# Urology Residency Policy Manual
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Welcome
Welcome to the University of Connecticut program in urology. The program is designed to provide training in all facets of urology and prepare you for the general practice of urology or for additional training in a fellowship program. This policy manual has been developed as a guide and resource for you to use throughout your training. It provides answers to most of the commonly asked questions and concerns. The manual outlines our expectations of you and what you can expect from the program. This manual supplements the General Medical Education manual that outlines policies and procedures that must be followed by all residents in University of Connecticut residency programs. This manual can be found on Blackboard.

Mission Statement
The University of Connecticut Program in Urology’s mission is to promote excellence in education, research and clinical practice and insure competence in the ability to practice urology safely, ethically and effectively. The program will help facilitate residents’ professional and personal growth during the time spent in the training program. Throughout each of the four years each resident is expected to achieve the following general goals and objectives:

1) Patient Care – Residents are expected to develop the ability to deliver care that is compassionate, appropriate and effective for the treatment of problems encountered in general urology practice and for the promotion of appropriate preventive measures practiced by urologists. Urology residents must develop and execute patient care plans appropriate for their level of training and develop manual surgical skills that progress with their level of training.

2) Medical Knowledge – Residents are expected to master the established and evolving biomedical, clinical and cognate (e.g. epidemiological and social-behavioral) sciences as outlined in the urology core curriculum and be able to apply this knowledge to patient care. Residents are also expected to develop the skills needed to contribute to and critique medical literature.

3) Practice Based Learning and Improvement – Residents are expected to assess their own ability to deliver patient care including both clinical and surgical outcomes. They are expected to develop the skills that permit lifelong learning in medicine.

4) Interpersonal and Communication Skills – Residents are expected to develop the necessary skills that result in effective information exchange and collaboration with attending physicians, their resident colleagues, patients, their families and other health professionals.

5) Professionalism – Residents are expected to commit themselves to carrying out their professional responsibilities, adhere to ethical principles, and be sensitive to a diverse patient population. As professionals, residents are expected to maintain high standards of ethical behavior, demonstrate a commitment to patient continuity of care, and become sensitive to age, gender and cultural differences among patients and other health care professionals.

6) Systems-Based Practice – Residents are expected to develop an increasing awareness of and response to the larger system of health care delivery. Residents are expected to call on resources of the entire health care delivery system to provide optimal care. Urology residents are expected to practice high quality cost effective patient care, demonstrate an understanding of risk-benefit analysis, and recognize the roles of different specialists and other health care professionals in overall patient management.
The University of Connecticut Program in Urology program will strive to continually improve the program to address and meet the healthcare needs of the citizens of Connecticut. The program will incorporate appropriate curricula, evaluation, and resident supervision and will support safe and appropriate patient care. The urology program will incorporate information and evaluation systems for clinical and educational activities and integrate the expertise and perspectives of both university and community-based faculty. The urology program will also provide appropriate support services to residents to establish a safe and healthy learning and working environment.
Compact between Faculty and Graduate Medical Trainees
(Adopted from the AAMC guidelines)

Preparation for a career in Medicine demands the acquisition of a large fund of knowledge and a host of special skills. It also demands the strengthening of those virtues that embody the doctor/patient relationship and that sustain the profession of Medicine as a moral enterprise. This compact serves both as a pledge and as a reminder to teachers and learners that their conduct in fulfilling their mutual obligations is the medium through which the profession inculcates its ethical values.

The teacher-learner relationship between faculty and medical learners - students, residents, and fellows - should demonstrate the highest standards of ethical conduct in all educational settings and be conducted without abuse, humiliation, harassment or exploitation of relationships for personal gain or advantage.

GUIDING PRINCIPLES:

DUTY - Medical educators have a duty not only to convey the knowledge and skills required for delivering the profession’s contemporary standard of care, but also to instill the values and attitudes required for preserving the medical profession’s social contract across generations.

INTEGRITY - The learning environments conducive to conveying professional values must be suffused with integrity. Medical learners gain enduring lessons of professionalism by observing and emulating role models who epitomize authentic professional values and attitudes.

RESPECT - Fundamental to the ethic of Medicine is respect for every individual. Mutual respect between learners, as novice members of the medical profession, and their teachers, as experienced and esteemed professionals, is essential for nurturing that ethic. Given the inherently hierarchical nature of the teacher/learner relationship, teachers have a special obligation to ensure that students are always treated respectfully.

COMMITMENTS OF FACULTY - As members of the faculty, we agree to do our utmost to ensure that all components of the educational program for medical learners are of high quality. As mentors for our learner colleagues, we maintain high professional standards in all of our interactions with patients, colleagues, and staff. We respect all learners as individuals without regard to gender, race, national origin, religion, or sexual orientation; we will not tolerate anyone who manifests disrespect or who expresses biased attitudes towards any medical learner. We recognize that personal wellness is important; therefore we support our learners’ needs to have sufficient time to fulfill personal and family obligations, enjoy recreational activities, and obtain adequate rest. We will nurture both the intellectual and the personal development of our learners. We do not tolerate any abuse or exploitation of medical learners.

COMMITMENTS OF STUDENTS, RESIDENTS, & FELLOWS - We agree to do our best to acquire the knowledge, skills, attitudes, and behaviors required to fulfill all educational objectives established by the faculty. We cherish the professional virtues of honesty, compassion, integrity, fidelity, and dependability. We will respect all faculty members and all students as individuals without regard to gender, race, national origin, religion, or sexual orientation. As physicians in training, we embrace the highest standards of the medical profession and will conduct ourselves accordingly in all of our interactions with patients, colleagues, and staff. In fulfilling our own obligations as professionals, we will assist our fellow students and residents in meeting their professional obligations.

COMMUNICATION BETWEEN FACULTY AND STUDENT - We encourage any medical learner or faculty member who experiences mistreatment or who witnesses unprofessional behavior to report the facts immediately to appropriate faculty or staff; we treat all such reports as confidential and do not tolerate reprisals or retaliations of any kind. Any documented unprofessional behavior will be referred to the appropriate Department Chair/Education Director for further action.

I agree to this Compact.

_________________________________________  _______________________
Name (print) and signature       Date

____ Resident/Fellow
____ Faculty/Attending Physician

_________________________________________
Program/Department
Urology Residency Structure and Administration

Accreditation
The University of Connecticut Residency Program in Urology is accredited by the Accreditation Council for Graduate Medical Education (ACGME). The Program was last reviewed in 2009 and received a five year accreditation with no citations. The Program now participates in the new accreditation system developed by the ACGME.

Participating Institutions
The University of Connecticut School of Medicine residency program in Urology has affiliated with four Hartford area hospitals for the education of residents and fellows. These hospitals include John Dempsey Hospital, Connecticut Children’s Medical Center, Hartford Hospital, and St. Francis Hospital and Medical Center. These hospitals belong to the Capital Area Health Consortium (CAHC). CAHC has been contracted by the sponsoring institution to be the administrator of salary and benefits for all residency and fellowship programs, in addition to working closely with the GME office and participating on GME committees.

Residency Leadership
Program Director        Peter Albertsen, MD, MS
Program Coordinator     Debbie Savino

Site Directors
John Dempsey Hospital   Brooke Harnisch, MD
CCMC                    Eric Nelson, MD
Hartford Hospital       Stuart Kessler, MD
St. Francis Hospital    Hugh Kennedy, MD

Core Faculty
Oncology                John Taylor, MD
Female Urology          Philip Smith, MD
Robotics                Carl Gjertson, MD
Stone Disease           Carl Gjertson, MD
Andrology Male Infertility, Impotence Brooke Harnisch, MD
Pediatrics              Eric Nelson, MD
General Urology/Research Peter Albertsen, MD, MS

Urology Residency Education Committee
The Urology Residency Education Committee insures that the objectives of the ACGME and the Urology Residency Review Committee of the ACGME are being met.

The Urology Residency Education Committee is chaired by the Program Director. Membership on the committee includes the core faculty (full time faculty at the University of Connecticut) and each of the site directors at the three affiliated hospitals. The committee meets every summer to review the program evaluation and faculty evaluation by the residents. It also meets in the fall to select resident applicants.
**Urology Clinical Competency Committee**
The Urology Clinical Competency committee is chaired by Dr. Eric Nelson. Membership on the committee includes the program director and each of the site directors. The Clinical Competency Committee meets after each 10 week rotation to review resident evaluations by the faculty and to determine whether residents have satisfied the milestones established for the rotation. At the end of each year the committee determines whether residents have progressed sufficiently within the year to be promoted from junior to senior status and to graduate from the program.

**Resident Eligibility & Selection**
The Urology Residency Program selects residents from eligible applicants on the basis of preparedness, ability, aptitude, academic credentials, communication skills, personal qualities such as motivation and integrity, and other factors. Applicants to the University of Connecticut Program in Urology are expected to submit their applications to ERAS. The University of Connecticut School of Medicine does not discriminate with regards to gender, race, age, religion, color, natural origin, disability, or any other applicable legally protected status.

The Program Director, along with the Urology Residency Education Committee, selects residents to the urology program. The Urology Residency Program participates in the AUA matching program for the URO 1-4 positions and the National Residency Matching Program (NRMP) for the PGY1 program in general surgery. Residents must meet the eligibility requirements listed below as the minimum standard. All residents who successfully match with the University of Connecticut Program in Urology will be guaranteed a position as a PGY1 resident in University of Connecticut Program in General Surgery.

The GME office is responsible for issuing all letters of appointment (contracts). In order to issue a contract, the Program Director sends a written request to the GME office along with the application materials for the resident showing that all criteria for appointment have been met. The GME office will verify credentials, request additional information, if needed (e.g. gaps in CV, better documentation, etc.), and confirm that the numbers of trainees in the program are approved and salary and benefits are available. The GME office will issue a letter of appointment for all eligible residents that describes the terms and conditions of appointment to the Urology program. The letter of appointment will outline the resident’s responsibilities, duration of appointment and conditions of reappointment, including timing required for non-renewal or non-promotion. The policies on due process (grievance), liability, health insurance, leaves of absence, duty hours, moonlighting, counseling, impairment, harassment, disabilities, and program closure or reductions are outlined in the letter of appointment and are fully described in the policy handbook that is provided to all residents at the start of their training program. No resident will be required to sign non-compete guarantees.
Applicants must meet one of the following qualifications to be eligible for appointment to the Urology residency program:

a. Graduate of U.S. or Canadian medical school accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA).

b. Graduate of a foreign medical school with:
   1. A valid ECFMG certificate only with J-1 visa sponsorship. (University of Connecticut-sponsored residency/fellowship programs do NOT sponsor H1b visas.)
   2. Completion of Fifth Pathway Program provided by a medical school accredited by the LCME or –
   3. A full and unrestricted license to practice medicine.

Applicants must fulfill the following requirements to be admitted to the residency:

a. Passed USMLE Step 1.

b. Passed USMLE Step 2.

c. Met all requirements of ECFMG

**Resident Evaluation**

Residents are evaluated by faculty members at the rotation site at the completion of each 10 week rotation. Residents are evaluated on each of the 31 milestones. Evaluations are submitted to the Urology Clinical Competency Committee for review. Every six months the Program Director meets with each resident individually to review evaluations and other pertinent material such as the in-service examination scores and operative logs. Residents are required to record every surgical procedure performed on the operative log software maintained by the ACGME. The Program Director will review these logs at the end of each 10 week rotation. Residents should monitor their performance against the minimum standards needed for graduation from the program. At the completion of the program, residents must attest to the completeness and accuracy of their operative logs for the entire four year program.

**Faculty and Program Evaluation**

Residents must evaluate the faculty and the program annually. The Program Director will ask residents to submit their evaluations of core faculty and the program as a group exercise so that each individual resident evaluation will remain anonymous. The faculty will use resident evaluations to modify and improve the program. Resident evaluations will also guide the development and implementation of program improvement projects.

**Resident Promotion and Graduation**

Residents performing satisfactorily on each of the required rotations can expect to have their contract renewed annually. If the Program Director, in conjunction with the Urology Clinical Competency Committee, determines that a resident is not progressing as required in any or all of the six ACGME core competencies as needed to warrant continuation in the program a remediation program will be developed by the Program Director. If attempts at remediation do not succeed, non-renewal of the annual contract or non-promotion may occur. The Program Director, along with the Urology Clinical Competency Committee, must notify the resident and the GME office of the decision. In the case of non-renewal, the resident will be given the option to resign. In both cases, the resident will be informed of the right to appeal this decision.
The Program Director is responsible for submitting a list of names of residents who have progressed satisfactorily in all of the six ACGME competencies before March 1st of each academic year. The GME office will review this list for completeness and make sure that there is not conflicting information. A continuing letter of appointment (contract) will be issued by the GME office to the residents on the list once it is determined to be accurate.

In order to enter the urology residency program at the University of Connecticut School of Medicine, a resident must have passed USMLE Step 3. In order to graduate from the urology residency program at the University of Connecticut School of Medicine, a resident must have completed the Institutional Curriculum sponsored by the office of graduate medical education; and completed the formal exit requirements of the Capital Area Health Consortium.

**Educational Program**

The University of Connecticut Program in Urology strives to create an educational environment that allows residents to attain the technical and intellectual skills necessary to become professionally trained urologists and the educational skills that foster a career of lifelong learning. The program provides each resident with a core knowledge base in each of the domains of urology including: andrology, male infertility, impotence, calculus disease, urinary obstruction, endourology, extracorporeal shock wave lithotripsy, neuro-urology, urodynamics, female urology, pediatric urology, infectious diseases, transplantation, adrenal disorders, trauma and oncology. Through a series of structured rotations, the program provides training for each resident in basic office and operative skills needed to become a proficient urologist. This includes training in endoscopic surgery, open pelvic surgery, flank surgery, laparoscopic and robotic surgery. Through journal clubs, grand round presentations and topic oriented seminars, the program fosters an environment that encourages the search for new information and that teaches the skills necessary for continuous self-improvement.

The long-term goal of the program is to prepare individuals to be competent and compassionate urologists who can compete successfully for additional fellowship training or pursue practice in a community setting. The program also strives to expose residents to the research environment with the hope of stimulating some to enter the field of academic urology and encouraging those entering clinical practice to participate in clinical research.

To accomplish these goals the residency consists of a preliminary year in general surgery followed by four years of training in urology. During the general surgery year the resident is trained in basic surgical skills and gains knowledge and experience in the care of patients in the pre and post operative environment. Rotations include general surgery, trauma, intensive care management and outpatient care.

The urology education program is divided into 2 two year segments: junior rotations and senior rotations. Both of the junior and senior rotations are divided into five 10 week blocks. Every resident will rotate through these blocks twice at both the junior and senior level before their education is completed. Each of the hospital rotations has specific goals and objectives along with milestones that must be completed before the resident can advance from junior to senior status or from the senior status to graduation.
The didactic component of the residency consists of three core conferences usually conducted on Thursdays. Thursday mornings begin with grand round presentations. These are followed by topic specific seminars drawn from the urology core curriculum. One evening per month is devoted to journal club which focuses on basic statistical and epidemiologic concepts and trains the resident to critique medical literature. During the summer months residents receive intensive instruction in radiology, pathology, statistics and epidemiology in lieu of grand round conferences.

Pre – Urology Resident Education
A preliminary year of training in general surgery is offered by the University of Connecticut Program in general surgery. During this preliminary year the resident is expected to become familiar with basic surgical principles and attitudes. Didactic teaching consists of a weekly surgical conference. Practical surgical skills are taught during rotations concentrating on general surgery, vascular surgery, cardio-thoracic surgery, trauma, and the intensive care unit. While on these rotations, the first year resident is expected to become proficient in the management of patients in the inpatient setting. This includes the pre-operative evaluation, post-operative care and the management of patients in an acute health care delivery setting such as the emergency room or the surgical intensive care unit. Operative assignments include basic surgical procedures such as hernia repair, abdominal incisions, and appendectomy.

Urology Education
During the first two years of training the urology resident is expected to become familiar with common urological problems, terminology, procedures and diagnostic studies. This is accomplished by having residents rotate twice through 5 ten week rotations. During the first rotation the resident is expected to become familiar with the key milestones associated with each module. After completing the second rotation, the resident is expected to have mastered these key milestones. Mastery of the milestones allows the resident to progress to the next level of training. Each of the two junior years of training will include 1 ten week rotation each at John Dempsey Hospital, Connecticut Children’s Medical Center, St. Francis Hospital and 2 ten week rotations at the Hartford Hospital.

During the second two years of training the urology resident is expected to function at a senior level. At this level the resident is expected to master complex surgical procedures and be familiar with peri-operative care and the management of outpatient urological problems. A senior resident is expected to function with increasing independence and require less direct supervision. Once again residents rotate twice through 5 ten week rotations. During the first rotation the resident is expected to become familiar with the key milestones associated with each module. After completing the second rotation, the resident is expected to have mastered both clinical and surgical skills so that the resident can provide proficient urological care in an unsupervised setting.

Specific goals and objectives for each of the urology ten week rotations: Each of the two senior years of training will include one, ten week rotation at John Dempsey Hospital and Saint Francis Hospital and two, ten week rotations at Hartford Hospital. One, ten week block will include three weeks at the other hospitals and three weeks elective time.
Urology Junior Years – Expectations at all five rotations
Perform a detailed and comprehensive history and physical examination.
Demonstrate a familiarity with basic diagnostic tools utilized in urology such as cystoscopy, rectal ultrasound, bladder scan, and diagnostic radiology including a CT examination, renal and scrotal ultrasound examinations, MRI examinations and nuclear medicine studies.
Demonstrate a familiarity with urological pathology.
Demonstrate a familiarity with urological trauma and urological emergencies such as renal colic, hematuria, testicular torsion, blunt and penetrating renal trauma, pelvic fracture, urinary retention, and urinary infections of the bladder, kidney, testis and prostate.
Demonstrate a familiarity with outpatient urological problems such as urinary obstruction, urinary frequency, urinary tract infections, hematuria, renal and ureteral stone disease, prostate problems including an elevated serum PSA, sexually transmitted diseases, impotence, prostatitis, renal cysts, renal masses, spinal cord injury and psychic conditions.

John Dempsey Hospital
Residents at JDH will be expected to demonstrate a familiarity with the ambulatory environment, female voiding dysfunction including a focused pelvic examination, the performance and evaluation of urodynamic studies, and the performance of basic surgical procedures for female voiding problems. Residents should develop familiarity with the evaluation and management of the infertile male. Residents will also demonstrate a familiarity with outpatient procedures such as transrectal ultrasound and biopsy, cystoscopy, and bladder scan.
Residents should develop proficiency in the surgical techniques involved with managing renal and ureteral stones

Connecticut Children’s Medical Center
Residents at CCMC will be expected to demonstrate proficiency in the evaluation and management of common outpatient and inpatient pediatric urological problems. This includes exposure to procedures such as urodynamics, hypospadias repair, orchidopexies and ureteral implants. The resident will also be expected to develop a familiarity with basic diagnostic tools utilized in pediatric urology such as cystoscopy, bladder scan, and diagnostic radiology including voiding cysto-urethrogram, CT examination, ultrasound and nuclear medicine studies.
Demonstrate a familiarity with pediatric urological trauma and urological emergencies such as flank mass, testicular torsion, blunt and penetrating trauma, and urinary infections of the bladder and kidney.
Demonstrate familiarity with common outpatient urological problems such as urinary obstruction, posterior urethral valves, urinary frequency, urinary tract infections, ureteral reflux, hematuria, renal masses, and congenital abnormalities such as meningomyelocele, hypospadius and undescended testis.
Demonstrate proficiency in performing common pediatric studies such as cystoscopy and urodynamic studies.
St. Francis Hospital
Residents at St. Francis will be expected to demonstrate a familiarity with the following urologic procedures: scrotal surgery and hydrocelectomy, circumcision, transurethral surgery, ureteral endoscopy and lithotripsy, and management of urological trauma. Learning at St. Francis is done in a less intense and more protected environment allowing for increased one to one mentoring between residents and the attending staff.

Hartford Hospital (track 1)
Residents in track 1 will be expected to demonstrate a familiarity with the following urologic procedures: scrotal surgery and hydrocelectomy, circumcision, transurethral surgery, ureteral endoscopy and lithotripsy, and management of urological trauma.

Hartford Hospital (track 2)
Residents in track 2 will be expected to demonstrate a familiarity with minimally invasive surgical techniques including training in the simulation laboratory at the Hartford Hospital.

Key Milestones
At the completion of the first two years of training a urology resident is expected to have achieved the following milestones (rated Level 2 or higher) in each of the six core competencies:

1) Patient Care
   a. Gather information by interviewing the patient or surrogate and performing a physical exam
      i. Acquires general history from patient and able to elicit genitourinary complaint
      ii. Performs an accurate physical exam
      iii. Acquires accurate relevant history in a customized, prioritized fashion
   b. Use diagnostic tests and procedures, including performance and interpretation of imaging studies
      i. Selects and orders appropriate diagnostic and imaging tests
      ii. Selects tests appropriate to a patient's genitourinary complaint
   c. Generate a differential diagnosis
      i. Creates a differential diagnosis
      ii. Includes common causes of urologic complaints
   d. Develop a patient care plan, including medical, surgical, and/or radiologic interventions. Counsel preoperative patients regarding treatment options. Discuss risks, benefits and alternatives that make up the informed consent process. Counsel patients regarding potential short and long term impact of interventions on quantity and quality of life, as applicable. Adapt initial plan as sub-acute or chronic conditions evolve.
      i. Develops rudimentary plan for routine clinical problems
      ii. Understands basic elements of informed consent
      iii. Counsels patients for routine low risk procedures
e. Perform intra-operative and post-operative management of patients, including recognition and treatment of physiologic alterations and complications.
   i. Identifies alterations in normal physiology
   ii. Identifies common intraoperative and post-operative complications
   iii. Manages common complications
f. Perform open surgical procedures
   i. Closes routine urologic procedures
   ii. Performs routine surgical procedures such as moderate hydrocele or circumcision
g. Perform endoscopic procedures of the upper and lower urinary tract
   i. Cystoscopy including stent placement
   ii. Bladder biopsy
   iii. Ureteroscopy
h. Perform laparoscopic/robot-assisted surgical procedures (examples listed)
   i. Hold and manipulate laparoscope for simple renal procedures
   ii. Function as first assistant for a laparoscopic nephrectomy
i. Perform office base procedures
   i. Performs routine outpatient procedures such as remove drains, sutures, staples
   ii. Performs flexible cystoscopy
2) Systems Based Practice
   a. Work effectively within and across health delivery systems
      i. Identifies patient issues that are beyond the residents’ scope and abilities that may require consultation
      ii. Places consults for non-urologic issues affecting individual patients
      iii. Reconciles medications at transfer
   b. Incorporates cost awareness and risk benefit analysis into patient care
      i. Recognizes concept of risk-benefit analysis
      ii. Identifies basic laboratory and radiographic tests
      iii. Knows common socio-economic barriers that impact patient care
      iv. Knows relative costs of frequently used diagnostic and therapeutic procedures
   c. Works in inter-professional teams to enhance patient safety
      i. Recognizes teamwork and communication failures
      ii. Identifies critical incidents
      iii. Identifies near misses and preventable medical errors
      iv. Describes tools such as check lists, briefings to prevent adverse events
d. Uses technology to accomplish safe health care delivery
   i. Can use an electronic medical record and a computerized order entry system
   ii. Demonstrates efficiency in accomplishing repeated tasks
   iii. Understands the risks of using defaults and cut and paste strategies to create notes
3) Practice Based Learning
   a. Improves via feedback and self-assessment
      i. Accepts feedback from faculty members and other residents
      ii. Accepts criticism from nurses and other professionals and changes behavior
   b. Learns and improves by asking and answering clinical questions from a patient scenario
      i. Recognizes general information deficits
      ii. Identifies specific information needs and consults literature for specific management options
   c. Acquires the best evidence
      i. Uses general search engines to find information
      ii. Uses specific search engines such as library databases to identify appropriate treatment of specific entities
   d. Appraises the evidence for validity, impact and applicability
      i. Can identify well designed, randomized control trials
      ii. Can differentiate between experimental study designs
      iii. Understands the basics of confounding, randomization, blinding and hierarchy of evidence
   e. Applies the evidence to decision making for individual patients
      i. Uses information obtained at Grand Rounds to make treatment recommendations to patients
      ii. Reviews clinical setting and inclusion criteria of a trial to determine if it is applicable to a clinical situation.
   f. Improves quality of care for a panel of patients
      i. Demonstrates general appreciation of need to constantly improve quality and safety
      ii. Demonstrates commitment to providing high quality care
   g. Participates in the education of other team members
      i. Fully participates in required didactic activities
      ii. Actively participates in teaching conferences
4) Interpersonal Communication Skills
   a. Communicates effectively with patients and families with diverse socioeconomic and cultural backgrounds
      i. Demonstrates sensitivity to patients’ cultures
      ii. Exhibits acceptable communication skills during medical interviews, counseling and education, and hospitalization
   b. Effectively counsels, educates and obtains informed consent
      i. Provides limited information, minimal therapeutic advocacy and general risk
      ii. Consistently checks for patient understanding and invites questions
c. Communicates effectively with physicians, other health professionals, and health-related agencies
   i. Can communicate and document basic information regarding a patient’s urologic problem
   ii. Exhibits skills in some cases. May include non-essential information

d. Communicates effectively during care transitions and consultations with fellow residents
   i. Demonstrates ability to summarize and transfer key information
   ii. Capably uses one form of communication and invites questions and seeks advice

e. Works effectively as a member or leader of a health care team or other professional group
   i. Communicates and listens with sensitivity and respect
   ii. Consistently engages in basic communication and interpersonal behaviors that facilitate effective teamwork

5) Professionalism
   a. Adheres to ethical principles
      i. Recognizes examples of limiting task selection among more senior residents
      ii. Asks for assistance when taking on tasks beyond the residents’ ability
   b. Demonstrates compassion, integrity and respect for others
      i. Recognizes and reflects in writing on both positive and negative witnessed examples of compassion and integrity
      ii. Usually displays respectfulness and compassion
   c. Demonstrates responsiveness to patient needs that supersede self interest
      i. Recognizes and reflects in writing on both positive and negative examples of physicians’ responsiveness to patients
      ii. Usually follows through with patient care obligations
   d. Demonstrates respect for patient privacy and autonomy
      i. Recognizes and reflect in writing on both positive and negative examples of physicians’ respect for privacy
      ii. Usually maintains patient confidentiality
   e. Demonstrates accountability to patients, society and the profession
      i. Demonstrates importance of record completion
      ii. Demonstrates importance of compliance and improvement
   f. Demonstrates sensitivity and responsiveness to diverse populations, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
      i. Recognizes situations that raise cultural and diversity issues
      ii. Usually sensitive to cultural and other patient diversity matters

6) Medical Knowledge – Achieves a score of at least 45% on the AUA Resident In Service Exam
Urology Senior Years – Expectations at all five rotations
As a senior resident, each resident will serve as the Chief Resident at each of the 4 participating hospitals. Emphasis is placed on mastering specific surgical skills that will allow residents to practice independently once they have completed their training. Two senior residents will serve at the Hartford Hospital. One resident will rotate on track 1 which will concentrate training on flank procedures including nephrectomy and nephroureterectomy. The other resident will rotate on track 2 which will concentrate training on pelvic procedures including cystectomy and prostatectomy. Residents are expected to become proficient in open, laparoscopic and robotic techniques. The Chief resident at St. Francis Hospital is expected to participate in all major urological procedures and will gain confidence and proficiency working under the mentorship of the St. Francis attending physicians. The Chief resident at the Connecticut Children’s Medical Center is expected to participate in complex reconstructive procedures, common pediatric procedures such as hypospadius repair, ureteral reimplantation and hydrocelectomy, and more complex outpatient management procedures. The Chief Resident at John Dempsey Hospital receives training in flank procedures such as nephrectomy, pelvic procedures such as cystectomy and prostatectomy, endoscopic procedures such as percutaneous nephrolithotomy, laparoscopic nephrectomy and transurethral procedures such as resection of the prostate and resection of bladder tumors. In the outpatient setting the Chief resident is expected to become proficient in transrectal ultrasonography and biopsy and vasectomy. Finally, the Chief resident at John Dempsey Hospital is expected to become proficient at basic organizational and management tasks. This includes tasks such as organizing call schedules, vacation schedules, grand rounds topics, journal club articles and gathering complications for morbidity and mortality conference.

Specific Goals and Objectives – All 5 rotations
Perform a detailed and comprehensive history and physical examination of complex urology patients. Synthesize the information gathered into a diagnosis and develop an appropriate treatment plan.

Master basic diagnostic tools utilized in urology such as cystoscopy, rectal ultrasound, and bladder scan. Develop the ability to interpret diagnostic radiology studies including a CT examination, renal and scrotal ultrasound examinations, MRI examinations and nuclear medicine studies.

Master basic urological pathology.

Diagnose and manage urological trauma and urological emergencies such as renal colic, hematuria, testicular torsion, blunt and penetrating renal trauma, pelvic fracture, urinary retention, and urinary infections of the bladder, kidney, testis and prostate.

Diagnose and manage outpatient urological problems such as urinary obstruction, urinary frequency, urinary tract infections, hematuria, renal and ureteral stone disease, prostate problems including an elevated serum PSA, sexually transmitted diseases, impotence, prostatitis, renal cysts, renal masses, spinal cord injury and psychic conditions.
**John Dempsey Hospital**
Master care in the ambulatory environment including office urology, male and female voiding dysfunction, the performance and evaluation of urodynamic studies.
Master outpatient procedures such as transrectal ultrasound and biopsy, cystoscopy, vasectomy and bladder scan.
Master surgical techniques involved with managing renal and ureteral stones including percutaneous nephrolithotomy.
Master open, laparoscopic and robotic approaches to pelvic and flank surgery.
Master surgical procedures related to female urinary incontinence
Master surgical procedures related to male infertility and impotence.

**Connecticut Children’s Medical Center**
Master the evaluation and management of outpatient and inpatient pediatric urological problems such as urinary obstruction, posterior urethral valves, urinary frequency, urinary tract infections, ureteral reflux, hematuria, renal masses, and congenital abnormalities such as meningomyelocele, hypospadias and undescended testis.
Master procedures such as urodynamics, hypospadias repair, orchidopexies and ureteral implants.
Master basic diagnostic tools utilized in pediatric urology such as cystoscopy, bladder scan, diagnostic radiology including voiding cysto-urethrogram, CT examination, ultrasound, nuclear medicine studies and urodynamics.
Master the evaluation of pediatric urological trauma and urological emergencies such as flank mass, testicular torsion, blunt and penetrating trauma, and urinary infections of the bladder and kidney.

**St. Francis Hospital**
Master major flank, pelvic and endoscopic surgical procedures. Learning is done in a less intense and more protected environment allowing for increased one to one mentoring between residents and the attending staff.

**Hartford Hospital (track 1)**
Master basic open, laparoscopic and robotic techniques used in flank surgery
Master procedures related to impotence

**Hartford Hospital (track 2)**
Master basic open, laparoscopic and robotic techniques used in pelvic surgery.
Key Milestones
At the completion of the second two years of training a urology resident is expected to have achieved the following milestones (rated Level 4 or higher) in each of the six core competencies:

1) Patient Care
   a. Gather information by interviewing the patient or surrogate and performing a physical exam
      i. Obtains relevant historical subtleties that inform and prioritize differential diagnoses and diagnostic plans
      ii. Identifies common and subtle physical findings
      iii. Efficient in gathering information including history and physical exam
   b. Use diagnostic tests and procedures, including performance and interpretation of imaging studies
      i. Familiar with indications for advanced diagnostic and imaging tests
      ii. Makes appropriate clinical decisions based on common and advanced diagnostic test results
      iii. Consistently employs routine and advanced diagnostic tests in and efficient manner
   c. Generate a differential diagnosis
      i. Creates a differential diagnosis that includes common and uncommon urologic findings
      ii. Prioritizes causes of common urologic complaints
      iii. Rapidly generates a differential diagnosis and treatment strategy
   d. Develop a patient care plan, including medical, surgical, and/or radiologic interventions. Counsel preoperative patients regarding treatment options. Discuss risks, benefits and alternatives that make up the informed consent process. Counsel patients regarding potential short and long term impact of interventions on quantity and quality of life, as applicable. Adapt initial plan as sub-acute or chronic conditions evolve.
      i. Develops a more complex plan in patients with multiple co-morbidities
      ii. Counsels patients for complex, high risk procedures
      iii. Counsels patients for problems affecting quantity and quality of life
   e. Perform intra-operative and post-operative management of patients, including recognition and treatment of physiologic alterations and complications.
      i. Identifies and manages common and uncommon intraoperative and post-operative complications
      ii. Identifies and treats these problems efficiently
   f. Perform open surgical procedures
      i. Plans creates and closes routine urologic procedures
      ii. Manipulates and repairs internal structures with appropriate instruments
g. Perform endoscopic procedures of the upper and lower urinary tract
   i. Obtains access to bladder, ureter and kidney
   ii. Manipulates endoscopic instruments with appropriate speed and dexterity
   iii. Manipulates endoscopic equipment for the majority of routine and complex procedures

h. Perform laparoscopic/robot-assisted surgical procedures (examples listed)
   i. Obtains access and insufflates abdomen for routine procedures
   ii. Manipulates laparoscopic and robotic instruments with appropriate speed and force
   iii. Performs laparoscopic procedures with independence

i. Perform office base procedures
   i. Demonstrates capacity to teach and supervise the performance of office based procedures
   ii. Performs complex diagnostic and therapeutic outpatient procedures

2) Systems Based Practice
   a. Work effectively within and across health delivery systems
      i. Manages and coordinates care and care transitions across multiple delivery systems
      ii. Advocates for quality patient care
      iii. Discusses non-pharmacologic and non-procedural patient resources
      iv. Capably leads a health care team

   b. Incorporates cost awareness and risk benefit analysis into patient care
      i. Identifies role of various health care stakeholders
      ii. Incorporates cost awareness and risk benefit in complex clinical scenarios
      iii. Minimizes unnecessary procedures and tests
      iv. Uses highly specialized equipment efficiently in the operating room

   c. Works in inter-professional teams to enhance patient safety
      i. Dialogues with care team members to identify risk and prevent medical errors
      ii. Understands methods for analysis and correction of system errors
      iii. Partners with other professionals to identify and implement improvement opportunities
      iv. Coordinates or leads quality improvement studies

   d. Uses technology to accomplish safe health care delivery
      i. Efficiently uses information systems for patient care
      ii. Demonstrates medication reconciliation for patients using various strategies
      iii. Reports system problems and recommends system re-design
3) Practice Based Learning
   a. Improves via feedback and self-assessment
      i. Maintains awareness and responds to situational needs
      ii. Actively responds to and uses feedback from all members of the health care team
   b. Learns and improves by asking and answering clinical questions from a patient scenario
      i. Formulates focused clinical questions
      ii. Distinguishes different types of clinical questions
   c. Acquires the best evidence
      i. Effectively and efficiently searches National Library of Medicine databases
      ii. Effectively and efficiently searches evidence-based summary medical information sources
   d. Appraises the evidence for validity, impact and applicability
      i. Assesses the impact and applicability of results from a variety of study designs
      ii. Understands the concepts of hypothesis testing and study design
      iii. Appraises studies of harm, diagnosis, and prognosis for validity, impact and applicability
   e. Applies the evidence to decision making for individual patients
      i. Seeks to integrate the entire body of evidence for a clinical question in reaching a clinical decision
      ii. Assesses the clinical context, patient values and preferences to reach a clinical decision
   f. Improves quality of care for a panel of patients
      i. Engages in team based quality improvement interventions
      ii. Identifies areas in his or her own practice and local system that can be changed or improved
   g. Participates in the education of other team members
      i. Informally teaches fellow residents, medical students and other health care professionals
      ii. Organizes didactic, educational activities

4) Interpersonal Communication Skills
   a. Communicates effectively with patients and families with diverse socioeconomic and cultural backgrounds
      i. Consistently and capably exhibits basic communication skills
      ii. Communicates capably in challenging and emotionally charged situations
   b. Effectively counsels, educates and obtains informed consent
      i. Consistently and capably performs patient-centered skills while counseling and obtaining informed consent
      ii. Provides patient-centered counseling in cases of acute and probable terminal illness
c. Communicates effectively with physicians, other health professionals, and health-related agencies
   i. Capably and consistently delivers complete, key and timely information in an organized fashion
   ii. Anticipates and prevents poor communication and effectively manages conflicts arising from less skilled residents
d. Communicates effectively during care transitions and consultations with fellow residents
   i. Consistently and capably demonstrates all hand-over components across a range of situations
   ii. Transfers care in a manner that is thorough, personal and clearly delineates responsibility. Invites questions and feedback
e. Works effectively as a member or leader of a health care team or other professional group
   i. Follows communication protocols for updating members on patient status
   ii. Demonstrates good team leadership skills and fosters continuous, collaborative communication

5) Professionalism
a. Adheres to ethical principles
   i. Displays discomfort with unfamiliar tasks
   ii. Never takes on tasks beyond own ability and refers patients when appropriate and necessary
b. Demonstrates compassion, integrity and respect for others
   i. Viewed as a team player
   ii. Consistently honest and responsive to other members
   iii. Strong team leader who puts patient needs above his/her own
c. Demonstrates responsiveness to patient needs that supersede self interest
   i. Consistently prompt and responsive even when not personally convenient
   ii. Always follows through with obligations to patient care
d. Demonstrates respect for patient privacy and autonomy
   i. Always honors and recognizes patient privacy
   ii. Maintains patient confidentiality
e. Demonstrates accountability to patients, society and the profession
   i. Takes responsibility for actions and behavior
   ii. Completes medical records and surgical logs
   iii. Mentors and supports junior residents
   iv. Recognizes conflicts of interest
f. Demonstrates sensitivity and responsiveness to diverse populations, including diversity in gender, age, culture, race, religion, disabilities, and sexual orientation
   i. Demonstrates sensitivity to patient diversity matters
   ii. Anticipates complex needs of diverse patient groups
   iii. Never discriminates in providing care
6) Medical Knowledge – Achieves a score of at least 65% on the AUA Resident In Service Exam

Resident Scholarly Activities
Residents are expected to participate in scholarly activities. Each year each resident must make at least two formal presentations at Grand Rounds that includes a presentation of a topic and a literature review. The presentations are given either at the monthly morbidity and mortality rounds, or at the bi-monthly case presentations.

Senior residents are expected to submit at least one abstract to either the annual meeting of the New England Section of the AUA or the annual meeting of the American Urological Association. Ideally these abstracts will be submitted as a formal paper for publication. Alternatively, residents are expected to work with a faculty mentor to write a book chapter or monograph on a relevant urologic topic. The manuscript must be completed prior to graduation.

Employment Policies and Benefits

Financial Support for Residents
The sponsoring and participating institutions provide all residents with appropriate financial support and benefits to insure that they are able to fulfill the responsibilities of their educational program. All residents have pay and benefits according to the same scale. The Housestaff Policy Book is updated annually and reflects the current salaries and benefits for all resident levels.

The Capital Area Health Consortium (CAHC) establishes the salary levels for each PGY, and the University of Connecticut School of Medicine signs a contract with CAHC to cover all of the related salaries, fringe benefits and CAHC administrative expenses.

Leave Policies

Paid Vacation Leave
The CAHC and the University of Connecticut School of Medicine provide residents with three weeks paid vacation per academic year (A week is equal to 5 weekdays and 2 weekend days). Each resident is responsible for knowing and following the Urology Residency Program’s policy on paid vacation. Vacation leave is scheduled at the beginning of each academic and is organized by the residents. No more than one resident may be on vacation during any given week. Selection of vacation weeks is based on seniority. The Program Director must approve the schedule submitted by the resident staff before it becomes final. Any disagreements concerning vacation leave will be resolved by the Program Director. The vacation schedule will be posted on Blackboard. Vacation leave cannot be carried over into a new academic year.

Any extension of time in a training program will be for the amount of time needed to complete the training requirements only and will not include vacation time.
Paid Sick Leave
The CAHC and the University of Connecticut School of Medicine provide housestaff with paid sick leave up to 15 working days per contract year. No accrued sick time may be carried over into the next contract year. In the event of serious injury or prolonged illness, additional paid leave may be granted. (See section on Medical Leave/Short Term Disability.) This must be coordinated with and approved by the Program Director and the Associate Dean for GME or designee in connection with the regulations on long and short-term disability. All housestaff may use up to 10 days of their accrued sick leave to attend to a family member’s serious health condition or for the birth or adoption of a child.
A resident requesting sick time MUST inform the appropriate site director and fellow resident physicians at their rotation site immediately once he/she determines that he/she is incapable of fulfilling any educational or clinical responsibilities. A resident MUST also inform the Program Director with 24 hours that he/she is absent on sick leave. At the discretion of the Program Director, a physician’s letter may be required for any absence due to illness. A physician’s letter is mandatory after 3 work days off for illness or injury.

Paid Educational Leave
The University of Connecticut Program in Urology provides residents with paid educational leave to attend the following conferences:
   1) Basic Science Review Conference (Charlottesville, VA) URO 2 residents
   2) New England Section AUA annual meeting each fall
   3) American Urological Association annual meeting each spring
All residents will attend the Basic Science Review course once during their residency. Residents may attend the New England Section AUA and the annual meeting of the AUA provided that they have an abstract accepted to the meeting. Residents may be allowed to attend specialty society meetings such as the American Academy of Pediatrics provided that the resident is seriously considering applying for a fellowship in the field. Abstract submissions to these programs MUST be approved by the Program Director PRIOR to their submission.
A chief resident may request approval to attend the annual meeting of the American Urological Association during his/her senior year if he/she has never attended such a meeting before. Approval for this activity is dependent on the ability to provide adequate coverage for clinical responsibilities.
Reasonable travel expenses for these meetings will be covered by the urology residency education fund maintained at Hartford Hospital. Residents will be allowed to participate in an exchange program with Argentina during their senior year. This is NOT required. Should a resident decide to participate in this program he/she MUST obtain approval from the Program Director and the site director. Travel is limited to two weeks one of which will be considered a vacation week as defined above. Travel arrangements and expenses are the responsibility of the resident and are NOT covered by the Urology residency education fund.
Administrative Leave Without Prejudice:
A resident may be placed on Administrative Leave without Prejudice during the time it takes to investigate possible misconduct when the DIO determines that such action is in the best interests of the University, affiliated hospitals, and/or the resident. The length of such Administrative Leave can be no longer than ninety days and will be determined in consultation with the Program Director. Residents will receive full pay and benefits during this time.

If the investigation of misconduct results in clearing the resident of all charges, the resident will return to the program and this leave will be reported only as Personal Leave. If necessary, the resident’s time in the program will be extended to meet all requirements. If the resident chooses to use vacation time, (a maximum of one-year’s worth of vacation), this will be approved. No sick time may be used to make up for Administrative Leave.

Bereavement Leave
In the event of a death in the immediate family, a resident, at the sole discretion of the University of Connecticut School of Medicine and the Program Director, may take up to three consecutive work days with pay. Immediate family is defined as parents, parents-in-law, siblings, spouse/domestic partner, children, grandparents or grandchildren. Consideration may be given in cases where significant travel is involved. Bereavement leave does not reduce sick or vacation time.

Emergency Leave
Under certain circumstances documented to be beyond the resident’s control, emergency leave without pay but with continued benefits may occur. This type of leave must be approved by the Program Director and by the Office of Graduate Medical Education.

Family Leave
The University of Connecticut School of Medicine provides Family Leaves of Absence without pay to eligible residents who wish to take time off from work duties to fulfill family obligations relating directly to childbirth, adoption, or placement of a foster child; or to care for a child, spouse, or parent with a serious health condition. A serious health condition means an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or continuing treatment by a healthcare provider.

Eligible residents may request Family Leave only if they have completed one year of service and have worked 1,000 hours or more in the 12-month period preceding the first day of leave. (unless otherwise allowed by the Program Director, who must notify the GME office). Residents should make requests for Family Leave to their Program Directors at least 30 days in advance of any foreseeable events and as soon as possible for any unforeseeable events.

Residents requesting Family Leave related to the serious health condition of a child, spouse, or parent may be required to submit a healthcare provider's statement verifying the need for a family leave to provide care, its beginning and expected ending dates, and the estimated time required.
Eligible residents may request up to a maximum of 12 weeks of family leave within any 12-month period or 16 weeks within any 24-month period. Residents will be required to substitute any accrued paid sick time for Family Leave time at the beginning of their leave. Married resident couples will be restricted to a combined total of 16 weeks leave within any 24-month period for childbirth, adoption, or placement of a foster child, or to care for a parent with a serious health condition.

Subject to the terms, conditions, and limitations of the applicable plans, health insurance and other benefits will continue for 12 weeks (3 months) of Family Leave to eligible housestaff. After 12 weeks, residents will become responsible for the full costs of these benefits if they wish coverage to continue. When the resident returns from family leave, benefits will again be provided by CAHC according to the applicable plans. Benefit accruals, such as vacation or Sick Leave, will be suspended during any leave period greater than 30 days, and will resume upon return to active employment.

So that a resident’s return to work can be properly scheduled, any resident on Family Leave is requested to provide his/her Program Director with at least two weeks advance notice of the date the resident intends to return to work. When Family Leave ends, the resident will be reinstated to the same position, if it is available, or to an equivalent position for which the resident is qualified. If a resident fails to report to work promptly at the end of the approved leave period, CAHC will assume that the resident has voluntarily resigned.

**Maternity/Paternity Leave**
Housestaff may use paid vacation time, paid sick time, and unpaid family leave for purposes of maternity/paternity leave. Women who qualify may also use up to 90 days of paid medical leave (short-term disability) for serious health conditions or for temporary disabilities associated with pregnancy, childbirth, and related medical conditions. Residents will be required to substitute any accrued paid sick leave for family leave time at the beginning of their leave. For more information please refer to the sections on Family Leave and Medical Leave of Absence (Short Term Disability).

**Pregnancy-Related Absences**
CAHC and the University of Connecticut School of Medicine will not discriminate against any resident who requests an excused absence for medical disabilities associated with a pregnancy. Such leave requests will be made and evaluated in accordance with the medical leave policy provisions outlined above and in accordance with all applicable federal and state laws. Any resident may take this leave for as long as she is disabled due to the pregnancy, even if she has exhausted medical leave.

**Medical Leave and Short-Term Disability**
The University of Connecticut School of Medicine provides medical leaves of absence with pay and benefits for up to 90 days to eligible residents who are unable to work due to their own serious health condition or disability. For purposes of this policy, serious health conditions or disabilities include inpatient care in a hospital or residential medical care facility; continuing treatment by a healthcare provider; and temporary disabilities associated with pregnancy, childbirth, and related medical conditions.
A health care provider’s statement must be submitted verifying the need for medical leave and its beginning and expected ending dates. Any changes in this information should be promptly reported to the Office of Graduate Medical Education and to the respective Program Director. **Residents will be required to first use any accrued paid vacation and sick time before using Short-Term Disability. The total of all paid time off may not exceed 90 days.** Residents returning from Medical Leave must submit a healthcare provider’s verification of their fitness to return to work to their Program Director. If the resident learns, before the 90 day period expires, that he/she may be unable to return to work at the end of the Short-Term Disability period, the resident should file a claim for Long-Term Disability Insurance, provided by the CAHC (see Long-Term Disability under Section 5.G.).

So that a resident’s return to work can be properly scheduled, a resident is requested to provide CAHC and his or her Program Director with at least two-weeks advance notice of the date the resident intends to return to work. When a Medical Leave ends, the resident will be reinstated to the same position, if it is available. If a resident fails to report to work promptly at the end of the Medical Leave, CAHC and the resident’s Program Director will assume that the resident has resigned and all pay and benefits will be terminated.

Residents who sustain work-related injuries are eligible for a Medical Leave of Absence for the period of disability in accordance with all applicable laws covering occupational disabilities.

**Military Leave**
If a resident is called unexpectedly to serve in the military for an extended period of time, the training position will be held, unpaid, until the resident’s return from service. Accommodations will be made based on training program requirements and accreditation standards.

**Unpaid Leave (other than medical or family leave)**
Under certain circumstances, a resident may request a **Leave of Absence** for personal reasons. Whether or not the position is held open for the resident is dependent upon the Urology program and Urology RRC requirements. Re-instatement is not automatic. All pay and benefits are terminated. **Should the resident take a personal leave without appropriate notification/approval from the Program Director, the resident may be considered to have resigned from the program.**

**Major Holidays**
Major public holidays are scheduled in the same way as weekends in order to provide adequate clinical coverage. There are six designated major holidays:

- New Year’s Day
- Memorial Day,
- July 4th
- Labor Day
- Thanksgiving Day
- Christmas Day

All other holidays are considered working days unless otherwise scheduled, excused or reassigned by the Program Director. Please note that this list is subject to change at the sole discretion of CAHC and the University of Connecticut School of Medicine.
Jury Duty
The Office of Graduate Medical Education will provide the resident with a letter requesting release from jury duty. Residency training has been recognized as an activity that should not be interrupted but this letter does not automatically result in the resident being released from this responsibility.

Professional Liability/Malpractice Insurance
Residents have liability coverage only while they are carrying out assigned duties as part of their urology residency training program. Coverage includes claims filed after completion of the program for acts that occurred during the training program. State regulations require that the hospital site where the resident is working provide liability coverage. Professional activities outside the program are not covered and are the sole responsibility of the resident.

Information is sent to hospitals, other GME programs and licensing agencies when they inquire about the type of malpractice coverage the residents and fellows in the University of Connecticut School of Medicine sponsored programs have. If information about a claims history is requested, Risk Managers from all affiliated hospitals must be contacted to facilitate the process. If it is simple coverage information that is needed, the attached letter can be sent out right away.

Residents concerned about any patient interaction, or critical incident, are encouraged to contact the Risk Management Office at the site where the incident occurred. Information on Critical Incident can also be found in this policy book.

Worker’s Compensation
CAHC provides a comprehensive workers’ compensation insurance program at no cost to employees or residents. This program covers any injury or illness sustained in the course of employment that requires medical, surgical, or hospital treatment. Subject to applicable legal requirements, workers’ compensation insurance provides benefits after a short waiting period or, if the employee or resident is hospitalized, immediately. Employees or residents who sustain work-related injuries or illnesses should inform their supervisor immediately. No matter how minor an on-the-job injury may appear, it is important that it be reported immediately. This will enable an eligible employee or resident to qualify for coverage as quickly as possible.

Neither CAHC nor the insurance carrier will be liable for the payment of workers’ compensation benefits for injuries that occur during a resident’s voluntary participation in any off-duty recreational, social, or athletic activity sponsored by CAHC.

The resident MUST get medical help immediately at the current facility. During the day, he/she must go to the Employee Health Department; at night, to the Emergency Room.

The resident must report the injury to the University of Connecticut Employee Health Service (679-2893) within 24-hours. If off-hours, a message with beeper number must be left at this number. A back-up call to the Capital Area Health Consortium (676-1110), the following work day is encouraged.

A report of the injury or exposure must be left with UConn Employee Health. If you have any questions, call (860) 676-1110. To see a physician beyond the initial visit, you may not go to any outside physician without contacting the Capital Area Health Consortium or Workers Compensation Trust (203) 678-0100 for an approved list of providers.
General Policies

Bylaws
Every hospital has a set of bylaws that identify rules and regulations that must be followed by all hospital employees. Even though residents are not employees of any of the affiliated hospitals, residents are still required as per the resident contract to abide by the hospital bylaws when working within that institution.

Code of Conduct for Residents
Residents should strive for excellence in all aspects of their personal and professional lives. This implies a professional demeanor and conduct in direct patient care and in communication with patients, family members, other healthcare professionals, support staff and the public.

The University of Connecticut School of Medicine and all of its major affiliates have codes of conduct that state that employees are expected to act in a professional, courteous, respectful, and confidential manner. The resident contract states that residents shall abide by all rules, regulations and bylaws of the program, clinical department, and institution in which he or she is assigned. Violating these rules may be a cause for disciplinary action up to and including dismissal. It is, therefore, expected that residents be courteous, respectful, and collaborative.

Conduct that is considered to be in violation of this code includes, but is not limited to, the following:

- Unlawfully distributing, dispensing, selling or offering for sale, possessing, using or being under the influence of alcohol, drugs, or a controlled substance when on the job, or in a position to be called into work, subject to duty; or smelling of alcohol or having the odor of alcohol on the breath.
- Misusing or willfully neglecting property, funds, materials, equipment or supplies from any of the affiliate hospitals or ambulatory sites in which you work.
- Fighting or acting in any manner that endangers the safety of one’s self or others.
- Destroying property in any way.
- Stealing or possessing without authority any equipment, tools, materials, or other property of any of the hospitals or ambulatory sites in which you work.
- Refusing to do assigned work or to work.
- Falsifying your attendance record.
- Falsifying institutional or personal records.
- Providing patient care under circumstances of possible physical, mental or emotional lack of fitness that could interfere with the quality of that care.
- Being repeatedly or continuously absent or late, or being absent without notice or reason.
- Conducting one’s self in any manner which is offensive, intimidating, physically threatening, verbally abusive or contrary to common decency or morality.
- Carrying out any form of harassment, including sexual harassment.
- Providing medical advice or information to patients without authorization.
- Providing medical care outside of the scope of the resident permit. This includes writing prescriptions for patients that are not under the resident’s direct care.
- Failing to comply with any of the major affiliates’ confidentiality policies.
- Engaging in activities that violate either the Health Center’s, any of the affiliate hospitals’ or the State of Connecticut’s “Code of Ethics.”
- Gambling or unauthorized solicitation in the workplace.
• Computer abuse, such as, but not limited to, accessing or viewing offensive or pornographic material, misuse of computer accounts, unauthorized destruction of files, creating illegal accounts, possession of or use of unauthorized password, disruptive or annoying behavior on the computer and non-work-related utilization of computer software or hardware.
• Being convicted of a crime.
• Failure to cooperate or to be truthful in a program-related investigation.

All violations can interfere with the resident’s performance and, therefore, can potentially interfere with meeting expectations and requirements of a resident physician’s job.

Program Directors, faculty, other residents, and any other individual who has contact with resident physicians can report misconduct and notify the Office of Graduate Medical Education staff. If misconduct has occurred, the following corrective discipline options are available and are not appealable:

1. Verbal warning to clarify the standards of acceptable conduct or performance and the possible consequences if the problem is not corrected.
2. Written warning in the form of a letter of concern that states the nature of the misconduct or performance and includes what change is required and the possible consequences if the problem is not corrected.
3. Administrative leave, which could lead to extension of training.
4. Suspension
5. Termination of employment

Please see full description of each category in the Housestaff Policy Book

All cases of misconduct will be directed to the Office of Graduate Medical Education. **Official Communication with the University of Connecticut School of Medicine, Urology Residency, Capital Area Health Consortium**

All residents are required to monitor and use their University of Connecticut endorsed e-mail accounts. Accounts must be monitored at least weekly to guarantee that all correspondence regarding the Urology Program, the Graduate Medical Education Office, the Capital Area Health Consortium is reviewed regularly. Any correspondence with the University of Connecticut Office of Graduate Medical Education or the Capital Area Health Consortium personnel for work related issues must be conducted through these accounts. Please refer to the Policy on the Appropriate Use of the Internet and Social Networking Sites in the House Staff Policy Manual regarding communication of Protected Health Information.

Residents should be aware that all official residency related material, announcements and schedules will be posted on Blackboard. Residents are expected to check this source regularly.
Sleep Deprivation/Fatigue Management
NOTE: All residents are responsible for following the policy/procedure at each training site. All sites have policies that comply with State and Federal Laws.
Residents are expected to obtain adequate rest after their standard duty hours at each of the participating sites. Since residents take call from home, residents may have inadequate rest after some nights on call. Residents must inform the site director any time they have had inadequate rest during the previous night. The site director will either determine that the resident must return home for rest or will excuse the resident for a period of time to obtain adequate rest in a call room. Residents who need relief from duty due to fatigue, or feel excessively fatigued when work hours end, should not drive home. They should seek assistance from a colleague, family member or friend, or ride home in a taxicab. Residents must complete annual training on recognizing the symptoms of sleep loss and fatigue as part of the core curriculum series on Blackboard. The Health Center Community and public expect that employees and students perform their duties safely and efficiently. The effects of sleep deprivation on students and employees would be impediments to realizing this expectation.

Residents should obtain adequate rest when off call. Residents should sleep at least 7 hours per day and 8 hours prior to a 24 hour duty shift. Chronic sleep deprivation occurs when residents routinely sleep less than 6 hours per night.

Sleep loss and fatigue result in significant neurobehavioral impairments. Excessive fatigue can jeopardize the quality of patient care, as well as the health and well-being of physicians. The University of Connecticut Urology Residency is committed to assisting faculty and residents to recognize, prevent and counteract the negative effects of fatigue. Signs of fatigue include cognitive features such as poor memory, slow thinking, trouble concentrating and impaired decision making; performance features such as sleepiness, low energy, poor vigilance, slowed speech and clumsiness, and low work output; and emotional features such as irritability, anger, depressed mood, anhedonia, de-realization, depersonalization, and numbness. Physicians should be especially vigilant for signs of fatigue between the hours of 2 AM and 9 AM, the circadian nadir.

Drug & Alcohol Abuse Policy
The drug and alcohol abuse policy prohibits the unlawful possession, use or distribution of illicit drugs and alcohol on all locations related to the University of Connecticut health Center (UCHC) or as part of any of its activities. The Health Center Community and public expect that employees and students perform their duties safely and efficiently. The presence of drugs or alcohol or the effect of these substances on students and employees would be impediments to realizing this expectation.
Substance abuse assistance resources at UCHC
The UCHC provides any student or employee primary access to a physician to discuss any personal problems which may be affecting his/her work performance. This service includes questions or concerns related to substance abuse. If a recommendation for treatment results from these discussions, arrangements can be made for the employee to select a program from either John Dempsey Hospital or an outside provider. If you are in need of this service, an appointment can be arranged with the Employee Student Health Service by calling 679-2893 between the hours of 8:30 a.m. and 4:30 p.m. This service is completely confidential.

The Compassionate Help for Impaired Professional Students (CHIPS) Program provides education and early identification and compassionate assistance to an impaired student who is abusing drugs or alcohol. The services and resources of CHIPS are available to any student. A brochure on CHIPS is distributed to each incoming student. Referrals are made through a CHIPS Council member and are held in the strictest confidence. If you are in need of this service, an appointment can be arranged by calling Dr. Ronald M. Kadden, telephone number 679-4249 or Dr. Fred Rowland, telephone number 679-3956.

Duty Hours
Urology Residency duty hours are limited to 80 hours per week and 14 hours per day. The Urology Residency program follows the institutional policy on duty hours. This policy is in the Housestaff Policy Book. The duty hour policy takes into consideration the educational needs of the resident and the needs of the patient, including patient safety and continuity of care. This policy is in compliance with the ACGME and urology RRC policies. Urology residents must record their duty hours accurately in the institutionally sponsored software. In general residents are expected to be on duty at approximately 6:00 AM on a typical work day and should be completing work around 6:00 PM. In no instance should they depart the hospital later than 8:00 PM. If residents believe that they must stay beyond 8 PM, they MUST contact the site director or physician on-call to request permission to stay beyond 8:00 PM. The actual hours worked including the rationale for staying beyond 8 PM must be recorded in the appropriate log in MyEvaluations.

The Program Director submits quarterly duty hour reports to the Office of Graduate Medical Education. These reports include the duty schedules for all residents, notification of any duty hour violations, and steps taken to prevent repeat violations. The Graduate Medical Education Committee (GMEC) is responsible for monitoring compliance with the duty hour requirements. GMEC will carry out this charge by reviewing and monitoring the quarterly duty hour reports, annual surveys of programs, random and unannounced interviews of residents, periodic ACGME resident surveys, mid-cycle reviews, and through the anonymous Hotline (860-679-4353) that has been set up so that residents may report violations of duty hour requirements.

Urology residents are expected to be “on-call” from home on week days and weekends. Call schedules will vary according to the call pool and vacation schedules. There are three “on-call” groups: 1) Hartford Hospital, 2) Children’s Hospital, and 3) UConn Health Center and St. Francis Hospital. Urology resident “on-call” schedules are created by the senior residents in each of the three “on-call” groups. In creating these schedules, the chief residents must ensure that they comply with ACGME and Urology RRC duty hour guidelines. Any disagreements or problems associated with on-call schedules will be resolved by the Program Director.
Urology residents **MUST** record all time spent in the hospital during any of the on-call periods whether weekday nights or weekends. Urology residents should keep a log of the number of calls received during on call periods for review with the Program Director. Residents should notify the site director and the Program Director if they have received a sufficient number of calls during any on call period that has compromised their ability to receive sufficient rest.

Residents are expected to comply with the ACGME mandated duty hours. These regulations prohibit residents from working more than 80 hours in any given week and more than 14 hours in any given day. Residents should have at least 10 hours free from the time they leave the hospital in the evening until they return for work the next day. Furthermore, residents must have one day off of every 7 completely free of any responsibilities to the hospital. A work week is defined from Sunday until the following Saturday.

**Supervision**

All residents practicing in a hospital or outpatient setting during normal working hours are under the *direct supervision* of an attending physician who must be physically present during the key portions of an operation. Senior residents may perform surgical procedures with indirect supervision provided that direct supervision by the responsible attending physician is immediately available. The attending physician must be present for the key portions of the operation. Senior residents may supervise junior residents performing surgical procedures provided that this is approved by the attending physician and is conducted under indirect supervision as described above. Junior residents performing procedures should be supervised directly by the attending physician or the senior resident throughout the entire procedure. This policy is the same at each of the core hospitals: University of Connecticut, Hartford, St. Francis and Connecticut Children's Medical Center.

Residents evaluating patients in the outpatient setting are under the *indirect supervision* of the attending physician assigned to the clinic who is on site and immediately available. The supervising physician is the attending staffing the outpatient operative procedure or conducting the clinic. For patients on the inpatient service, the supervising physician is the attending of record on the chart. All consultations are under the *direct supervision* of an attending physician and must be reviewed by an attending physician ideally during the same day, but within 24 hours. Unless a consult is specifically directed to an attending physician, the supervising physician is the attending physician “on-call”. Residents will have varying levels of experience that is determined in part by their time in training. Junior residents performing procedures such as cystoscopy, urethral dilation, catheter placement, priapism decompression, paraphimosis reduction must be supervised by either a senior resident or an attending physician until such time the junior resident is deemed competent to perform these procedures. At the end of each rotation the site director will confirm which junior residents have been credentialed to perform the following outpatient procedures:

1) Foley catheter insertion (simple and coudee tip)
2) Foley catheter removal (complex)
3) Flexible cystoscopy
4) Flexible cystoscopy with urethral dilation using balloon or sounds
5) Flexible cystoscopy with removal of stent
6) Incision and drainage of scrotal or perineal abscess
7) Reduction of paraphimosis
8) Dorsal slit of foreskin
9) Treatment of priapism
10) Cystoscopy, bladder irrigation and clot evacuation
11) Suture of lacerations
12) Retrograde urethrogram
13) Application of wound VAC
14) Wound debridement

Junior residents cannot be promoted to senior rotations until they have been approved to perform each of these procedures independently at each institution.

Residents who are “on-call” are under *indirect supervision* by an attending physician who is immediately available by telephone and/or other electronic communication device. This is true for each of the four participating institutions: University of Connecticut Health Center, Hartford Hospital, St. Francis Hospital and Connecticut Children’s Medical Center. A monthly schedule of on-call attending physicians for each hospital is maintained on Blackboard. The resident must contact the supervising attending for any medically significant problem such as a decision to admit a patient or a decision to recommend a surgical procedure. This is true for both Senior residents and Junior residents. Residents “on-call” are expected to manage routine clinical problems independently. The attending physician “on-call” provides *oversight* and must review care provided by the resident at least every 24 hours.

This information will be updated at the end of each rotation and kept on file on Blackboard.

**Circumstances requiring faculty involvement**

Certain medical situations require involvement by the supervising faculty. Residents at any level of training **MUST** contact the attending physician of record or the “on-call” physician if the attending physician is unavailable concerning any of the following situations where patients require: 1) admission to the hospital, 2) an urgent surgery or invasive procedure, 3) transfer to an intensive care unit or higher level of care, 4) an urgent medical or surgical consult because of a deteriorating situation, 5) a change in code status, 6) need for intubation or ventilator support, 7) cardiac arrest or significant change in hemodynamic status, 8) development of significant neurological changes, 9) development of major wound complications, 10) medication errors requiring clinical intervention, 11) when requested by any patient or family member, 12) any instance where a patient’s recovery or hospital experience does not follow the course outlined with the attending providing *oversight* during the previous 24 hours, and 13) patient death.

**Patient Handoff**

Continuity of patient care in a hospital setting is an essential component of safe medical practice. Patient care is provided by both the attending physician and the urology resident staff. Transitions in care between health care providers are frequently described as a “Handoff”. The following curriculum is designed to educate the urology resident of the importance of providing good medical handoffs and the critical information that should be included in the handoff.
The program director will review the essentials of a medical handoff at the start of each academic year. Residents are expected to read the following manuscript: Vidyarthi et al. Managing discontinuity in academic medical centers: Strategies for a safe and effective resident sign-out. Journal of Hospital Medicine 2006: 1:257-266. A PDF copy of this article will be distributed to each resident before the start of the academic year.

Residents are expected to provide a written and/or face to face handoff to the covering physician at the end of each weekday or the end of weekend call. The covering resident physician is listed on the monthly on-call schedule. The handoff should include all of the elements listed below. A written handoff can be maintained in the electronic medical record specific to that hospital. At the end of each ten week rotation, the resident on call for the weekend from each of the four hospital teams is expected to forward a copy of the handoff to Dr. Albertsen and the program coordinator, Debbie Savino. At the start of each academic year, residents are expected to forward a copy of the written handoffs to the site director and program director. The site director will review the handoff reports to determine if documentation has been adequate. Residents will continue this practice until the site director has determined that handoff reports are adequate. The program director will monitor the handoff process through a review of the handoff reports forwarded at the end of each rotation. The program director and site director will evaluate residents on the quality of the handoff.

Required elements for an effective written handoff in urology

1) Administrative data
   a. Patient name, age and sex
   b. Floor and room number
   c. Admission date
   d. Attending physician name

2) Illness severity
   a. Is the patient stable or unstable
   b. DNR status

3) Clinical information
   a. Diagnosis
   b. Procedure performed or reason for hospitalization
   c. Current active problem list
   d. Medications or fluids started during previous 24 hours
   e. Pertinent allergies or other significant medical issues (e.g. alcoholic)

4) Tasks
   a. Labs, imaging, tests or consultant reports that need to be reviewed
   b. Any medical or surgical therapy that must be provided by the covering physician

5) Contingencies
   a. Problems that might occur during coverage period
   b. Any relevant treatments tried previously that have either worked or failed
   c. Any difficult family or social issues
Inability to perform patient care duties (Back Up)
Residents unable to perform their assigned duties must inform the “on-call” resident, the site director and the program director. The site director is responsible for reassigning clinical duties to the remaining resident(s) and to any physician assistances that may be present. If the resident unable to perform his or her duties is the resident “on-call”, the resident must inform the “on-call” attending immediately and the site director as soon as practical. The “on-call” physician will assume the resident’s clinical duties until the following morning when the site director will assign clinical duties to appropriate individuals. Site directors are expected to communicate with the program director should they anticipate that a resident will be absent for an extended period. The program director and the site director will determine how clinical duties will be reassigned.

Moonlighting
Professional activities outside the program or “moonlighting” may be engaged in by urology residents only with the permission of the Program Director. Urology residents must be in good standing and have scored at the 25 percentile or higher on the previous in-service examination. The Program Director will monitor the moonlighting activities of urology residents. Residents must report their plans for moonlighting. These plans must not violate the 80 hour work rule per week or the 14 hour work rule per day. Written permission will be placed in the resident’s file. Any resident who engages in moonlighting activities without the knowledge and approval of the Program Director is subject to disciplinary action. Residents cannot schedule any of these activities in such a way that they interfere with the requirements of the urology program or their health or performance. Residents must obtain the appropriate license, liability coverage, and DEA number for use in activities not related to the residency. Residents may not hold admitting privileges in any hospital or charge or receive fees for professional services rendered as part of the residency program.

Moonlighting is prohibited if a resident is on a leave of absence for any reason, in remedial status or has a letter of deficiency. Also, residents who have completed all educational requirements but have not been given a diploma because administrative requirements have not been met (e.g. USMLE3, Consortium exit interview, etc.) are NOT allowed to moonlight.

Residents are advised to investigate the limits of their malpractice liability coverage in activities such as moonlighting outside of their program. Those activities are not part of the malpractice liability coverage provided by the residency program. Internal moonlighting is covered by the malpractice liability coverage at each institution.

Medical Records
Residents are expected to be compliant with medical record policies at each of the participating hospitals. Residents are expected to record patient progress as inpatients on a daily basis. Entries must be legible. Residents are also expected to complete consult notes legibly. Residents are expected to dictate discharge summaries and medication reconciliation forms. When requested by an attending physician, a resident may also be expected to dictate an operative note. Clinic notes and operative notes should be dictated on the day of occurrence. Discharge summaries should be completed on the date of discharge. At the end of any 10 week rotation, the chief resident on the service is expected to check that all dictations are complete and up to date.
When a resident fails to complete required patient records after being notified of a deficiency by the site director or the Program Director, he or she can be removed from clinical service responsibilities until those records are complete. At the sole discretion of the Program Director, the resident may be required to use vacation leave during this time. If the resident has graduated prior to completion of medical records, it is the responsibility of the supervising attending to make sure the charts are completed.

Residents are expected to sign charts on which they have dictated discharge summaries. However, if a resident rotates away from a hospital prior to the time that the discharge summary is transcribed, the signature of the attending physician of record will be considered adequate.

The resident should not be held responsible for delays that originate in the record room.

*Prolonged failure to comply may result in additional disciplinary action which may include suspension without pay and dismissal from the program.*

**CONCERN POLICY**

A concern is defined as any issue perceived by a resident/fellow or Program Director as needing resolution. Generally, such a matter will not significantly threaten a resident’s/fellow’s intended career development or have the potential of leading to a recommendation of dismissal or non-renewal. Resident/fellow related concerns may be brought to the Administrative Chief Resident, Program Director, Faculty, Department Chair, Resident/Fellow Council or anonymous hotline. If not resolved, the concern may be brought to the Graduate Medical Education (GME) Office staff. The GME Office staff may act as a mediator and intercede for the resident/fellow, so as to try to reconcile differences and resolve the concern in a confidential manner. This is the final step with the GME Office.

Created 8/11
Revised 2/12

**Critical Incident Policy**

Critical incidents occur during training and may result in investigations which involve residents. When critical incidents occur during training and result in a formal investigation, individuals or groups will be strongly encouraged to notify the Program Director or designee (e.g., Site Director) of the resident training program before contacting a resident directly.

During the course of an investigation of a critical incident, residents should follow the protocol outlined below:

If a resident is contacted directly by an attorney, the Connecticut Department of Health, or other investigating entity in the course of an investigation of a critical incident, the resident should decline to discuss the matter until he/she can contact his/her Program Director or Site Director.

If the resident or fellow is contacted directly by the Hospital Risk Manager, he/she will be directed to contact his/her Program and/or Site Director, who will then schedule a meeting with the Risk Manager and resident.
The Program Director will inform the institution’s Assistant Dean for Education of the investigation. If the site has no Assistant Dean for Education, the Medical Director for the site and relevant Department Chair will be contacted.

The Program Director or designee and Risk Manager will discuss with the resident the nature of the investigation and what is expected from the resident regarding the investigation.

The Program Director or designee and Risk Manager will assist the resident in determining whether the resident may benefit from a separate advocate throughout the investigation.

If the Program Director and/or the designated authorities at the involved institutional site determine on an ad hoc basis that the resident should have a separate, qualified advocate, legal services will be provided by the institutional site involved. When not applicable, e.g. when training is in a non-affiliated private practice and with the concurrence of both the UCHC Executive Director of Risk Management and the UCHC-based Assistant Attorney General, legal services will be provided by the University of Connecticut School of Medicine.

All parties, including the resident, may contact the University of Connecticut Graduate Medical Education official (679-2147) with additional concerns.

**Policy on Interactions between Urology Residents and the Pharmaceutical, Nutriceutical and Biomedical Industries**

1. Personal gifts from Industry may **not** be accepted by trainees at any clinical facility in which graduate medical training occurs. Unrestricted educational grants may be provided by industry to training programs, (to Program Director or designee), but not directly to trainees or teaching faculty. Educational materials such as textbooks, pocket books, or PDR may be provided by Industry to training programs (to Program Director or designee) at the Program Director’s discretion. Identifying labels such as pharmaceutical inserts or logos must be removed or covered prior to their use with trainees.

2. Sales and marketing representatives are **not** permitted in any *direct patient care* areas in which graduate medical education occurs and where protected health information is accessible, with one exception: when providing necessary training on a previously purchased device or a device considered for purchase, and in the presence of teaching faculty. This training must adhere to HIPAA privacy rules.

3. Industry support of trainees must be free of any actual or perceived conflict of interest and must be specifically for the purpose of education.

4. All education events sponsored by University of Connecticut School of Medicine training programs must be compliant with ACCME Standards for Commercial Support whether or not CME credit is awarded. Meals or other types of food directly funded by Industry may **not** be provided for trainees. Unrestricted educational funds may be provided to programs (Program Director or designee) and expended for refreshments at trainee educational sessions. The contributing Industry(ies) can be credited for contributing an unrestricted educational grant for the session.

5. Teaching faculty may accept free drug, nutriceutical, or device samples from industry for distribution to patients. Since distribution of sample products to patients may encourage use of costlier products, trainees and teaching faculty should be cautious in distributing such products.
6. Trainees are prohibited from publishing articles under their own names that are written in whole or material part by Industry employees.

7. All trainees must receive training regarding potential conflicts of interest in interactions with Industry.

Details of the full policy can be found in the Housestaff Policy Book

**Prescription Writing/Medical Treatment**

Residents who provide treatment, can write prescriptions for patients they are caring for on their assigned rotations, both inpatient and outpatient, as activities within the resident/fellow program. (A resident who provides treatment, including a prescription for medication, for someone who is not under his/her care as part of the residency training program, is NOT covered by malpractice liability. This activity is prohibited.)

The resident/fellow who engages in this activity may be subject to disciplinary actions per the Code of Conduct.

**Sexual Harassment/Harassment Due to Bias or Discrimination**

Residents and other health team members, should not be mistreated or abused, nor should they be participants in behaviors such as discrimination, harassment, sexual harassment, and/or hostile work environment. Concerns may be discussed first with the Program Director, Chief Resident, faculty, and/or Department Chair. If not resolved, the concern must be brought to the attention of the Associate Dean for Graduate Medical Education or designee. The Housestaff may also report this directly to the GME Hotline or report to the Office of Medical Education and discuss the concern confidentially.

Sexual harassment, or harassment due to bias or discrimination, is a Code of Conduct violation (please see Code of Conduct) and will be handled according to the policy on misconduct.

The policy on sexual harassment (see attached Institutional Policy) includes a policy on consensual relationships between attendings/supervisor and trainees. All residents/fellows are responsible for following the policy/procedure at each site at which they train. All sites have policies that comply with State and Federal laws. Reporting procedures may vary, but all reports must be made to one of the listed offices at the University of Connecticut School of Medicine.

**Contacts:**

**Associate Dean for Graduate Medical Education (860)679-4458**
Kiki Nissen, MD, FACP

**Designated Institutional Official (860)679-4477**
Steven Angus, MD, FACP

**GME Hotline: (860) 679-4353**
State of Connecticut Controlled Substance Registration

The State Department of Consumer Protection mandates that all residents and fellows (with or without a state Medical license) practicing in the State of Connecticut must be registered in order to prescribe any controlled substance to any patient. This is different than the Federal DEA number as this is a State regulation. The biennial fee is $20. As long as the resident is employed by the Capital Area Health Consortium, the Consortium will cover the registration fee.

All new incoming residents and fellows will submit their paperwork to the Consortium prior to beginning work and the Consortium. After the initial registration, all housestaff will be notified by the State of Connecticut when renewal is required. Residents are required to renew their biennial registration. The Consortium will automatically reimburse the resident via their paycheck annually.

All physicians are required to notify the State of Connecticut Department of Consumer Protection License Services Division at 165 Capitol Ave., Hartford, CT 06106 within five (5) days of a change in address or department.

FAILURE TO COMPLY WITH THIS REQUIREMENT COULD RESULT IN YOUR INABILITY TO PRESCRIBE CONTROLLED SUBSTANCE MEDICATIONS AND MAY ALSO RESULT IN A FINE. The Capital Area Health Consortium and the UConn School of Medicine will not be responsible for any loss of privileges or fines as the result of the Resident/Fellows failure to comply with the above mandate.

If a resident/fellow is identified as not fit for duty (see Fit for Duty Policy) and substance abuse or mental health impairment is identified, the resident/fellow will be referred to the HAVEN (Health Assistance InterVention Education Network) which conducts programs for impaired healthcare workers for the State of Connecticut. They will make recommendations about further treatment and will work with our EAP program, the GME office and the Program director in identifying whether or not the resident/fellow is fit for return to duty.

In instances when the resident/fellow is identified as impaired due to substance abuse or mental health impairment by an outside agency such as the DEA, the Program Director should be informed and with the assistance of the Associate Dean for GME or designee, the EAP or HAVEN will be contacted to evaluate the resident/fellow.

Costs for evaluation and treatment are covered by the resident/fellow’s insurance with any balance paid by the Capital Area Health Consortium while resident/fellow is in his/her training program.

Re-Entry into Training Program/Monitoring: The final decision about possible re-entry into a program rests with the residency/fellowship program director in consultation with and approval from the GME office. One factor for re-entry is that the resident/fellow will need to have medical clearance to work (HAVEN will make a recommendation). Regardless of whether or not the program decides to have the resident/fellow re-join the program or be dismissed, the GME office will help the program decide how to proceed.
**Lead Exposure and Radiation Exposure**

Residents must wear protective lead aprons when a potential exist for radiation exposure and must monitor radiation exposure at all times. To monitor radiation exposure, the Radiation Safety Officer will deliver badges to the division the first Thursday of each month at the grand round meeting. Residents are expected to return the previous month’s badge in exchange for a new one. Residents will receive an annual report in mid-July concerning their cumulative radiation exposure.

Policy added February 2013