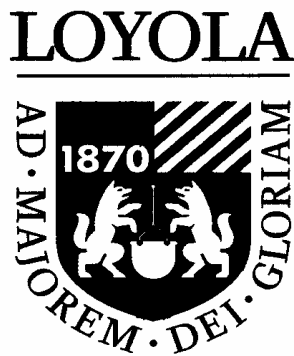


# UROLOGY

## RESIDENT POLICY MANUAL

### DEPARTMENT OF UROLOGY

CHAIRPERSON: ROBERT C. FLANIGAN, MD



Revised 01/06

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## **I. Medical Record Policy**

Patient care documentation is an essential aspect of the urology residency and must be completed on a timely basis. This patient care documentation includes (but is not limited entirely to) a properly completed admission note, history and physical examination, progress notes, consultations, and reports of operations. Discharge progress notes must be completed at the time of discharge. All operative notes must be dictated within 24 hours of surgery, preferably immediately following the procedure. Discharge summaries must also be dictated within 24 hours of discharge. All medical student's notes and orders must be countersigned by the resident or attending physician within 24 hours. All operations and procedures must be entered into the ACGME website tracking system no later than one week after the procedure (preferably the same day). (See Loyola and Hines V.A. instructions-Appendix A)

## **II. Resident Responsibilities**

Resident responsibilities include patient care, education of other house staff and medical students, personal education, medical records (quality and promptness), and maintenance of a personal operative log.

## **III. Evaluation Process**

The evaluation process consists of the tri-annual (every 4 months) review by the faculty who were involved with the individual resident using an evaluation tool (Appendix B, B1). These will be done electronically with summary of comments provided to the Department Chairperson's office after being compiled into a single anonymous evaluation. These evaluations are reviewed with the residents every four months by the Chairperson (Program Director). Resident progress is discussed in detail for each residents at faculty meetings (q 1-2 months) and the annual faculty retreat. Residents are required to participate in the in-service examinations of the American Board of Urology. Although, a passing score is not required for graduation, grades are used to establish promotion and academic probation, that requires improvement in a given time period. Attendance and participation in Journal Club, Tumor Board, Urologic Grand Rounds, Case Review and Outcome Conference, and all other departmental instructional conferences is mandatory and is evaluated. See evaluation of competencies at the end of section XIV. (Appendix C, Table X)

## **IV. Continuing Medical Education**

The Department of Urology strongly believes that continuing medical education is an essential part of the Urology Residency Training Program. The urology residents are, therefore, required to attend the six yearly Chicago Urologic Society meetings (unless specifically unable to do so because of clinical care emergencies) and to participate in all afternoon educational activities associated with these meetings. The resident is also required to attend the semi-annual visiting professor series of the department. The urology resident is entitled to attend, at the Urology Department's expense, the Basic Science Urologic conference held in Charlottesville, Virginia, during the PGY 3 year and one additional meeting of his/her choice during the PGY 6 year. The resident is also entitled to attend one pre-board review course at departmental expense. In addition, the Department of Urology will provide monetary support for residents to attend meetings at which they present research papers within the continental U.S.

## **V. Vacation**

A vacation time of 3 weeks (21 days including Saturdays and Sundays) per year is available. Preferences for vacation plans should be indicated to the Departmental office as soon as possible. In general, only 1 week of vacation per rotation is acceptable. Vacations may be taken at any time, except that vacations during the first 2 weeks of July and the last 2 weeks of June are to be evaluated on an individual basis.

## **VI. Sickness and Maternity/Paternity Leave**

Details regarding sickness and maternity/paternity leave are provided in the Loyola University House Staff Officer's Agreement under the Benefits Addendum. (See Appendix D)

## **VII. Duty Hours Policy**

Four-month rotation assignment schedules and monthly call schedules will be provided to the GME office.

The educational goals and learning objectives of the Department of Urology will not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hour assignments will take into consideration the fact that responsibilities to patients cannot automatically be released at specified times. Appropriate back-up will be provided to residents for patient care responsibilities that are uniquely difficult or long in duration. Careful and timely completion of duty-hour records is required.

In order to be in compliance with the Accreditation Council for Graduate Medical Education (ACGME) duty hours regulations, the following guidelines will be followed:

Residents will not be scheduled for more than 80 duty hours per week, averaged over a four-week period.

- A. Residents will be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period.
- B. Residents will be given at least a 10 hour period for rest and personal activities between daily duty periods.
- C. In house call will not occur more than every third night, averaged over a four-week period.
- D. On-site duty, including in-house call, will not exceed 24 consecutive hours. However residents may remain on duty for up to 6 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, or transfer care of patients.
- E. A resident who has been on duty 24 continuous hours will accept no new patients.
- F. When residents take call from home, time spent in house will be counted toward their 80 duty hours per week.
- G. Moonlighting will be approved and monitored by the Program Director.
- H. Duty hours will be monitored in regular intervals by the Program Director.

## VIII. Educational Goals and Objectives

During each rotation, the resident will be expected to demonstrate abilities in one or more of the core competencies and will be evaluated by the faculty in each area. Specific educational goals for each rotation and level of training are provided below.

### Junior Resident Loyola Rotation (PGY-2)

The primary objective of the junior resident rotation at Loyola is to introduce the resident to the basics of care of urologic patients including urologic diseases and their management (medical knowledge). This rotation allows the resident to have a broad spectrum of care including women and pediatric cases. As such, the resident is responsible for the day by day performance of histories and physical examinations and care management under the supervision of the chief residents and attendings on the service (patient care). The resident is also responsible for attending clinics at which time continuation of care of the patients is emphasized. The residents also learn more fundamentals of open and laparoscopic surgery including making and closing incisions and laparoscopic access. The resident begins to learn the basics of cystoscopy and retrograde pyelography and other endoscopic management of urologic patients (patient care). The resident also begins to present and discuss cases at preoperative conferences and educational conferences of the department (interpersonal communication skills, practice-based learning). He/she begins to learn the basics of ethics through instruction in conferences and to understand the aspects of professional behavior which is expected of a person during his/her residency and beyond (professionalism). The resident is also expected to begin to understand the University system of health care, particularly that of Loyola University, and its relationship to other health care systems in the local, regional and national arenas, including the transfer of patients between health systems (system based practice).

### Junior Resident Hines Rotation (PGY-2)

The primary objective of the junior resident rotation at Hines Veterans Administration Hospital is to introduce the resident to the basics of care of urologic patients including urologic diseases and their management (medical knowledge). This rotation allows the resident to have specific experience in the care of men who are primarily older and many with numerous medical concerns. As such, the resident is responsible for the day by day performance of histories and physical examinations and care management under the supervision of the chief residents and attendings on the service (patient care). The resident is also responsible for attending clinics at which time continuation of care of the patients is emphasized. The residents also learn more fundamentals of open and laparoscopic surgery including making and closing incisions and laparoscopic access. The resident begins to learn the basics of cystoscopy and retrograde pyelography and other endoscopic management of urologic patients (patient care). The resident also begins to present and discuss cases at preoperative conferences and educational conferences of the department (interpersonal communication skills, practice-based learning). He/she begins to learn the basics of ethics through instruction in conferences and to understand the aspects of professional behavior which is expected of a person during his/her residency and beyond (professionalism). The resident begins to understand the basics of care in the Veterans Administration system and how it relates to local, regional and national medical care systems including the transfer of patients between health systems (system based practice).

### Pediatrics Resident Rotation Loyola (PGY-3)

The resident begins to provide care to children and to learn communication skills with children and their parents (patient care, interpersonal communication skills) at Loyola's Ronald McDonald Children's Hospital. The resident is introduced to the basic understanding of pediatric urologic medical problems, their diagnosis and management (medical knowledge). The resident is responsible for history and physical examination, discharge and daily rounds under the supervision of the attending surgeon (patient care). The resident becomes familiar with the pediatric urology scientific literature and understands how to work effectively with the pediatric patients and their families (interpersonal communication skills). The resident also begins to understand how pediatric health care systems differ from adult health care systems and their inter-relationships, especially given the "hospital within a hospital" concept at Loyola University (systems based practice). The pediatric resident sees all pediatric inpatient and emergency room consultations (patient care, interpersonal communication skills).

### Lutheran General Rotation (PGY-3)

The resident at Lutheran General is, for the first time, exposed to a practice outside of the university setting, directed by voluntary faculty who are in private practice (system-based practice). The special emphasis of this rotation is on lithotripsy and infertility, but the resident also furthers their understanding of urologic cancer treatment (patient care, medical knowledge). They gain additional experience with the evaluation of the male infertility patient and patients with urinary stone disease (medical knowledge). The resident begins to understand how a non-university practice functions and its relationship to the provision of care at the local, regional and national levels (system-based practice).

### Loyola Consult Rotation (PGY-3)

The Loyola consultation resident is responsible for responding to all consults (both inpatient and emergency room) for adult urology (patient care, interpersonal communication skills). All consults are staffed and supervised by an attending physician. The resident becomes familiar with common urologic emergency and acute care issues (medical knowledge) and how these problems relate to patient's basic medical status. The resident presents his/her consultation recommendations to an attending, the patient and, the patient's family (interpersonal communication skills). The resident generally participates in the operative treatment of consult patients and follows them through their admission and is involved in discharge planning (system based practice, medical knowledge).

During the PGY-3 interval, the resident begins to formulate a research plan by meeting with their research advisor and begins to create a research protocol (practice based learning). See research rotation listed below.

### Multi-organ Transplantation Rotation Loyola (PGY-4)

During this rotation, the resident is introduced to the basic knowledge of transplant immunology, and the management of renal insufficiency and, renal and hepatic insufficiency (medical knowledge). The resident is responsible for the daily care of multi-organ transplantation patients and is expected to function in the diagnosis, management and treatment of these patients (patient care). The resident is expected to become familiar with the transplantation scientific literature and the scientific literature related to chronic renal insufficiency (practice based learning). The resident learns how to work with

renal failure and transplant patients with particular emphasis on the specific emotional and practical economic aspects of transplant care (interpersonal communication skills, system based practice). The resident is expected to begin to understand the ethics involved with organ transplantation and organ recruitment (system based practice, professionalism) and the issues regarding payment for renal transplantation and dialysis and the role that the federal government plays in funding these important areas of health care (system based practice). The resident has supervisory responsibility for the junior resident (interpersonal communication skills).

#### Female Pelvic Medicine Rotation Loyola (PGY-4)

During this rotation, the resident is exposed extensively to the care of women. The resident is expected to master the complete pelvic examination and to be able to evaluate incontinence, prolapse and other pelvic disorders (patient care). The resident is expected to achieve the basic knowledge regarding the anatomy of the female pelvis (medical knowledge) and to evaluate the scientific literature regarding female pelvic disorders (practice based learning). Specifically, the resident works extensively with women to learn the nuances of caring for women in a women's healthcare arena (interpersonal communication skills, system based practice). The resident is exposed to the national research efforts of the female pelvic medicine faculty and begins to understand clinical research trials (system based practice). The resident has supervisory responsibility for junior residents (interpersonal communication skills).

#### Children's Memorial Pediatric Rotation (PGY-4)

The resident serves as the chief resident at Children's Memorial Hospital and as such provides care to children and learns communication skills with children and their parents (patient care). The resident expands his/her understanding of pediatric urologic problems, their diagnosis and management (medical knowledge). The resident is responsible for history and physical examination, daily rounds and discharge under the supervision of the attending surgeon (medical knowledge). The resident becomes familiar with the pediatric urology scientific literature. The resident also begins to understand how a free-standing pediatric health care system differs from adult health care systems and their inter-relationships (system based practice). In this rotation the resident has a more extensive exposure to high intensity, complicated pediatric care. The resident learns to work with residents from other programs (professionalism) and learn how pediatric care is delivered in a multidisciplinary pediatric free standing hospital (system based practice). The resident has supervisory responsibility for the junior resident (interpersonal communication skills).

#### Research Rotation Loyola/Hines (PGY-5)

During the research rotation, the resident begins to expand his/her global urologic knowledge and is expected to serve as a director of education for urologic conferences, in rotation with the other residents at his/her level (medical knowledge, interpersonal communication skills). The resident begins to understand statistics and research methodology and understand how to report research findings (practice based learning). He/she learns to communicate research findings effectively by presenting at conferences and producing manuscripts related to their research activity (interpersonal communication skills). The resident begins to schedule research conferences as well as clinical conferences for their fellow residents and learns the basics of ethics as it relates to basic science and clinical studies (professionalism). Finally, the resident begins to understand how research funding is accomplished in our country from a local, regional and national level (system based practice).

#### Chief Resident Rotation Loyola (PGY-6)

The chief resident at Loyola is expected to master the complexities of treatment of high intensity medical problems including reconstructive surgery, cancer care, and minimally invasive technologies (medical knowledge). The resident is expected to perform advanced surgical procedures under the supervision of attending surgeons (patient care). The resident learns to facilitate the education of others including fellow residents, medical students and other health care professionals rotating on his/her service (practice based learning). The resident's communication skills with lower level residents and their communication with one another are evaluated as well as supervisory skills associated with directing a clinical service (interpersonal communication skills). The resident is a teaching source for ethics and an example of high ethical behavior (professionalism). The resident understands and teaches the issues regarding practice in a university setting.

Chief Resident Rotation Hines (PGY-6)

The chief resident at Hines is expected to master the complexities of treatment of high intensity medical problems including reconstructive surgery, cancer care, and minimally invasive technologies (medical knowledge). The resident is expected to perform advanced surgical procedures under the supervision of attending surgeons (patient care). The resident learns to facilitate the education of others including fellow residents, medical students and other health care professionals rotating on his/her service (practice based learning). The resident's communication skills with lower level residents and their communication with one another are evaluated as well as supervisory skills associated with directing a clinical service (interpersonal communication skills). The resident is a teaching source for ethics and an example of high ethical behavior (professionalism). The resident understands and teaches the issues regarding practice in a Veterans Administration setting.

**IX. Urology Department Resident Research Program**

**A. Faculty Research Advisors**

The following Urology Department faculty members are actively engaged in research projects and may serve as research advisor to the Urology Residents:

Dr. Robert Flanigan	Oncology, Renal Transplant
Dr. David Hatch	Pediatric Urology, Renal Transplant
Dr. John Wheeler	Bladder Physiology, Neurourology, Interstitial Cystitis
Dr. Thomas Turk	Min. Invasive Surgery, Endourology
Dr. Jeffrey Branch	General Urology
Dr. Kent Perry	Min. Invasive Surgery, Endourology
Dr. Marcus Quek	Oncology
Dr. Linda Brubaker	Female Pelvic Medicine & Reconstructive Surgery
Dr. Mary Pat Fitzgerald	Female Pelvic Medicine & Reconstructive Surgery
Dr. Kim Kenton	Female Pelvic Medicine & Reconstructive Surgery
Dr. Elizabeth Mueller	Female Pelvic Medicine & Reconstructive Surgery
Dr. James Walter	Bladder Physiology, Neurourology

## Research Project Time Table

- 1) PGY-3 year (7/1-12/30). Resident Decision re: Research Area of Interest  
During this period, the residents will explore research possibilities within the department and will discuss potential research projects with faculty members. (Each resident is encouraged to talk with all urology faculty to develop a sense of the types of research projects potentially available).
- 2) PGY-3 year (1/1-2/28) Identification of Research Advisor. The resident is expected by 1/1 to identify a potential research advisor to Dr. Flanigan. Dr. Flanigan will approve this request by 2/28.
- 3) PGY-3 (3/1-6/30) Development of a Research Abstract
- 4) By July 1, of their PGY-4 year, residents will begin to develop a research project with the selected faculty member. A one page abstract of the specific research proposal will be completed by each resident by Sept. 1 of their PGY-4 year and provided to their research advisor and Dr. Flanigan.
- 5) Draft of Research Project or Program by Individual Resident (7/1-11/30, PGY-4) By Nov. 30 of their PGY-4 year, residents will write a draft of their research proposal. This proposal will take the form of an abbreviated National Institutes of Health RO-1 a practice based learning, and will include a brief abstract, specific aims, background and significance, and a detailed section describing the research design and methods to be used. This proposal will serve to focus the resident's thoughts, to introduce them to the grant writing process, and to provide a listing of the research steps that are to be taken. The proposal will be submitted to their research advisor and to Dr. Flanigan. It is the responsibility of the resident and their research advisor to ensure that all of the necessary reagents, techniques, and animals (if necessary) will be in place in time for the research to begin. In addition, this will help the resident (and advisor) to carefully plan out the research program, to maximize the probability of successful accomplishment of the key specific aims. In addition, the Research Committee encourages review by other faculty members.
- 6) Preparation of Final Research Proposal (12/1-6/30, PGY-4)  
If the research project is considered appropriate for funding by outside sources (American Cancer Society, Kidney Foundation, etc.) the final research proposal will be the grant (practice based learning) that is submitted to that organization. For projects that are not submitted for funding, the abbreviated RO-1 format will serve as the final proposal. The time for completion of the proposals submitted for outside finding will be determined by deadline dates set by individual funding sources. The final date for submission of any research proposal will be June 30th, of the PGY-4 year.
- 7) Dr. Flanigan and the Research Committee will review all final proposals. Proposals for outside funding will be reviewed before they are submitted to the granting agency. Residents are reminded that all grant proposals for outside funding must go through a series of review steps before they can leave the University. These include review of budgets (Loyola Grants Accounting Office), and review of all proposals dealing with human subjects or patient material (Institutional Review Board), all research using animals (Institutional Animal Care and Use Committee), biohazardous materials (Institutional Biohazard

Committee), and radioactive compounds (Institutional Radiation Safety Committee). As these committees meet for consideration of research proposals on a published schedule, residents are encouraged to complete grant (practice based learning) in a timely fashion to allow scheduled review before the grant deadline submission date.

- 8) PGY-5 Begin research project. (12 months)

**X. Resident Job Description**

The urology resident will spend his/her PGY 1 year on surgical rotations under the auspices of the Department of Surgery. It is anticipated that the PGY 1 resident rotations will receive supervision commensurate with their level of training provided by the Department of Surgery during this year. PGY 1 resident rotations will primarily involve increasing responsibility for patient management (history and physical examinations, ward patient care, out-patient clinic care, etc.). The resident will be supervised by attending surgeons until they are familiar with these various procedures, invasive monitoring techniques, and minor operative procedures. The beginning of experience with endoscopic techniques will begin during the PGY-2 year and the attending urologist will supervise all such techniques.

PGY 2-6. The rotations in which the resident will participate by year are shown below. During the PGY-2 and 3 years, the resident will become facile with most endoscopic procedures and will be directly supervised by the attending in all cases. The resident will also acquire skills in diagnosis, evaluation, and management (both medical and surgical) of pediatric urologic conditions. During the PGY-4 year, the resident will be exposed to major procedures, particularly in the areas of pediatric urology, erectile dysfunction, stone disease, female pelvic medicine and reconstructive surgery, infertility, and peritoneal dialysis. All such procedures will be supervised by attendings. During the PGY-4 year, the resident will also learn multiorgan transplantation, again being supervised by the attending. During the PGY-5 year the resident will become proficient in basic science and clinical research under the direction of a research mentor. Finally, during the PGY-6 year, the resident will be involved in sophisticated cancer and reconstructive procedures as well as minimally invasive procedures under the supervision of attendings.

In all cases, supervision of the residents will be commensurate with the resident's level of advancement and responsibility. These levels of supervision correspond to requirements of the JCAHO.

		<u>4 months</u>	<u>4 months</u>	<u>4 months</u>
PGY	2	Jr Loyola 1	Jr Loyola 2	Jr Hines
	3	Pediatric	Lutheran General	IntermedL1/L2
	4	Transplant	FPMRS	Children's Memorial
	5	Research	Research	Research
	6	CR Loyola 1	CR Loyola 2	CR Hines

## **XI. Resident Responsibilities/General/Procedures Junior Resident/Supervising Resident/Attending Physician Notification/Order Writing**

### **General:**

Each resident will be offered the opportunity to assume direct responsibility for patient care. The transfer of this responsibility will occur in a graded fashion. The degree to which each resident is permitted to function “independently” depends upon individual initiative, interest, medical knowledge, and continually demonstrated competence. In fact, each resident’s performance will be closely supervised.

A major pitfall to be avoided is the attempt to assume responsibility for decisions in situations of inexperience or uncertainty. Since final responsibility for the patient’s welfare rests on the attending physician, he or she must be apprised of any significant change in the status of a patient or be informed of a change in treatment plan or decision to proceed with any non-routine procedure. Your management of difficult or bothersome patient problems should be guided by the maxim, “when in doubt, call”. Similarly, it is mandatory that the attending physician be notified immediately in the case of a patient’s death, admission of an emergency or unscheduled patient, discharge of a patient against medical advice, transfer of a patient to any other unit, service or hospital, or for your own reassurance and/ or protection in situations in which you feel unsure. Except in an emergency situation, the attending physician should also be notified before consultations are requested on his/her patients.

### **Procedures:**

Procedures to be done by house staff only with the attending physician’s permission and instruction are:

- A. Chest tube placement
- B. Thoracentesis
- C. Sigmoidoscopy
- D. Skin biopsy (punch biopsy)
- E. Paracentesis
- F. Lumbar puncture
- G. Swan-Ganz catheter
- H. Central line placement

### **Junior Resident: PGY1-4**

The PGY1/2 resident is responsible for recording the **ADMISSION NOTE** (admitting history and physical, problem list, assessment, diagnostic plan and admitting orders) for all new admissions assigned to him/her by their supervising senior resident. (The supervising resident should write a brief addendum outlining the treatment plan.) If a third year medical student is assigned to that particular patient, the student should record the admitting history and physical exam; the PGY1 or PGY2/3/4 is responsible for reviewing and correcting the history and physical, making appropriate additions, and countersigning the student’s note; however a full H&P must still be written by either the PGY1 or supervising resident. The same policy applies (practice based learning) to transfers between medical services (including from/to the intensive care units) or patients admitted by the previous night’s on call residents (i.e., night float). However, the **TRANSFER ACCEPTANCE NOTE** should be a brief summary of the patient’s presentation and hospital course; the remaining details of the H&P need not be rewritten but should be referenced as appropriate. Transfers to medial services from outside hospitals or non-medicine services require a **COMPLETE ADMISSION**

## **NOTE.**

- A. The PGY1/2 is responsible for **DAILY PROGRESS NOTES** on his/her patients. It is expected that any sub interns will enter daily progress note on the patients they are following. These notes must be reviewed and countersigned by the senior resident, who is directly responsible for all necessary sub intern supervision. Prior to countersigning, the notes must be read carefully and corrected when necessary so that the included data, assessment, and plans accurately reflect the status of the patient and the thinking of the service.
- B. The PGY 1/2/3/4 residents are responsible for all the **CROSS-COVERAGE** when on call. (See below for cross-coverage assignments.) When cross-coverage includes critical decision making and/or patient assessment, or the PGY 1/2 has any doubts regarding patient management, the on-call supervising resident should be involved immediately.

### **Supervising Resident PGY 5-6**

The supervising resident is ultimately responsible for the overall organization and conduct of the service and its participating members as well as for the specific details of patient care. Included among the senior year resident's daily responsibilities are:

- A. Leading work rounds with the entire team
- B. Organization of attending rounds
- C. Assuring team attendance at all required conferences
- D. Conduct of afternoon chart rounds
- E. Education of PGY 1-4 and medical students.

In addition, the supervising resident is responsible for reviewing the medical record of each patient. This implies close scrutiny of the PGY1/2 and medical student entries.

### **Attending Physician Notification Policy and Procedure**

Residents should notify their attending in the event that:

- A. A patient is admitted
- B. A patient's condition deteriorates significantly
- C. A patient is transferred to an intensive care unit
- D. A patient expires
- E. A patient desires to leave against medical advice (AMA)
- F. A significant procedure or test is being performed (central lines, angiograms, etc)
- G. The resident has any questions about the diagnostic and/or therapeutic plan

At the beginning of each month, each service attending and house staff should discuss their preferred means of communicating during off-hours. All of the following options should be exercised in the event that there is difficulty in reaching the service attending:

- A. Contact the chief resident
- B. Page the attending directly via the hospital paging network (usually 68777)
- C. Call the attending directly at home
- D. Contact the physician answering service (68000) and have them locate the appropriate attending

- E. Contact the attending on call for the department again through the answering service
- F. Contact the fellow on call for the service

**Order Writing Responsibilities**

The house staff is responsible for writing **ALL** orders on **ALL** patients on their service.

**XII. Resident Supervision**

All residents are supervised in all operative procedures and patient care examinations. The complexity of the procedure, the resident’s previous experience with similar procedures, and the level of training determine the level of supervision.

PGY 1 & 2 - Complete supervision of all procedures.

PGY 3 - Complete supervision minor endoscopic procedures and minor open cases until the resident is judged competent, then presence in the OR for these procedures. Complete supervision for major endoscopic, major open and laparoscopic cases.

PGY 4 - Presence in the OR for minor endoscopic and minor open cases. Complete supervision for major endoscopic, major open and laparoscopic cases, and transplantation cases.

PGY 5 - Presence in the OR for minor cystoscopic, minor open, and major open cases excepting multiorgan transplantation.

PGY 6 - Presence in the OR for all cases, including major cases and laparoscopic cases.

**Supervision Levels**

Level	<u>Minor cystoscopic</u>	<u>Major endoscopic</u>	<u>Minor open</u>	<u>Major open</u>	<u>Laparoscopic</u>
PGY 1-2	C	C	C	C	C
PGY 3	C/P	C	C/P	C	C
PGY 4	P	C	P	C	C
PGY 5	P	C	P	P	P
PGY 6	P	P	P	P	P

C = complete supervision (scrubbed in)  
P = presence in OR

Clinic Residents are supervised in all clinics. Residents are expected to see patients before the attending (all patients are seen by the attending) at Loyola University Medical center and see the

patients with attending coverage or stipulated by the Hines Veteran's Adm. Hospital (an attending is to be present in all clinics for supervision).

### **Intensive Care Unit Procedures**

<b><u>Procedure</u></b>	<b><u>Practitioner w/ Independent Privileges</u></b>
Chest Tube	PGY2 after notification of attending
Flexible Cystoscopy	PGY2 after notification of attending
Central Line Placement	PGY2 after notification of attending

### **XIII. Outcome Measures for the Residency Program**

- A. The residency program outcome is measured by:
- B. Success of residents in achieving employment in good positions (academic or private practice)
- C. Annual evaluation of the resident's experience at Loyola (done by the GME office).
- D. Ability of graduates to pass Part 1 & 2 of the American Board of Urology Examinations
- E. Frequent contact with previous residents to assess practice patterns, successes and problems.
- F. Performance of residents on in-service exams.
- G. Performance of residents on tri-annual reports.

### **XIV. Core Competencies**

The Accreditation Council for General Medical Education has requested evaluation of core competencies within residency programs. This program will include the 6 core competencies identified by the ACGME:

- A. Patient care
- B. Medical knowledge
- C. Practice based learning and improvement
- D. Personal and communication skills
- E. Professionalism
- F. Systems based practice

These areas will be addressed using departmental, institutional, and national programs of education and evaluation techniques. These competencies will be an important aspect of resident's evaluations. The urology residency program will require the residents to develop the competencies in the 6 areas below to the expected level of a new practitioner. Toward this end, programs must define the specific knowledge, skills, and attitudes required and provide educational experiences as needed in order for their residents to demonstrate the competencies.

#### **A. Patient care**

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

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

## **B. Medical Knowledge**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:

1. Demonstrate an investigatory and analytic thinking approach to clinical situations
2. Know and practice the basic and clinical supportive sciences which are appropriate to their discipline

## **C. Practice-Based Learning and Improvement**

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

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

## **D. Interpersonal and Communication Skills**

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

professional associates. Residents are expected to:

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

#### **E. Professionalism**

Residents must demonstrate a commitment to carrying out professionalism responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:

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

#### **F. Systems-Based Practice**

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:

1. Understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
2. Know how types of medical practice and delivery systems differ from one another, including methods controlling health care costs and allocating resources
3. Practice cost-effective health care and resource allocation that does not compromise quality of care
4. Advocate for quality patient care and assist patients in dealing with system complexities
5. Know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect a system performance

Competencies will be evaluated by multiple tools including faculty evaluations. Each conference will be expected to provide competent education in specific areas. See Table X

## **XV. Faculty and Rotation Evaluations**

The resident will be responsible for evaluating the Urology faculty on a yearly basis. The evaluation forms will be provided to the resident by the Administrative Secretary, filled out by the resident, combined anonymously by the Administrative Secretary, and provided to the Chairman for review with the individual faculty member. (Appendix F, F1) In addition, the residents will evaluate the residency rotations and programs yearly. (Appendix G, G1)

## **XVI. Moonlighting**

Moonlighting is not encouraged during the program, but may be done during the research year if the resident is in good standing, and Dr. Flanigan approves the proposal. This approval will be documented in the resident's file. (Appendix H)

## **XVII. Reporting Medical Equipment/Medical Device Malfunctions Under the Safe Medical Devices Act (SMDA)**

### **What is the Safe Medical Devices Act?**

The Safe Medical Devices Act (SMDA) is a federal regulation instituted in 1990. The regulation requires all hospitals to report adverse events related to medical devices under a uniform report system and prescribes the conditions under which reports must be submitted. At Loyola, the Risk Manager is the designated person for reporting adverse events to manufacturers and the FDA.

### **What is a "medical device"?**

A medical device is any item that is used for the diagnosis, treatment or prevention of a disease, injury or other medical condition. Drugs and biological agents are not considered medical devices. Some examples of medical devices are:

- Catheters
- Ventilators
- Perfusion equipment
- Surgical instruments
- Lasers
- Saws
- Drills
- Bronchoscopes
- Infusion pumps
- Prostheses
- Implantable devices such as pacemakers, plates, screws
- Ventricular assist devices
- Intra-aortic balloon pumps

### **What must be reported?**

Adverse events in which a medical device causes or contributes to an illness or injury that is 1) life-threatening; 2) results in permanent impairment of a body function or permanent damage to a body structure; or 3) necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

Malfunctions are not reportable if they have not resulted in death, serious injury or other significant

adverse event. If you are not sure if an event is reportable, contact Risk Management.

Once Risk Management is notified of the event, the Risk Manager will complete the FDA MedWatch form and submit it to the manufacturer and the FDA. Physicians should **not** complete the FDA MedWatch form, since the Risk Manager is the designated reporter for Loyola.

**What do I do if a device injures a patient?**

- A. Remove the device from service and label it “**DO NOT USE. HOLD FOR RISK MANAGEMENT.**”
- B. Contact the Risk Management Department as soon as possible, since reports to the FDA must be made within ten days. A member of the Risk Management staff will retrieve the device. For large mechanical or electrical devices, contact clinical engineering and they will retrieve the device. If you have the outer wrapper or packaging for the device, store it with the device. The model numbers, serial numbers, etc. on the packaging will be helpful in identifying the device.
- C. Complete an incident report and list the type of device, model number, serial number and any other identifying information. Submit the incident report to Risk Management.