



FLORIDA HOSPITAL

Graduate Medical Education

The skill to heal. The spirit to care.®

GENERAL SURGERY RESIDENCY

PROGRAM MANUAL

2016-2017

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FHGSR at its option, may change, delete, suspend or discontinue parts of, or the policy in its entirety, at any time, without prior notice. In the event of a policy change, employees will be notified. Any such action shall apply to existing as well as to future employees.

The following material is a program-specific supplement to the Graduate Medical Education (GME) manual. Referral to, and familiarity with, each manual is expected by your Program Director and the Graduate Medical Education Committee.

Program Mission & Education Statement

Mission:

To extend the healing ministry of Christ by preparing compassionate and competent surgeons.

Education:

The purpose of the General Surgery Residency is to provide an organized educational program with guidance and supervision which facilitates the resident's personal and professional development while ensuring appropriate and safe patient care. Ultimately, this will produce a surgeon capable of high level performance who is certified by the American Board of Surgery.

We commit to:

- Provide residents the opportunity to learn the fundamentals of basic science as applied to clinical surgery.
- Provide an experience in preoperative, operative, and postoperative care for patients in all areas of general surgery, including abdominal, alimentary, breast, vascular, endocrine, head & neck, pediatric surgery, skin & soft tissue, trauma and surgical critical care. We will also provide experience in cardiac and thoracic surgery, endoscopy, and transplant surgery.
- Provide a five-year program consisting of at least 36 months in the principal components of surgical education.
The 48 weeks of full-time clinical activity in each residency year, regardless of the amount of operative experience obtained. The 48 weeks may be averaged over the first 3 years of residency, for a total of 144 weeks required and over the last 2 years, for a total of 96 weeks required. There should be at least 54 months of clinical surgical experience with increasing levels of responsibility over the 5 years, with no fewer than 42 months devoted to the content areas of general surgery. The content areas are: Alimentary Tract, Abdomen and its contents, Breast/Skin/Soft Tissue, Endocrine System, Solids Organ Transplantation, Pediatric Surgery, Surgical Critical Care, Surgical Oncology(including Head and Neck surgery), Trauma/Burns and Emergency Surgery, and Vascular Surgery.
- Require residents to participate in research and provide teaching and mentoring of medical students.
- Provide residents with the opportunity to maintain continuity of care for their patients through time spent in the General Surgery office suite and on night call.

- Provide residents and faculty with educational goals and objectives at the beginning of each rotation, and the opportunity to complete peer evaluations at the end of the rotation.
- Provide each resident with a summative evaluation of performance on a semi-annual basis to show progression of expertise.
- Provide each resident with supervisory lines of responsibility, fair grievance policies, and resources for mental/emotional support.
- Provide a sufficient number of surgical cases, as determined by RRC standards of achievement, to advance operative skill and surgical judgment.
- Provide educational conferences on a weekly basis with a protected block of time designated on Friday mornings. These conferences will follow a set format with a developed curriculum. Attendance is mandatory and conference time is protected.
- Provide a working environment that is optimal for resident education and patient care. This environment will be safe and will provide adequate space for sleep, food, and lounge/study facilities.

*Program Goals & Objectives Booklet is made available in the New Innovations homepage to Residents and Attendings for review.

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Accreditation Council of Graduate Medical Education (ACGME):

The ACGME is the accrediting body for the General Surgery residency program. They may be contacted with questions via their website at: www.acgme.org or by mail and phone at: 515 North State Street, Suite 200, Chicago, IL 60654, Phone (312) 755-5000, and fax (312) 755-7498.

Recruitment, Eligibility & Selection:

Florida Hospital GME offers clinical clerkships to medical students from affiliated medical schools and other accredited medical schools on a case by case basis

Applicant Eligibility:

I. Medical School Diploma

II.

1. LCME (Liason Committee of Medical Education) graduates:

- i. Eligible for Doctor of Medicine diploma without reservations
 - ii. Dean's Letter
 - iii. Letter from residency program director (if applicable)
 - iv. Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination) at first attempt.
 - 1. Transcript directly from the FSMB (Federation of State Medical Boards)
 - v. Acceptable explanation of any break in education (if applicable)
 - vi. Demonstrated written and spoken fluency in English language
 - vii. Proof of Citizenship or resident alien status as required by Florida Hospital Human Resources
 - 2. AOA graduates:
 - i. Eligible for Doctor of Osteopathy diploma without reservations
 - ii. Dean's Letter
 - iii. Letter from residency program director (if applicable)
 - iv. Successfully passed USMLE I and USMLE II (United States Medical Licensing Examination) at first attempt.
 - 1. Transcript directly from the FSMB (Federation of State Medical Boards)
 - v. Internship year in Osteopathic Program (required by Florida Board of Osteopathic Medicine and the American Osteopathic Association) or AOA-approved waiver
 - vi. Acceptable explanation of any break in education (if applicable)
 - vii. Demonstrated written and spoken fluency in English language
 - viii. Proof of citizenship or resident alien status as required by Florida Hospital Human resources
- III. ERAS Application
- 1. Completed application through ERAS (Electronic Residency Application Service), through the AAMC (American Association of Medical Colleges), and participation in the NRMP (National Resident Match Program) match.
 - i. Online application
 - ii. Personal statement
 - iii. CV
 - iv. Transcript

- v. Dean's letter
- vi. Three letters of recommendation by surgeons
- vii. USMLE/COMLEX scores, Part I and II (USMLE preferred)
- viii. Photograph

III. Reasons for Ineligibility:

- A. Applicant does not demonstrate sufficient commitment to the specialty of General Surgery, included but not limited to:
 - 1. No advanced-level electives during medical school
 - 2. No letters of support from surgeons
 - B. Applicant did not present favorable impression to faculty, resident physicians and/or residency coordinator during elective time or interview process at Florida Hospital.
 - C. Quality of interaction during preliminary contact with staff suggests incompatibility with the mission and values of Florida Hospital
 - D. Quality of personal statement (content, typographical and grammatical errors), including no obvious commitment to General Surgery
 - E. Limited verbal and written English skills, including the inability to write clearly and legibly
- IV. Non-eligible candidates may not be offered an interview or accepted into Florida Hospital Graduate Medical Education residencies (see exception in #IX).
- V. Applicants must have successfully participated in formal clinical training, medical school, residency training, or full-time clinical practice within the last 24 months (from date of application to the residency program).
- VI. A personal interview at the Florida Hospital General Surgery program is required for applicants who wish to be considered for a residency position. The interview process is conducted as follows:
- 1. The applicant reports to the first meeting location at 7:00 AM.
 - 2. The applicant is interviewed by: The Program Director, select General Surgery faculty, subspecialty preceptors and select current residents.
 - 3. The applicant tours Florida Hospital facilities, General Surgery Department, and has lunch with a group of our residents.
- VII. Each interview completes an evaluation form which includes four areas:

1. Presentation
 2. Attitude/Maturity/Motivation
 3. Educational Background
 4. Ability to function as a house officer and fit in as a team-player
- VIII. The files are reviewed and screened by the selection committee, program director and residency coordinator. The following criteria are utilized:
1. Personal statement
 2. Transcript score
 3. Dean's Letter
 4. USMLE scores
 5. Letters of recommendation
 6. Input from resident interaction with applicant
- IX. The program director may permit the waiver of one or more of these requirements under special circumstances.
- X. All applicants who have been interviewed will be reviewed for ranking by the selection committee made up of faculty and resident leaders in early February with the resident rank list taken into account.
- XI. The Program Director may contact applicants to answer any questions. The rank order list will be compiled and submitted to the NRMP. The Match list is at the discretion of the Program Director and is confidential.

Examinations, Licensure & Certification:

USMLE:

All interns must complete USMLE Step 3 prior to the end of the PGY-1 year. We urge you to take USMLE Step 3 as soon as possible. The cost of application is paid by the program for your first attempt only. All application paperwork should be submitted directly to the Residency Coordinator for processing.

To obtain an application for USMLE Step 3, go to their website and download the application. They can be reached at:

<http://www.fsmb.org>

Or: (800) 876-5396.

Once you have filled out and submitted the application (along with a copy of your medical school diploma), please let the Residency Coordinator know immediately when you schedule the exam since the Department will need to adjust coverage for your approved absence. Taking the exam means two days away from your rotation.

You will also need to submit a "Certification of Post-Graduate Training" form to the Residency Coordinator to fill out. This form can be obtained from the website when you download the application forms.

Licensure:

Until such time as the USMLE Step 3 is completed and the resident is eligible to apply for full licensure in the State of Florida, the resident must maintain a Florida Department of Health Training License. The application for this will be sent to the newly-matched resident directly after the Match results are in. This training license fee will be paid by the Program, and the application and all supporting documents must be sent to the Department of State by the Program not later than April 1st in order to give adequate time to process the application for a start date of July 1st in the training program.

PGY-2:

Within three (3) months of completion of USMLE Step 3, the resident will be expected to complete the application for full medical licensure in the State of Florida. The fee for this will be paid by the Program. Application for license can be obtained from the Residency Coordinator or via the Department of Health website. Make sure to download all forms and read directions carefully to expedite your application (EBAHR, National Practitioner Data Bank Self Query, AMA Profile), also request a fingerprint card from the www.fldoh.sofn.net website.

MD Applicants: www.doh.state.fl.us/mqa/medical/me_applications.html

DO Applicants: www.doh.state.fl.us/mqa/osteopath/os_applications.html

Certifications:

Residents in the General Surgery Program are required to maintain current certifications in ACLS and ATLS in order to be able to participate in the training program. We encourage the resident to obtain ACLS certification prior to the start of training, however if ACLS is not in place, the resident is required to complete certification as part of orientation in June. ATLS certification must be completed within the first year of training. Current ACLS certification must be in place in order to qualify for ATLS training. Further recertification will be paid for by the Program and is mandatory for continuation of training. Fundamentals of Laparoscopic Surgery (FLS) is a requirement and the program will provide access to this certification during the resident's training in preparation for the Fundamentals of Endoscopic Surgery (FES), ABS, QE and CE.

FLS: <http://www.flsprogram.org/>

FES: <http://www.fesprogram.org/fes-required-american-board-surgery/>

Copies of all certifications must be given to the Residency Coordinator for permanent record.

American Board of Surgery Requirements:

- The American Board of Surgery has defined guidelines for certification eligibility. Senior residents applying for board certification should coordinate applications through the Residency Coordinator. Candidates planning to take the American Board of Surgery examination will be required to have a total of **750** cases as surgeon with a minimum of **150** cases during the chief year. Cases performed as teaching assistant do not count as cases performed as surgeon. The American Board of Surgery booklet of information states: Residents will be required to have participated as **teaching assistant in a minimum of 25 cases** by the completion of residency. Applicants may count up to 50 cases as teaching assistant toward the 750 operative case total; however these cases may not be counted toward the 150 chief year cases. Residents will be required to have performed **250 operations by the conclusion of the PGY-2 year**. These can include operative procedures performed as surgeon or first assistant, as well as operative exposures (e-codes) and endoscopies. Since the ABS does not receive residents' operative data until the application for certification, the RRC-Surgery will track this requirement through its case log system.
- A minimum of **25 cases in surgical critical care**, with at least one in each of the seven categories: ventilatory management; bleeding (nontrauma); hemodynamic instability; organ dysfunction/failure; dysrhythmias; invasive line management and monitoring; and parenteral/enteral nutrition.
- Applicants who complete residency in the **2017-2018 academic year** or thereafter will be required to have completed the ABS Flexible Endoscopy Curriculum.
- **Procedure logs:** The ACGME mandated log of **operations will prove** to be invaluable in preparing your American Board of Surgery (ABS) application and is essential for our residency accreditation. Beginning in July of 2002, each resident became responsible for keeping an accurate log of all procedures performed during his/her residency. Procedures are to be recorded in the operative log database via the ACGME Resident Data Collection System, which is an Internet-based data collection system utilizing CPT codes. Procedure data may be entered from any computer connected to the World Wide Web.

ACGME Website: <https://www.acgme.org/ads/CaseLogs>

The Program Director will provide each resident with an ID and password. Procedures and cases should be logged as soon as completed and are required to be entered prior to Friday AM conference on a weekly basis, so that the Program Director can assure adequate and equivalent experience in the index cases. This will allow prompt and accurate submission to the American Board of Surgery as a

preface to the qualifying examination. The RRC requires a minimum number of cases in the following categories (note: The ABS does count first assist but the RRC does not.):

RRC Minimum Cases: (Defined Categories)

- Skin and Soft Tissue/Breast (25)
- Head and Neck (24)
- Alimentary Tract (72)
- Abdomen (65)
- Liver (4)
- Pancreas (3)
- Vascular (44)
- Endocrine (8)
- Thoracic (15)
- Pediatric (20)
- Plastic (5)
- Trauma Surgery (10)
- Endoscopy (85)
- Basic Laparoscopic Procedures (60)
- Complex Laparoscopic Procedures (25)
- Trauma non-operative (20)

Timely and accurate records of the resident's and the Department's operative experience are important, not only for each resident's ABS application at completion of residency, but also for the Residency Program's reaccreditation.

The ABS application will not be signed or supported by the Program Director unless the residents' ACGME logs are updated and complete.

ABSITE: All residents will take the annual American Board of Surgery In-Training Examination (ABSITE) each academic year. The examination is customarily given the last week of January or first week of February (date to be announced annually). This examination is most helpful in the resident's and the faculty's assessment of clinical and basic science knowledge and allows the resident to be able to compare his own academic progress with his peers on a nationwide basis. Although performance on this exam alone is not the sole determinant in promotion and advancement in the Residency, it is a helpful tool in assessing that the resident will be able to pass the ABS Qualifying Exam. Residents are expected to score above the 40th percentile for the appropriate year in training. In the event a resident scores at or below the 40th percentile, a remediation plan will be set based on the recommendation policy for MK.

Remediation Policy

- Residents that score less than 40th percentile on the annual In-Training exam (ABSITE) will be placed on academic remediation
- Development of a Personal Learning Plan (PLP)

- weekly meetings with their advisor to review PLP
- Residents that score <40th %ile 2 years in a row will be required to undergo consultation with education specialist and may be considered for non-promotion.
- Residents that score <40th %ile will be mandated to utilize the following year's CME monies to attend an ABSITE review course
- Noncompliance will result in Probation, with consideration of nonrenewal
- Seniors on academic remediation will attend a board review course in the year with the opportunity to repeat the course if the resident does not improve. The resident will use their CME funds to cover the course.

Emphasis is also placed on the ABSITE results when applying for fellowship. If poor performance on this exam is thought to be based upon learning disabilities, the Program Director may refer the resident for evaluation and the learning plan.

Program Curriculum:

The curriculum of the Program will provide experience in all areas mandated by the Residency Review Committee. For any requirements not available at Florida Hospital, the Program will make such arrangements as necessary in order to provide the resident with the requisite experience. If such arrangements mandate rotations in remote sites, the Program will provide living facilities at its expense.

For the Trauma rotation, residents will rotate at Orlando Health during their PGY-2 and PGY-4 years in order to gain the necessary experience.

It is required for PGY-1 residents to complete the *ACS Fundamentals of Surgery Curriculum* before the start date of July 1st.

Program Goals and Objectives:

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.

1. During their clinical rotations, residents are exposed to experiential learning opportunities through the following:
 - a. Inpatient and outpatient patient care experiences
 - b. Operative patient care experiences
 - c. Operative log completion and review

- d. Case review at M&M conference
- e. Case discussion at weekly resident conferences
- f. Bedside teaching
- g. Ward rounds
- h. Operating room instruction
- i. Journal Club participation

2. With appropriate supervision, balanced with increasing responsibility and autonomy residents are expected to:

- a. Communicate effectively and demonstrate caring and professional behaviors when interacting with patients and their families
- b. Gather Information that is timely, essential and accurate about their patients
- c. Make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
- d. Develop and execute patient management plans
- e. Counsel and educate patients and their families
- f. Use information technology to support patient care decisions and patient education
- g. Perform competently all medical and invasive procedures considered essential for the area of practice
- h. Provide health care services aimed at preventing health problems or maintaining health
- i. Work with health care professionals, including those from other disciplines, to provide patient-focused care

Resident Assessment includes observation of performance in these areas:

- a. Medical Interviewing (CAMEO)
- b. Physical Examination (CAMEO)
- c. Procedural Skills- on patients and on simulators (OSATS)
- d. Clinical Judgment (Mock Oral, M&M)
- e. Ongoing Care. (Rotation Eval)
- f. communication with staff and colleagues (Rotation & 360 Eval)

MEDICAL KNOWLEDGE:

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

Residents are exposed to Medical Knowledge Learning Activities through the following:

- a. Weekly resident conferences
- b. Presentations at M&M

- c. Experiential learning opportunities in clinic, hospital, operating room
- d. Regularly scheduled conferences (departmental and/or service specialized conferences)
- e. Resident self study using SESAP, appropriate standard surgical text and SCORE curriculum/modules
- f. Periodic quizzes based on lecture material
- g. Mock Oral Examination at the 3rd, 4th and 5th year level
- h. Critical Review of literature in preparation for Journal Club
- i. Mock Oral Experience and M&M conference

Residents are expected to:

- a. Demonstrate an investigatory and analytic approach to clinical situations
- b. Know and apply the basic and clinically supportive sciences, which are appropriate to their discipline

Resident Assessment includes observation of performance in these areas:

- a. Annual ABSITE
- b. Bi-Annual Mock Oral examinations at the 3rd , 4th ,and 5th year level
- c. Daily Attending Rounds
- d. Written evaluation by faculty
- e. Periodic quizzes
- f. Weekly teaching rounds

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 exposed to Practice-Based Learning and Improvement Learning Activities during surgical rotations which provide experience in this competency development include:

- a. Case review at weekly M&M Conference
- b. Case log review during rotation and at semi-annual performance reviews
- c. Case discussion at weekly resident conferences
- d. Discussions at Journal Club
- e. Presentations at Scholarly Activity Conference

Residents are expected to:

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

Resident Assessment includes observation of performance in these areas:

- a. Appraisal of scientific evidence
- b. Maintenance of Portfolio
- c. Presentations at Journal Club
- d. Knowledge of study designs, statistical methods
- e. Analysis of own practices-self evaluations
- f. Data gathering and feedback
- g. Use of information technology
- h. Student education

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.

Interpersonal and Communication Skills Learning Activities during surgical rotations which provide experience in this competency development include:

- a. Patient care experiences in outpatient clinic and hospital
- b. Resident performance during Oral Examination
- c. National exposure at professional meetings, networking opportunities
- d. M3 and M4 teaching interactions with student learners; analysis of student feedback on teaching
- e. Teaching of junior level residents

Residents are expected to:

- a. Create and sustain a therapeutic and ethically sound relationship with patients

- b. Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
- c. Work effectively with others as a member or leader of a health care team or other professional group

Resident Assessment includes observation of performance in these areas:

- a. Compassion for patients and their families
- b. Counseling, education, and informed consent instructions to patients
- c. Patient inclusion in treatment decisions
- d. Listens to patients, and other members of the health care team
- e. 360 evaluations by nurses and mid level practitioners
- f. Communicate effectively with faculty and the attending

PROFESSIONALISM:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population.

Professionalism Learning Activities during surgical rotations, which provide experience in this competency development, include:

- a. Professionalism seminars
- b. Surgical faculty and other role modeling
- c. Personal presentations at regional and national conferences
- d. Performance during Mock Oral Examination
- e. Frequent practice through hosting resident applicants during Match activities
- f. Journal Club
- g. Recording of duty hours and case logs

Residents are expected to:

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

Resident Assessment includes observation of performance in these areas:

- a. Regard for welfare of others
- b. Adheres to a code of moral and ethical values
- c. Respectful of patients and their families
- d. Respectful of other members of the health care team
- e. Provides prompt consultations upon request
- f. Sensitive to patients' cultural backgrounds
- g. Accountable for own actions
- h. Reliability
- i. Punctual

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.

Systems-Based Practice Learning Activities during surgical rotations which provide experience in this competency development include:

- a. Case review at M&M Conference
- b. Journal Club
- c. Planning discharge of complicated patients initializing case management to coordinate rehabilitation, home health, and nursing homes

Residents are expected to:

- a. 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
- b. Know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
- c. Practice cost-effective health care and resource allocation that does not compromise quality of care
- d. Advocate for quality patient care and assist patients in dealing with system complexities
- e. 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 system performance

Resident Assessment includes observation of performance in these areas:

- a. Provides cost-effective care
- b. Advocates for patients within the health care system
- c. Refers patients to appropriate practitioners and agencies
- d. Accesses assistance within the health care system for coordination and management of ongoing care
- e. Discharges patients in a timely and appropriate manner

Research and Scholarly Activity Requirements:

ACGME: the program must provide opportunity for residents to participate in research or scholarly activities.

The residents will be required to complete research projects as outlined by the Research Committee which meets with the residents on a monthly basis.

PROCESS:

This requirement will be accomplished through one-on-one mentoring by faculty of choice and/or team work with peers. The resident will also be responsible for the completion of certain tasks with the guidance from faculty and research coordinator.

GOAL:

Upon completion of these requirements, the resident will fulfill ACGME requirements of scholarly activities and clinical research.

REQUIREMENTS:

In order to graduate from the General Surgery Residency Program, residents are required to complete the following:

- 1) IRB certification-Collaborative Institutional Training Initiative(CITI)
 - Must be completed by September 1st of PGY-1
- 2) At least (1) publishable manuscript (original articles, case series, review manuscript, book chapters) per year
 - Starting PGY-1 through PGY-5
- 3) Presentation of at least 1 (one) abstract/manuscript yearly at the FH GME research day event
 - Starting PGY – 1through PGY - 5

EVALUATION:

- 1) Completion of items 1-3 listed in the requirements section prior to graduation.
- 2) A 10 minute oral presentation of the case report and/or research project to peers and faculty .
- 3) Submit the scholarly activity and research project to appropriate peer review journal and GME resident research day.

RECOMMENDED READING/RESOURCES:

- Florida Hospital Institutional Review Board Handbook.
- Florida Hospital Office of Research Administration Handbook.
- IRB NET user's manual.

- International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals: Writing and editing for biomedical publication www.icmje.org.
- Outlines and articles on how to write case reports, scientific papers, and preparation for presentations are available through the Research Coordinator.

INSTITUTIONAL REVIEW BOARD (IRB) CERTIFICATION COMPLIANCE REQUIREMENTS

Instructions for the completion of Collaborative Institutional Training Initiative Program (CITI training) www.citiprogram.org

- Once registered, go to Florida Hospital group.
- Select Course: Basic Human Subjects - Biomedical, Social Behavioral Basic Course
- Select Curriculum: Human Subjects Research – Biomedical Research Investigators
- Select HIPS Course

- Select Good Clinical Practices Course (GCP)
- Upload your course completion reports to your user profile on www.irbnet.org.
- Notify your GS Research Coordinator.
- Notify the GME research staff.

IMPORTANT REMINDERS FOR RESEARCH OR PUBLISHABLE PROJECTS

- 1) ALL research projects and case report writing must be submitted to the Office of Research Administration (ORA) and Institutional Review Board (IRB) for approval.
- 2) DO NOT begin study or case report writing until IRB approval has been obtained.
- 3) Data collected prior to IRB approval cannot be included in the current research.
- 4) Any changes to a research protocol and/or investigators must be submitted to and approved by the IRB.

BASIC REQUIREMENTS FOR RESEARCH PROJECTS

- 1) IRB & ORA requirements: CITI training certificate
- 2) Proposal – Guidelines for case report, clinical trial, prospective & retrospective observational proposal are available through the GS & GME's Research Coordinators or through the Office of Research Administration website.
- 3) IRB & ORA Applications: contact the GME Research Staff to determine which forms are needed pertaining to your project.
- 4) All documents should be typed and submitted to the GME Research Staff electronically at Victor.Herrera.md@flhosp.org;

Josephine.Gaabucayan@flhosp.org ; Program Coordinator and Program Director.

- 5) Only the GME Research Staff will have a full access status to your IRB Net project in order for them to upload and submit documents. **ALL DOCUMENTS WILL BE UPLOADED AND SUBMITTED ONLY BY THE GME RESEARCH STAFF.**
- 6) Should there be any changes in your protocol or research project after IRB submission, please notify the GME Research Staff immediately.

Respective faculty advisor or faculty of choice will mentor residents in their scholarly activities and research projects.

The Department of Medical Education provides a Research Manager, full-time Research Coordinator and a statistician to assist and monitor your research project.

At the current time, the Program does not offer the option of an entire year spent in laboratory research.

Conferences and Teaching Rounds:

Weekly conferences will be held on Friday mornings from 7:00 am to 12:00 noon and residents will be given dedicated time to attend. Attendance will be monitored via sign-in sheets, and is mandatory unless by exception made by the Program Director. Each section will last one hour. The conferences will be comprised of Basic Science, Grand Rounds, M & M, and practice questions. M&M conferences will be presented by residents at all levels. Invited guest speakers will also be utilized. Simulation lab is held at Florida Hospital Celebration Health a minimum of quarterly Robotic training will also be completed for senior residents.

The basic science curriculum will be taught on a weekly basis based on SCORE Curriculums and assigned readings

Evaluations and Process:

ACGME Core Competencies

Accreditation of the residency program is predicated on adherence during training to the ACGME-defined Core Competencies in all six areas. Residents at all levels of training will be continually evaluated based on the following six competencies.

1. Patient Care:

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

- Gather accurate information in a timely manner.
- Generate an appropriate differential diagnosis.
- Implement an effective patient management plan.
- Competently perform the diagnosis and therapeutic procedures and emergency stabilization.
- Prioritize and stabilize multiple patients and perform other responsibilities simultaneously.
- Provide health care services aimed at preventing health problems or maintaining health.
- Work with health care professionals to provide patient-focused care.

2. **Medical Knowledge:**

Residents must demonstrate knowledge about established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences and the application of this knowledge to patient care. Among other things, residents are expected to:

- Identify life-threatening conditions, the most likely diagnosis, synthesize acquired patient data, and identify how and when to access current medical information.
- Properly sequence critical actions for patient care and generate a differential diagnosis for an undifferentiated patient.
- Complete disposition of patients using available resources.
- Seniors on remediation will attend a board review course earlier in the year with the opportunity to repeat the course if the resident does not improve

3. **Practice-Based Learning:**

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

- Analyze and assess their practice experience and perform practice-based improvement.
- Locate, appraise and utilize scientific evidence related to their patient's health problems.
- Apply knowledge of study design and statistical methods to critically appraise the medical literature. Utilize information technology to enhance their education and improve patient care.
- Facilitate the learning of students and other health care professionals.

4. **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

families and professional associates. Among other things, residents are expected to:

- Develop an effective therapeutic relationship with patients and their families, with respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences.
- Demonstrate effective participation in and leadership of the health care team.
- Develop effective written communication skills.
- Demonstrate the ability to handle situations unique to the practice of surgery.
- Effectively communicate with out-of-hospital personnel as well as non-medical personnel.

5. Professionalism:

Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to demonstrate and model behaviors that include:

- Treats patients/family/staff/paraprofessional personnel with respect.
- Protects staff/family/patient's interests/confidentiality
- Demonstrates sensitivity to patient's pain, emotional state, and gender/ethnicity issues.
- Able to discuss death honestly, sensitively, patiently, and compassionately.
- Unconditional positive regard for the patient, family, staff, and consultants.
- Accepts responsibility/accountability.
- Openness and responsiveness to the comments of other team members, patients, families, and peers.

6. 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. Among other things, residents are expected to:

- Understand, access, appropriately utilize, and evaluate the effectiveness of the resources, providers, and systems necessary to provide optimal emergency care.
- Understand different medical practice models and delivery systems and how to best utilize them to care for the individual patient.
- Practice cost-effective health care and resource allocation that does not compromise quality of care.
- Advocate for and facilitates patients' advancement through the health care system.

Resident Performance:

Residents will be evaluated by the faculty/preceptor at the end of each rotation. Evaluations will be reviewed periodically, by the faculty and Program Director. Faculty evaluations and results from written examinations will be utilized in determining the progress of the resident. In addition, evaluations shall also include the American Board of Surgery operative and clinical assessment tools and, the Flexible Endoscopy Curriculum Evaluations – GAGES. The Program Director will meet with the resident at least quarterly to review performance. Any necessary remediation or counseling will be determined by the Program Director and when indicated, individuals may be placed on remediation, probation or suspended. Evaluations will be kept in the resident's personnel file and will be accessible to the resident through the Surgical Residency office under supervision. Please see "Resident File Access" on page 29. Seniors on academic remediation will attend a board review course earlier in the year with the opportunity to repeat the course if the resident does not improve their performance.

Resident Evaluation of Faculty Teaching:

Residents will submit anonymous evaluations of the program, rotations, and faculty on an on-going basis through New Innovations. The results of these evaluations will be reviewed by the Program Director and appropriate feedback will be given to individual faculty members. The information will also be used by the Core Curriculum Committee to revise and alter the educational content of the program and its rotations.

Other Evaluations of Residents:

Residents will be evaluated by means of a 360-degree approach which will include evaluations by peers (senior residents), nurses, and patients. The results of these evaluations will also be discussed with the resident during quarterly meetings.

Confidentiality Process:

All evaluations, counseling and probationary actions involving a resident will be kept in a confidential fashion. Under no circumstances will such actions be discussed in a public forum. Additionally, all evaluations of faculty by residents will be treated as confidential by the Program Director.

Faculty Advisors:

Each resident will be assigned a faculty advisor at the beginning of residency training. The faculty member will be considered a mentor of the resident and will be expected to meet with the resident at a minimum of quarterly. These meetings will be arranged by the

advisors throughout the year. However, all of our faculty members are eager to be of assistance to residents, and you should feel free to discuss problems, situations, ideas, etc. with the faculty at any time.

As the resident progresses through training and discovers a specific area of interest for which she/he may pursue fellowship training, she/he may also utilize, without prejudice, a faculty advisor in that area of interest.

Residents will be required to discuss their on-going research projects on at least a quarterly basis as part of their meetings with their advisors. Research meetings are held a minimum of quarterly and residents are expected to present possible topics, drafts, and results of literature.

The mentor/advisor shall:

- Meet on a regularly scheduled basis with each resident, at least once every quarter to offer professional mentorship.
- Advise and assist the resident in the definition and resolution of interpersonal and system problems that may arise.
- Assist the resident in identifying and evaluating strengths and weaknesses in his/her clinical abilities and training on an ongoing basis.
- Oversee and guide the resident's overall educational and professional progress.
- Follow up with the resident on suggestions and recommendations and document in the mentor form for submission to the Program Director.

Supervision Policy:

A resident's privilege of conditional independence, progressive authority and responsibility, and supervisory roles in patient care is delegated by the program director and faculty members. The program director evaluates the resident's abilities based on specific criteria that are guided by specific national standards.

Every resident is assigned to a designated service. The attending surgeon on that service is responsible for the overall care of each individual patient admitted to the service as well as for the supervision of the resident(s) assigned to the patient. All patients are admitted in the name of the attending surgeon and residents make the attending aware of each admission and treatment plan. There is a clear chain of command centered around graded authority and clinical responsibility.

General Surgery residents can function in two capacities: indirectly supervised and directly supervised.

Direct Supervision:

The supervising physician is physically present with the resident and patient

Indirect Supervision – Can be achieved in two ways:

- 1) The supervising physician can be physically within the hospital or other sites of patient care and is immediately available to provide Direct Supervision
- 2) The supervising physician is not physically present within the hospital or other sites of patient care, but is immediately available by means of telephonic and/or electronic devices to provide Direct Supervision.

Oversight:

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

General surgery residents can evaluate outpatients, write prescriptions, write orders and progress notes, and otherwise complete medical records. General Surgery residents cannot function without either direct or indirect supervision by an attending physician with privileges at Florida Hospital or resident as outlined in the competency guidelines, for patient care and is credentialed to perform the indicated procedures. The Resident must know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence.

The attending surgeon is expected to:

- Confirm (or change) the provisional diagnosis
- Approve the operative procedure and procedure timing
- Be available or physically present (as dictated by his/her judgment) during the operative procedure and assure that it is properly carried out
- Supervise postoperative care
- Assure continuing care after the patient leaves the hospital

The resident will keep the attending fully informed and document patient care with written progress notes. However, the supervising physician can provide feedback of procedures/encounters after care is delivered.

Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of the resident and delegate to him/her the appropriate level of patient care authority and responsibility.

Please see below:

A. Patient Management Competencies:

1. Initial evaluation and management of patients in the urgent or emergent situation, including urgent consultations, trauma, and emergency department consultations (ATLS required)
 - a. Interns will obtain ATLS certification fall of the intern year.
 - b. Supervision by in-house senior resident until competency achieved

- c. Competency
 - i. Observed examination with appropriate management plan and sign off through new innovations by observer
 - ii. 20 patients with 5 by an attending observer
- 2. Evaluation and management of post-operative complications, including hypotension, hypertension, oliguria, anuria, cardiac arrhythmias, hypoxemia, change in respiratory rate, change in neurologic status, and compartment syndromes
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Completion of ACS Fundamentals of Surgery Curriculum by July 1 of the intern year.
 - c. Competency
 - i. Observed examination with appropriate management plan formulated and discussed prior to implementation with subsequent sign off through new innovations by observer
 - ii. 10 patients with 3 by an attending observer
- 3. Evaluation and management of critically-ill patients, either immediately post-operatively or in the ICU, including the conduct of monitoring, and orders for medications, testing, and other treatments
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Completion of ACS Fundamentals of Surgery Curriculum by July 1 of the intern year.
 - c. Competency
 - i. Observed examination with appropriate management plan formulated and discussed prior to implementation with subsequent sign off through new innovations by observer
 - ii. 10 patients with 3 by an attending observer
 - iii. ICU orders must be cosigned by a senior resident or attending until completion of 2nd year ICU rotation
- 4. Management of patients in cardiac or respiratory arrest (ACLS required)
 - a. Interns will be ACLS certified by July 1 of the intern year.
 - b. Competency
 - i. Observed management of cardiac or respiratory arrest
 - ii. 5 patients with an attending observer
 - iii. Management cannot occur until completion of 2nd year ICU rotation
 - iv. They must also complete the Simulation arrest curriculum and experience

B. Procedural Competencies:

1. Carry-out of advanced vascular access procedures, including central venous catheterizations, temporary dialysis access, and arterial cannulation
 - a. 5 observed central venous access completions on simulation model prior to July 1 of the intern year.
 - b. Competency
 - i. 10 observed and completed vascular access procedures with minimum of 2 each IJ, subclavian and femoral in overall total.
 1. These must be recorded and signed off through new innovations by observer (senior or mid level resident or attending)
 2. An attending must sign off on 1 each of IJ, subclavian and femoral prior to competency achieved.
 3. An intern should not place a central line on their own.
2. Repair of surgical incisions of the skin and soft tissues
 - a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Observed skin closure and sign off through new innovations by observer (senior or mid level resident or attending)
 - ii. 10 patients with a minimum of 3 by an attending observer
3. Repair of skin and soft tissue lacerations
 - a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Competency achieved in Part B Number 2
 - ii. Observed laceration repair and sign off through new innovations by observer (senior or mid level resident or attending)
 - iii. 5 patients with a minimum of 1 by an attending observer
4. Excision of lesions of the skin and subcutaneous tissues
 - a. Completion of suture and knot tying skills lab prior to July 1 of the intern year.
 - b. Competency
 - i. Observed excision and sign off through new innovations by observer (senior or mid level resident or attending)
 - ii. 10 patients with a minimum of 3 by an attending observer

5. Tube thoracostomy
 - a. 2 observed thoracostomy completions on simulation model prior to July 1 of the intern year.
 - b. Competency
 - i. Observed tube thoracostomy placement and sign off through new innovations by observer (senior or mid level resident or attending)
 - ii. 5 patients with a minimum of 2 by an attending observer

6. Paracentesis
 - a. Competency
 - i. Observed paracentesis and sign off through new innovations by attending observer
 - ii. 3 patients by an attending observer

7. Endotracheal intubation
 - a. 3 observed intubations on simulation model prior to July 1 of the intern year.
 - b. Competency
 - i. Observed endotracheal intubations and sign off through new innovations by observer (senior level resident or attending)
 - ii. 5 patients by an attending observer

8. Bedside debridement
 - a. Competency
 - i. Competency achieved in Part B Number 2
 - ii. Observed bedside debridement and sign off through new innovations by observer (senior or mid level resident or attending)
 - iii. 5 patients with a minimum of 1 by an attending observer

**Until all competencies are received, Seniors will have to be present for procedures.

Level of Training Privileges

PGY- 1:

Under the direction of a mid-level resident or higher, the PGY-1 resident can bring patients into the operating room for induction of anesthesia; can insert IV lines and Foley catheters; can write admission orders; pre- and post-op orders and notes; can dictate discharge summaries, H&P's and operative notes; can write orders for restraints. Under supervision, the PGY-1 resident may provide in-hospital care, assist in surgery, and

perform certain operations at the discretion of the attending surgeon. She/he may place arterial lines, central lines, chest tubes, Swan-Ganz catheters under the direct supervision of a senior or mid level (\geq PGY- 3) resident. Eventually these procedures may be done under indirect supervision after having been directly supervised and certified by an attending. (see above)

PGY- 2:

The PGY- 2 resident can participate in SICU activities and can function in the SICU under the indirect supervision of the SICU attending in both the intensive care unit and non-intensive care unit. This will allow placement of arterial lines, central lines, chest tubes, Swan-Ganz catheters, endotracheal tubes and other superficial procedures. Under supervision, the PGY- 2 resident may assist in surgery and perform certain operations at the discretion of the attending surgeon. Under indirect supervision, the PGY- 2 resident can write orders for restraints.

PGY- 3:

The PGY- 3 resident can function as a senior resident on selected services under the direction of the chief resident and attending surgeon. The PGY- 3 resident can initiate surgical procedures after discussion with an appropriate attending surgeon who has privileges at Florida Hospital to perform the anticipated procedure. Under indirect supervision, the PGY- 3 resident can administer conscious sedation and write orders for restraints. The PGY- 3 resident can function as senior resident on call and as senior resident in the SICU. She/he can participate in clinics under indirect supervision. She/he can evaluate trauma patients in the ER and supervise their resuscitation (ATLS certification is required).

PGY- 4, 5 (Chief Resident):

Residents at these PGY levels can function as senior resident and supervise routine ward activities and SICU activities. They can participate in clinics under indirect supervision and supervise the conduct of outpatient clinics. These residents can evaluate outpatients for emergency surgical procedures and can initiate surgical procedures after discussion with an appropriate attending surgeon who has privileges at Florida Hospital to perform the anticipated procedure. Under indirect supervision, these residents can administer conscious sedation and write orders for restraints. Residents at these levels can oversee medical records completion.

Evaluation of Patients in the Emergency Department:

PGY-1 residents must be directly supervised by a more senior (\geq PGY-3) resident or faculty, until deemed competent per the supervision policy. PGY-2 residents may evaluate patients in the ER under the indirect supervision of a more senior (\geq PGY-3) resident. PGY-4 & 5 residents may evaluate patients in the ER under the indirect

supervision of the attending surgeon. If requested by the attending in the ER, the senior resident must consult with the attending surgeon on call prior discharging a patient from the emergency department. The attending physician must also be informed about all patients admitted to his/her service from the ER.

Change in Patient Status:

As demonstrated above, the program functions with respect to hierarchy. In these instances of patient need, direct, immediate contact with the attending may supersede this hierarchy. Attending surgeons must be informed when a patient on his/her service has a clinically important change in status; this includes but is not limited to instability in vital signs, transfer to the ICU, intubation, need for an invasive procedure/monitoring, or death.

Faculty must be notified and directly involved with the patient and/or family regarding end of life issues.

Chief Resident Duties:

The Chief Resident has administrative duties for which she/he is responsible to the Program Administration. Besides the clinical responsibilities of a senior resident, the Chief Resident's responsibilities also include the following:

1. Ensure that residents on their team adhere to the mandated duty hour restriction.
2. Ensure that all residents have at least of one day off in seven, averaged over 4 weeks.
3. Monitor all residents on their team for signs of fatigue or other possible impairment.
4. Ensure that all patients are staffed with the proper attending surgeons.
5. Notify the proper attending staff member of any change in patient condition or emergency surgery.
6. Make daily patient rounds with their team at a time that allows completion in time for scheduled conferences and surgery. Ensure sign over of patients, such that transitions of care are safe and appropriate.
7. Ensure attendance of their team members at educational conferences.
8. Supervise and educate medical students.
9. Monitor the interaction of junior residents with hospital staff, patients and families.
10. Notify the Program Director of any problems related to the previously described responsibilities.
11. Responsible to serve as liaison between faculty and residents.
12. Coordinate and schedule the resident call schedule with final approval by the PD.

Patient Charting Responsibilities:

Inpatient Charting:

See the “Health Information Management” section of the Florida Hospital Graduate Medical Education policy manual.

Outpatient Charting:

The General Surgery outpatient clinic uses an electronic medical record (EMR) system. Residents are encouraged to learn to chart concurrently with patient care. Ordering labs, x-rays and medications during the visit is a must, and charting the note during the visit aids in efficiency. Charts are expected to be completed within 48 hours of the visit and any charts still “open” after two (2) weeks will be considered “Delinquent.”

Delinquent Charts:

- Prompt and timely completion of charts (within 48 hours) is expected.
- Accumulation of charts longer than one (1) week will result in issuance of a notification.
- Failure to complete charts within 2 weeks may result in loss of one-half day of vacation time in order to complete the records.

Medical Records:

See also the GME Manual section on “Health Information Management.”

- Health care providers must maintain adequate medical records to:
 - Afford continuity of patient care
 - Document that quality care has been rendered
 - Justify payment for services rendered
 - Serve as defense against malpractice claims
 - Function as a basis for submitting required reports to appropriate governmental agencies
- All operative reports should be dictated immediately, but **absolutely** within 24 hours of the time of operation. They should contain sufficient information concerning the pathology found as well as techniques used.
- Discharge summaries are to be completed the day of discharge. Discharges are to be approved by the responsible senior resident. Correct terminology is essential, both for diagnosis and operation. Complete diagnoses, including complications and operations are necessary.
- Keep in mind that the patient’s record could become a legal document, which you may be asked to interpret and defend in a court of law many years from now. It, therefore, should not be treated as anything less. It is not a forum for unproven opinions, personality comments, assumptions, or derogatory statements to consultants, patients, peers, etc.: record the facts, omit opinions, judgments, and

assumptions. Never alter a medical record after a query regarding the care of a patient.

- Death Certificates must be completed within 72 hours of the patient's death.
- Medico-legal issues, such as adverse events, angry patients or family members, etc. should be relayed to the Chief Resident and/or attending immediately. A lack of timely intervention frequently exacerbates problems.
- Delinquency in record completion may result in loss of vacation time or loss of OR privileges in order to correct deficiencies.

Confidentiality Health Insurance Portability and Accountability Act of 1996 (HIPPA):

Compliance with HIPAA regulations is mandatory. All information presented to you by a patient, by a doctor about a patient, by a patient's family about a patient, with few exceptions, is CONFIDENTIAL.

- Do not discuss patients with others while walking in the halls, in the elevator, in the cafeteria, or while in any public areas.
- During Grand Rounds and conferences, patients are never to be presented by their names.
- Copies of discharge summaries, operative reports, and other medical data are confidential and must be disposed of by acceptable legal means when no longer needed.
- Confidential, locked shred bins are provided in the out-patient office as well as on the units. Do not place any confidential information in waste baskets or other receptacle that eventually ends up in a commercial or city dump.
- In all instances, patients are to be treated with the same respect and confidentiality that you would afford your own family members.
- Cases presented at morbidity and mortality conference are confidential and summaries sent to Florida Hospital patient safety organization are protected as part of the patient safety work product.
- Failure to comply could result in immediate dismissal from the program and termination from Florida Hospital.

Promotion Criteria:

When appointed to a position in the Florida Hospital five-year post-graduate program, any resident planning to continue in the five-year General Surgery program may expect to complete his/her training, provided that s/he continues to perform resident duties at a

level comparable to peers. There is no “pyramid” system in this program. Promotion to the next level will occur only if the resident’s performance and progress is satisfactory. The resident’s progress in the program will be evaluated by the Program Director and faculty, and is assessed by AGME Milestones for Surgery.

The training of surgeons for the practice of General Surgery encompasses education in the basic sciences, training in cognitive and technical skills, development of clinical knowledge and maturity, the acquisition of surgical judgment, communication skills, interpersonal skills, evidence of practice-based learning and systems-based learning. Through the course of training, each resident is expected to acquire progressively increasing competence in these areas. Promotion to the next resident level is based on a resident’s achievement of surgical and clinical competence and performance, including specific cognitive, clinical, technical skills, and professional and ethical conduct, as measured in on-going evaluations. Elements that will be considered for promotion include, but are not limited to: rotation evaluations, competencies as evaluated through ACGME Milestones, and ABSITE scores.

The Residency Clinical Competency Committee will meet to discuss the promotion status of each resident based on competencies, academic requirements, and performance standards. The Committee will develop plans to assist residents in meeting the established standards. By the end of January, the Residency Clinical Competency Committee will meet again to review each resident’s progress and to recommend promotion actions to the Program Director.

If the resident’s performance has been significantly deficient and additional training is required to correct the deficiency, the Program Director may request an extension of the resident’s contract from the Graduate Medical Education Committee. The Committee will give due consideration to the Program Director’s request. However, residents with inadequate performance may be subject to dismissal.

Dismissal & Grievance:

Dismissal/Non-Renewal:

Dismissal or non-renewal may occur because of failure of the resident to comply with his/her responsibilities or failure to demonstrate appropriate medical knowledge or skill as determined by the program’s supervising faculty. Dismissal may also occur where there is misconduct. Examples of misconduct include but are not limited to: being under the influence of intoxicants or drugs; disorderly conduct, harassment of other employees (including sexual harassment); the use of abusive language, fighting or encouraging a fight; threatening, attempting, or causing injury to another person while on the premises. Please refer to the GME Policy Manual for specific policies.

A resident is usually not dismissed without a probationary period, except in instances of flagrant misconduct. In other circumstances, it is the responsibility of the residency

Program Director to document a warning period prior to dismissal or failure to reappoint a resident and to demonstrate efforts for the provision of opportunities for remediation. Such opportunities must be provided and documented for the resident to discuss with the Program Director the basis for probation, the expectations of the probationary period, and the evaluation of the resident's performance during the probationary period. Discussions will be documented and placed in the resident's personnel file. The resident is entitled to a copy of the documentation upon written request.

In the event that a resident is to be dismissed or his/her contract not renewed, s/he may initiate a formal grievance procedure. Grievance procedures will follow the policy stated in the GME Manual.

Grievance:

Grievance procedures have been established by the Graduate Medical Education Committee and may be referred to in the GME manual.

Professional Relationships:

Patient Care:

- Team: The team (attending physician, chief resident, resident, nurse, pharmacist, and student) is responsible for each patient's care. Quality care for the individual patient is the ultimate goal of each team member.
- The PGY1 as directed by the senior/chief resident has the primary responsibility for patient care except within the Intensive Care Unit. S/he should evaluate the patient, write the necessary orders, perform the primary patient care procedures, and act as the primary physician with respect to the patient and his family. S/he dictates the discharge summary on each patient for whom they are responsible.
- Senior Resident: The senior resident is an active participant in the patient's care and is directly responsible for all care of the patient within the Intensive Care Unit. S/he conducts rounds and examines the patient every day with the junior resident. S/he does not dictate therapy, but does advise the junior resident of alternate possible explanations, direction of evaluation, or treatments. S/he also writes an admission note. S/he selects applicable articles from the surgical literature to enhance the education of his/her team and augment patient care. All consultations will be directed to the senior resident, and s/he will see consultations and make appropriate disposition.
- Attending Surgeon: The attending surgeon holds ultimate responsibility for every aspect of patient care. S/he is also actively engaged in patient care and rounds on all patients. S/he is responsible for providing guidance and experience in all facets of the patient's care. S/he will round at designated times daily throughout the week and will be available on call for other problems.

Nursing Staff:

- The nursing staff is an integral part of the health-care team. Personal and professional courtesy will be extended to the nursing staff at all times. The nursing staff should be present for rounds whenever possible and should be advised of any changes in treatment plans, special requests, or anticipated problems, if not present for rounds.
- Residents are responsible for a significant contribution to the education of the nursing staff. Such information is vital to assist them in taking better care of the patients. Explanation and thoughtfulness will yield manifold results.
- Simple “pick-up-after-yourself” and care in performance of procedures will allow the nursing staff more time with your patients.

Pharmacy Staff:

- The pharmacist is another vital member of the health-care team. S/he is responsible for all medications dispensed in the hospital.
- S/he is also a ready source of information on the various therapeutic agents, their dosages, compatibilities, toxicities, administration forms, and combinations.
- It is the pharmacist’s legal and professional responsibility to ensure that the intent of your order is fulfilled. When the pharmacist questions an order, s/he is doing so to ensure that the patient receives the appropriate medication in the appropriate dosage.
- If you are paged by the pharmacist, it is your duty to respond quickly and courteously.

Resident Interaction with Medical Students:

Medical students are not physicians. As learners they need appropriate guidance and leadership to ensure a safe learning environment. All residents will be expected to participate in the education and mentoring of medical students. This will enhance their training and will include:

- Teaching requisite patient care procedures
- Instructing in the development of logical approaches to clinical problems
- Encouraging reading in General Surgery texts and journals, providing the student with select review articles on topics concerning their patients
- Instructing and assisting in the development of good patient care and treatment
- Ensuring attendance at all necessary conferences
- Reviewing each student’s “work-ups” and providing constructive criticism
- Treating the medical student in a professional and courteous manner
- Maintain a professional interpersonal relationship with the medical students. Any concerns should be brought to the attending on service or program director.
- Assigning cases and patients

- Enforcing reading and preparation for specific cases that they will observe in the operating room

Continuity of Care/Night Call Activities:

Continuity of care is an important facet of residency training. There are multiple ways of obtaining this training. Among them are time spent in the practice office with pre- and post-surgical patients, another is in-house call.

Clinic Requirements:

A portion (minimum of ½ day per week) of the General Surgery rotations will be spent seeing patients in the practice suite currently located in the Health Village Medical Office Building , Suite 400. This time will provide continuity of care training for the resident as she/he sees pre- and post-operative patients as well as minor surgeries in the suite. This is in addition to any time spent in postop/ resident clinic.

Night Call/Night Float:

The objective of night call activities is to provide residents with patient care experiences throughout a 24-hour period, adding to their continuity of care experience. There are specific guidelines that provide for this experience while still maintaining adherence to duty hours policy:

- In-house call must occur no more frequently than every third night, averaged over a four-week period.
- Continuous on-site duty, including in-house call, must not exceed 24 consecutive hours. Residents may remain on duty for up to 4 additional hours to participate in didactic activities, maintain continuity of medical and surgical care, or transfer care of patients.
- No new patients may be accepted after 24 hours of continuous duty. Residents are not allowed to perform scheduled elective surgeries after 24 hours of continuous duty. A new patient is defined as any patient for whom the resident has not previously provided care.
- Responsibilities while on night call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate.

Call:

At-home call is defined as call taken from outside the assigned institution.

- The frequency of at-home call is not subject to the every third night limitation. However, at-home call must not be so frequent as to preclude rest and reasonable personal time for each resident.
- Residents taking at-home call must be provided with one day in seven completely free from all educational and clinical responsibilities, averaged over a four-week period.
- When the resident is called in to the hospital from home, the hours spent in house will be counted toward the 80-hour limit.
- The Program Director and faculty must monitor the demands of at-home call in the program and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue.
- Responsibilities while on at-home call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate.

Transitions of Care:

- Residents are responsible for providing safe and effective transitions of care during hand-off situations. Sign out sessions occur twice daily to ensure adequate communication and appropriate transfer of patient information
- Morning sign out begins at 6:00am daily, at the end of the night shift with transfer of patient information from the prior night's residents and the oncoming team (residents and nurse practitioner).
- At 6:00pm during the week, transition of night between the general surgery service residents and the oncoming resident. During this time all the day's surgeries are discussed in preparation for post-operative checks that evening. Additionally, the status of each patient on the general surgery service are communicated to the oncoming resident to ensure safe and effective patient care.
- Residents are instructed during the annual communication and patient safety lectures on proper, complete and successful transitions of care.

On-Call Guidelines:

- The GMEC adheres to ACGME guidelines regarding the frequency of call. The duty hour policy may be found in the GME manual.
- The call schedule will be made on a monthly basis.
- In-House Call duties extend on weekdays from 6:00 pm to 6:00 am and on weekend days from 6:00 am to 6:00 am. The appropriate phone is to be on during call hours and in your possession at all times. The correct phone number must

become available to the surgery scheduling office during weekdays or to the next resident on call during weekends.

Notification of the correct phone number must be given to the answering service and nursing staff units. Individual phone devices must be kept on at all times during work hours. While covering the Emergency Department or Operating Room, devices should not be unattended or turned off. Other staff should be able to respond to the call if the resident is not able to do so.

- Responsibilities while on call shall include responding to all calls in a prompt and courteous manner, either by phone or by personal evaluation of the patient, as appropriate. Additionally, any significant changes in patient coordination will be communicated to a senior resident and the responsible attending surgeon.
- Support systems: The resident on call will have access to support from both the Chief Resident and the faculty member/surgeon on call during all call assignments, when patient care responsibilities are unusually difficult or prolonged, or if unexpected circumstances create resident fatigue sufficient to jeopardize patient care. The chain of command is: Resident → Next more senior resident → Chief Resident → Attending. As mentioned previously, there are clinical situations where this hierarchy should and must be circumvented with direct contact with attending.

Personal communication devices are used as primary lines of communication. All proceeding communications are to be met by the residents.

Duty Hours:

As per ACGME guidelines, residents will be limited to a maximum of 80 hours per week (averaged over a 4 week period) in clinical and required educational activities, including on call. Required educational activities, such as teaching conferences, M&M conferences, etc., constitute work hours. PGY-1 residents are limited to a 16-hour shift .

Duty hours are defined as all clinical and academic activities related to residency training, i.e., patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and presentation preparation time.

The GMEC shall oversee that all specialty and subspecialty programs comply with ACGME policies on residents' duty hours which include on-call activities, at home call, moonlighting, and oversight compliance.

Maximum Hours of Work per Week

Duty hours must be limited to 80 hours per week, averaged over a four week period, inclusive of all in-house call activities.

Mandatory Time Free of Duty

Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

Maximum Duty Period Length

1. Duty periods of PGY-1 residents must not exceed 16 hours in duration.
2. Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital. The program encourages residents to use alertness management strategies in the context of patient care responsibilities. Strategic napping, especially after 16 hours of continuous duty and between the hours of 10:00 pm and 8:00 am, is strongly suggested.
 - A) It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
 - B) Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
 - C) In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.

The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

Minimum Time Off between Scheduled Duty Periods

- 1) PGY-1 residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods.
- 2) Intermediate-level residents [as defined by the Review Committee] should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.

3) Residents in the final years of education [as defined by the Review Committee] must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

a. This preparation must occur within the context of the 80 hour, maximum duty period length, and one-day-off-in-seven standards. While it is desirable that residents in their final years of education have eight hours free of duty between scheduled duty periods, there may be circumstances [as defined by the Review Committee] when these residents must stay on duty to care for their patients or return to the hospital with fewer than eight hours free of duty.

i. Circumstances requiring return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education includes:

Continuity of care for patients, such as for:

- a. a patient on whom a resident operated/intervened that day who needs return to the operating room (OR);
- b. a patient on whom a resident operated/intervened that day who requires transfer to the Intensive Care Unit (ICU) from a lower level of care;
- c. a patient on whom a resident operated/intervened that day who is in the ICU and is critically unstable;
- d. a patient on whom a resident operated/intervened during that hospital admission, and who needs to return to the OR for a reason related to the procedure previously performed by resident; or, a patient or patient's family with whom a resident needs to discuss limitation of treatment/DNR/DNI orders for critically-ill patient on whom the resident operated.

Also, a declared emergency or disaster, for which the residents are included in the disaster plan; or, to perform high profile, low frequency procedures necessary for competence in the field.

****The Program Director closely monitors these instances.****

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four-week period).

At Home Call

- 1) Time spent in the hospital by residents on at-home-call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirements for one-day-in-seven free of duty, when averaged over four weeks.
 - a. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Submission Policy:

Duty Hours should be recorded daily after completion of duties but must be current by Mondays at 9:00 am to allow for review by the Program Director and the Graduate Medical Education department. If by the following day, Tuesdays at 9:00am the duty hours have not been completed, the resident will be relieved from duty to report to the Graduate Medical Education office at which time the Designated Institution Official will complete a written notice of non-compliance to be placed in the Resident’s permanent file.

Residents who remain past the duty hour period or have a duty hour violation are responsible for submitting justification through New Innovations to the Program Director. The Program Director will review the violation and justification and determine if a true violation occurred and whether there is reasonable justification. If the justification is deemed unacceptable, a discussion ensues between the Program Director and the resident with appropriate counseling. If there are continued unjustifiable violations, this is determined to be unprofessional behavior and the resident will subsequently be disciplined.

Other Policies:

Dress and Grooming:

All individuals on the surgical service are expected to look and act as responsible physicians. Professional appearance and manners are to be exercised at all times in all environments, even though the work and conditions may be very stressful. Appropriate grooming and attire are always required. Good personal hygiene is mandatory. Use of deodorant is encouraged, and to be considerate of patients and fellow staff, residents should not wear strong fragrances.

The resident is expected to follow the dress code as printed in the GME manual. A white coat with name tag attached is to be worn at all times while on duty. Scrubs may not be worn in the outpatient office except when post-call. At any time that the resident is scheduled to be in the operating room, clean scrubs will be worn, including changing to fresh scrubs after a dirty/bloody case. The resident must ensure that no body fluids are

on his/her clothes/shoes when out of the operating room. Please refer directly to the GME Manual for specific dress requirements.

Work Environment:

Providing a sound academic and clinical education must be balanced with concerns for patient safety and resident well-being. The program will ensure that the learning objectives of the program are not compromised by excessive reliance on residents to fulfill service obligations. Didactic and clinical education must have priority in the allotment of residents' time and energies. Duty hour assignments must recognize that faculty and residents collectively have responsibility for the safety and welfare of our patients.

Leave:

The ABS requirements for residency training in order to qualify for certification are specific regarding the amount of time that may be taken away from training in each year. The requirement is that 48 of the 52 weeks per year must be used for training. In the case of maternity or documented medical leave, the ABS will accept 46 weeks of surgical training in **one of the first three years** and 46 weeks of training in **one of the last two years**, for a total of 142 weeks for the first three years and 94 weeks for the last two years. The resident who is unable to fulfill these requirements will need to extend the length of training and therefore will not be able to graduate with his/her class.

No time-off requests are permitted during the last two weeks of a resident's contract period. General guidelines for time away can be found in the GME manual. Program-specific guidelines follow:

- Paid Time Off (PTO): Residents are allowed 20 days to be used for vacation/leave/sick per academic year. This paid time off is in addition to granted days for Board Examinations.
- There will be no vacation time taken in July, January, or June – unless specifically approved by the Program Director.
- All scheduled vacation during the year must be approved by both chief residents, the coordinator, and the Program Director.
- The week of leave will also include the weekend following the vacation week(s). The weekend *prior* to leave is not part of the vacation and may or may not be granted depending on the call schedule – subject to approval by the Program Director.
- Sick leave or Emergency leave will first be deducted from credited holiday time and then from the last week of leave if necessary.
- Education: Florida Hospital provides the resident with an annual continuing education allowance and paid leave to attend educational activities that will contribute to the quality of their training.
- With the exception of the education leave allowance, leave may not be carried over from one appointment year to the next, and there is no payment for unused time.

- FMLA: Please refer to the GME Manual for specific policy on family and medical leave, extended sick leave, maternity leave, paternity leave, and adoption leave.
- Written request for time off is mandatory and must be submitted to the office of the Program Director. Initial requests will be solicited prior to the start of the academic year while the annual schedule is being written. Requested vacation periods are not guaranteed. Requests for changes must be accompanied by prearrangement of who will cover the resident's absence on a service with mandatory coverage.
- **Holidays:** Per previous mention, there are six national holidays that are observed at Florida Hospital (New Year, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas). Coverage of these holidays will be rotated among the residents while maintaining duty hour compliance. Coverage hours will be the same as on weekends.
- **Unexcused Absences:** If a resident does not show up for assigned hours, including night call, without notifying his Chief Resident and the Program Director, the absence will be considered unexcused. Unexcused time will be taken from the resident's leave bank. If the unexcused absence is repeated, disciplinary action will be taken by the Program Director depending on the severity and frequency of the infraction. Arrangements for "payback" to the other residents who may be assigned to cover in the resident's absence will be made at the discretion of the Program Director.

Elective Guideline:

Surgery Residents may choose to take one month for an away elective during their fourth year. This will be approved at the discretion of the Program Director and the following conditions must be met:

- The surgical resident must be in good standing in the program with a minimum of 400 cases at the time of request.
- The elective is with an ACGME accredited surgery residency or fellowship program. The chosen institution and program must be in good standing with the ACGME and respective RRC.
- The elective must demonstrate educational merit and be an operative rotation, not an observership.
- The resident must submit to the Program Director the elective request by April 1st of the preceding (PGY-3) year with:
 - i. Specialty
 - ii. Goals and Objectives (in accordance with the six core competencies)
 - iii. Location
 - iv. Month (The elective month cannot occur in (July or January)
- Preceptor and Off-Site agreements must be in place at the time of the rotation. Resident must provide contact information.
- During the away elective, the following is expected of the resident:
 - Adherence to the duty hour restrictions as outlined by the ACGME.

- The resident will continue to check designated Florida Hospital email address on a daily basis for communication/updates.
- Attendance and participation in M&M, Case Presentations, and didactic conferences on a weekly basis at elective site as outlined by the ACGME program requirements.
- On-going and current recording and documentation of participation in cases through the ACGME case log system.
- The resident is responsible for acquiring and paying for living arrangements during the elective month.
- The resident will be given a stipend of \$250 for ACGME-required food expenses during this time.

Moonlighting:

Because residency is a full-time endeavor, it is the policy of the General Surgery Residency Program that moonlighting is not allowed.

Stress, Fatigue, and Impairment:

The Program Director and faculty realize that residency training is a time of high stress. They will make every effort to monitor residents on their rotations for signs of stress, fatigue, and impairment. The resident can assist on his/her own behalf by adhering to duty-hour mandates and by communicating problems with his/her preceptor, faculty advisor, or the Program Director. Signs and symptoms of fatigue, stress, or impairment include some of the following:

1. Recent changes in behavior, including irritability, mood swings, inappropriate behavior, a breakdown in logical thought, trembling, slurred speech
2. Irresponsibility, such as failure to respond to calls, late arrivals at rounds or call, rounding at irregular times, neglect of patients, incomplete charting, unexplained absences
3. Inaccurate or inappropriate orders or prescriptions
4. Insistence on personally administering patients' analgesics or other mood-altering medications rather than allowing nursing staff to carry out orders
5. Poor concentration or poor memory, such as failure to remember facts about current and/or recent individual patients
6. Depression
7. Evidence of use or possession of alcohol or other drugs while on duty; intoxication at social events
8. Anger, denial, or defensiveness when approached about an issue
9. Unkempt appearance and/or poor hygiene
10. Complaints by staff or patients

11. Unexplained accidents or injuries to self
12. Noticeable dependency on alcohol or drugs to relieve stress
13. Isolation from friends and peers
14. Financial or legal problems
15. Loss of interest in professional activities or social/community affairs

In situations in which the resident feels stress, fatigue, or impairment that would disable him/her to perform their current patient care duties, the resident should take the following steps:

- Contact the Program Coordinator
- The Program Coordinator will contact the Program Director and Supervising Attending informing them of the residents' status. The Program Director will put in place the backup system to ensure proper continuity of patient care. Adequate transportation to return home will be offered to the resident.
(Adequate resources can include: Money for taxi, money for public transportation, one-way transportation service, transportation service which includes option to return to the hospital or facility the next day, reliance on other staff or residents to provide transport, or making use of in-house call room facilities).
- The Program Coordinator will contact the Resident and Supervising Attending to inform them of the plan that has been put in place.

If the Program Director feels that a resident has been showing signs of consecutively being stressed, fatigued, or impaired, the Program Director may choose to call a meeting with the resident. The problem will be discussed, and the Program Director will make recommendations for resolving the problem. Such recommendations may include use of services within Florida Hospital such as the Employee Assistance Program, Employee Health Services, Physician Support Services, or referral to a counselor or psychiatrist. For further information, please refer to the GME Manual.

Resources:

Florida Hospital, along with the medical staff and Graduate Medical Education is committed to providing safe, effective, timely, and respectful medical care while fostering an environment that promotes practitioner health. We affirm that substance use disorders and other behavioral health disorders are treatable illnesses and after treatment, practitioners can return to the safe and effective practice of medicine with appropriate monitoring.

Employee Assistance Program (EAP):

This program assists faculty, staff, and their families with the resources they need to resolve personal, family, or job-related problems. EAP offers a free of charge and comprehensive worksite-based program to assist in the prevention, early intervention, and resolution of problems that may impact job performance. The EAP is staffed with

well-trained, caring professionals who listen and offer support and guidance. EAP is confidential and voluntary. You can contact EAP at: (407) 303-3690 (or tie: 844-3690).

Employee Health Clinic:

The employee health clinic handles pre-employment physicals, performs annual physical assessments and PPD tests, and administers vaccinations. It also provides triage and evaluation for work-related injuries during normal business hours and does educational promotions, blood-borne pathogen counseling and treatment, and follows up on TB and other infectious disease exposures. The employee clinic can be reached at: (407) 303-1535 (or tie: 844-1535).

Physician Support Service:

This service is available to medical staff, including residents and their family members. The service may be utilized by contacting (407) 691-5476. Your Residency Coordinator will have pamphlets and business cards for your use if you have questions about this service.

Faculty Psychologists:

The faculty psychologists on the staff of Graduate Medical Education are also available to the residents and their families as a resource in times of stress.

General Information:

Cerner:

Cerner is the computer software that resident use to communicate regarding hospital and our hospital outpatient setting. We will be transitioning to Athena for outpatients during the 2016/2017 academic year.

Electronic communication device:

A stipend is expected to be used for purchase of an individual communication device (e.g. smart phone, android, tablet, etc.)

That device will be used as the primary method of communication while on duty. The device should be turned on during all duty hours and the battery should be checked frequently to assess signal strength. Damaged or lost devices shall be the responsibility of the resident and alternative means of communication is to be obtained as soon as possible.

While covering the Emergency Department or Operating Room, devices should not be unattended or turned off. Other staff should be able to respond to the call if the resident is not able to do so.

Not answering phone calls, texts, emails or pages during assigned duty hours will be considered grounds for discipline and/or dismissal from the residency.

Resident File Access:

The GMEC requires that the resident's file is regarded as confidential, is maintained in a secure location, and is available only to the following:

1. Program Director
2. Residency Coordinator
3. Director of Academic Affairs
4. Administrator of Medical Education
5. Chair of Medical Education
6. Resident (under supervision)

The GMEC authorizes the Program Director, Director of Academic Affairs, Administrator of Medical Education or the Chair of Medical Education to disclose the file or portions thereof to others whom they deem to have a legitimate need for the information or as authorized in writing by the resident. The GMEC policy requires that the exterior of each file will state "Confidential Information – Access to this File and its Information is governed by the GME Manual on Resident File and Access." Electronic files will have this statement on its opening or at a place within the file designated by the Program Director.

Resident Loan Deferment:

Loan Deferment forms should be submitted to the Residency Coordinator. The Department will certify the resident's current academic year of training and the anticipated graduation date.

Resident Workspace, Email, Lockers & Mailboxes:

Office space is provided in the General Surgery Office Suite in the Health Village Medical Office Building as well as in the Academic Office. Computers with inter- and intranet access are available and access to Cerner EMR for medical records and laboratory reports. Please keep the workspace neat and uncluttered to be considerate of your fellow residents and the office staff.

Residents are issued an Outlook email account through the Hospital. Your email must be checked on a daily basis for updates/schedule changes/ and program information. Residents will also be trained to use the New Innovations system and will be expected to use it for duty hours reports, curriculum, etc. Both your hospital email and New Innovations may also be accessed from your home computer.

Lockers are provided, as well, for storage of personal items. They will be located in the call rooms of the hospital.

Resident mailboxes for regular mail and schedules are located in the General Surgery Administrative office suite. These mailboxes must not become a repository for outdated

information, stale food, etc. and mail and notices should be dealt with **on a weekly basis** and cleaned out.

Travel:

Residents may be sent to regular or national meetings at the discretion of the Program Director. Residents also are allowed conference time during their years of training. They must submit a time away request which must be approved by the Program Director prior to attending the meeting. Presentation of resident research project at a regional meeting is encouraged.

Enough time in advance of any meeting must be allowed to register at the reduced resident rate, and for adjustments in the program schedule to cover in the absence of the resident. Request for attendance at meetings is not guaranteed, and in the case of conflicts, scheduled vacations, and service coverage/commitments take priority.

Travel guidelines and expense allowances have been established by the GMEC (please refer to the GME manual section on Continuing Education Allowance and FH Expense Report Regulations).