from any pharmaceutical, medical device, or other vendor

Policy

- The provision of food, in the form of "snacks" or full meals, and the acceptance thereof by any employee of Dartmouth-Hitchcock on any Dartmouth-Hitchcock campus is strictly prohibited. This includes the VA.
- The acceptance of gifts or trinkets of any kind, regardless of value, is prohibited at all times. This includes dinners that are not part of a CME accredited symposia or in conjunction with a CME accredited meeting.
- Employees are reminded that governmental agencies may be monitoring and publishing documented instances of gift giving (including meals) to physicians and/or others.

For full details, please go to the Clinical Policy Library on the DHMC Intranet Vendor-Sponsored Meals and Gifts policy.

31. Appendix: Dress Code Policy

Part of the DHMC mission is to make patients and their families comfortable and that they are being treated and/or helped by responsible and mature adults. Personal cleanliness and neatness of employees is essential due to contact with patients, visitors and other employees. Extreme hair color, certain tattoos, non-professional clothing, and visible body piercings- other than earrings- can create such an impression and will be deemed to be inappropriate.
NH State Law requires health-care providers, and others who come into direct contact with patients, must wear identification that includes name, licensure status and staff position. All employees are required to wear their DH photo ID during all working hours. In the event an employee is neglectful in the following guidelines, they may be asked by their supervisor to return home to change immediately.

For Patient Care Providers:

- Nails should be neatly trimmed, clean and not excessively long
- Closed toed shoes
- Jewelry should not interfere with job duties

Civility

The section of Urology insists upon a policy of civility and mutual respect. All interactions with patients and all members of the larger healthcare team, including nurses, referring providers, consultants, therapists, and all support staff must reflect the cardinal principles of respect, fairness, trust, cooperation, and mutual support. This applies to all forms of interaction—in person, by phone, or other electronic means of communication. Urologists have enjoyed a reputation as kind, compassionate, collegial, and collaborative surgeons. Behavior which diminishes this reputation will not be tolerated. We are committed to fostering a cohesive and inclusive atmosphere and workplace for all.