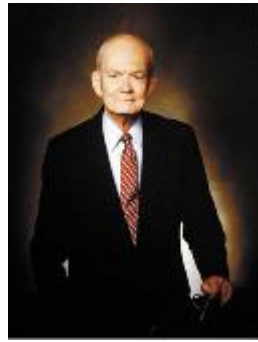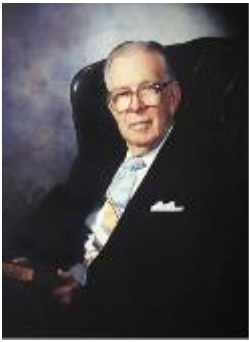# *2019-2020*

Medical Education General Surgery Department Program Handbook

Medical Education
Surgery *NavicentHealth*

Department of Surgery

Department Chairs: (Left to right) Milford B. Hatcher, Will C. Sealy, Martin L. Dalton, Don K. Nakayama, Dennis W. Ashley

The Residency in Surgery had its start under its founding Chair, Milford B. Hatcher, M.D., in 1958. Internationally famous for arrhythmia surgery, Will C. Sealy, M.D. succeeded him in 1984. In 1991, Martin L. Dalton, M.D. followed Dr. Sealy as Professor and Chair. The academic growth of the department continued with important clinical programs in trauma and critical care and surgical research. The Residency grew from two to four resident positions. Don K. Nakayama, M.D., a pediatric surgeon, was named the Milford B. Hatcher Professor and Chair of the Department of Surgery in 2007. Dr. Dennis W. Ashley was named the Milford B. Hatcher Professor and Chair of the Department of Surgery July 1, 2014. In 2017, a 5th resident position was added. The program is fully accredited by the Residency Review Committee in Surgery of the Accreditation Council for Graduate Medical Education. Residents regularly finish with more than 1,200 operations during the five-year training program with extensive experience in all areas of general surgery. Residents enter fellowships in all major surgical specialties. The Surgery Department also has a third year medical student clerkship providing a broad experience in trauma, vascular, general and pediatric surgery.

The Medical Center, Navicent Health (MCNH) has a 100-year history of serving the Central and South Georgia regions. At 603 beds, it is the second largest hospital in the state, the largest in a region of a 12 million population bounded by Atlanta, Augusta, Jacksonville, and Birmingham. MCNH has been named one of the top one hundred hospitals in the nation with top programs in cardiac services, orthopaedics, and neurosurgery. The hospital has 28 operating rooms with the full range of advanced surgical technology, including robotics, neuroimaging, and endovascular and minimally invasive surgery. It is certified by the Georgia Division of Public Health and the Office of Trauma as a Level 1 Trauma Center, with more than 3,000 trauma admissions. In 2016, MCNH was nationally verified as a Level 1 Trauma Center by the American College of Surgeons. MCNH supports residency training programs in family practice, general surgery, internal medicine, obstetrics, gynecology and pediatrics. Specialty fellowships in surgical critical care and geriatrics, orthopaedics are also available. MDNH's graduate medical education programs have more than 100 trainees.

Martin L. Dalton, Jr., M.D., FACS

May 15, 1932—June 22, 2018
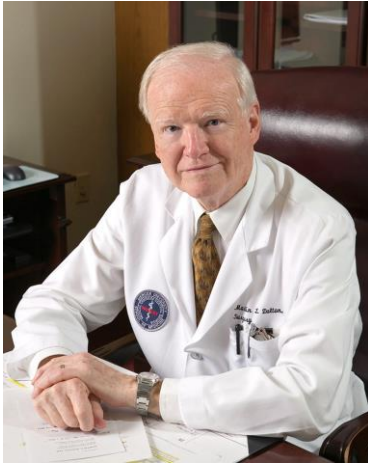
Dr. Dalton was born in Columbus, Georgia, and grew up in Eufaula, Alabama. He received a BS degree from Auburn University in 1953 and MD from the University of Alabama School of Medicine in Birmingham in 1957. In 1956, he married Alice Read Ligon in Nashville, Tennessee. His surgical residency was accomplished at the University of Mississippi Medical Center as was his fellowship in thoracic and cardiovascular surgery. It was during this time as the chief thoracic fellow that he became part of surgical history as he was one of the surgeons on the team that performed the first successful human lung transplant on June 11, 1963. Upon completion of his fellowship training, he entered the US Army and for two years was Chief of the Thoracic Section of the Department of Surgery at the Walter Reed Army Institute of Research in Washington, D.C. Following military service, he began the private practice of thoracic and cardiovascular surgery in Lubbock, Texas. From 1973 to 1983, he was Clinical Professor and Chief of the Division of Thoracic Surgery at the Texas Tech University School of Medicine.

In 1983, he returned to the University of Mississippi as Professor of Surgery under James D. Hardy and served in that capacity until 1991 when he became Professor and Chairman of the Department of Surgery of Mercer University School of Medicine and the Chief of Surgery and Program Director of the surgery residency program at the Medical Center of Central Georgia (Navicent Health) in Macon, Georgia.

In September of 2005, Dalton was appointed Dean of Mercer University School of Medicine and continued to serve as Chair of Surgery until June 30, 2007. He retired as Dean June 30, 2008, and completed a Sabbatical December 31, 2008, during which time he authored the *History of the Mercer University School of Medicine*.

Dr. Dalton has been a member of the American Surgical Association, the Southern Surgical Association, the American Association for Thoracic Surgery, the Society of Thoracic Surgeons, the International Surgical Society, the Society for Vascular Surgery, and the Southeastern Surgical Congress. He served six years as a Governor-at-Large for Georgia at the American College of Surgeons. He is a past president of the Mississippi Chapter of the American College of Surgeons, the Jackson, Mississippi, Surgical Society, the Lubbock, Texas, Surgical Society, the Georgia Surgical Society, the Georgia Chapter of the American College of Surgeons, and the Atlanta Vascular Society. He was a member of the James D. Hardy Surgical Society and a founding member of the Will C. Sealy Surgical Society.

Dr. Dalton has trained hundreds of residents that are practicing not only across the United States but around the world. He authored 150 publications in peer-reviewed journals, six books and four book chapters. The establishment of the trauma service at Navicent Health was one of his proudest achievements, and the Martin L. Dalton Fellowship in Critical Care bears his name.

Dr. Dalton passed away on June 22, 2018, in Macon, Georgia.

Atrium Health and Navicent Health form Strategic combination to serve communities in Central and South Georgia

The Medical Center, Navicent Health (MCNH) has a 100-year history of serving the central and South Georgia regions. At 637 beds, it is the second largest hospital in the state. MCNH was ranked second in the state in this year's ranking by *Newsweek* and is the only top performer in central Georgia. Nationally, MCNH ranked 110th in the entire U.S. Ten of Navicent's treatments for adult conditions were recognized, including: Cardiology; Diabetes & Endocrinology; Gastroenterology; Gynecology & Obstetrics; Memory Care & Geriatrics; Neurology & Neurosurgery; Pulmonology; Radiation Oncology; Traumatology; Orthopedics & spine surgery; and Urology. It is verified by the American College of Surgeons as a Level 1 Trauma Center, with more than 3,000 trauma admissions. Annually MCNH supports residency training programs in family practice, general surgery, internal medicine, obstetrics and gynecology and pediatrics. Specialty fellowships in surgical critical care, orthopedic traumatology, infectious disease, palliative care, and geriatrics are also available. MCNH's graduate medical education programs have more than 100 trainees.

Navicent Health was incorporated on November 17, 1994, as a nonprofit corporation whose primary purpose is to coordinate MCNH and other affiliated entities in their mission of providing a comprehensive continuum of high quality, reasonably priced healthcare services to the region. Navicent Health has 830 beds for medical, surgical, rehabilitation and hospice purposes. The health system includes The Medical Center, Navicent Health, Beverly Knight Olson Children's Hospital, Navicent Health, Navicent Health Baldwin and Medical Center of Peach County, Navicent Health (both rural critical access hospitals), Rehabilitation Hospital, Navicent Health, Pine Pointe, Navicent Health (provides palliative and hospice care in homes and in its facility), Carlyle Place, Navicent Health (continuing care retirement community), and Navicent Health Foundation, the philanthropic arm of Navicent Health.

On February 8, 2018, it was announced that Navicent Health would merge with healthcare giant Atrium Health. "Navicent Health has a shared mission with Atrium Health to continuously improve healthcare in this region," said Dr. Ninfa M. Saunders, FACHE, president and CEO of Navicent Health. "This is the first major partnership of its type in the Southeast region and ensures a Macon-based institution will continue to be the leading driver of healthcare in central Georgia and beyond, while continuing to elevate the care that is provided locally. This will also give us access to Atrium Health's wide array of award-winning, proven successes and best practices in healthcare delivery that we can deploy in our service areas. Our ability to provide high level services to improve the health of communities is only possible with support from our community, physicians, employees and partners. We are excited to find a partner that shares in our vision for the future of health." In December 2018, Atrium Health and Navicent Health signed a definitive agreement to finalize their strategic combination, which became effective January 1, 2019.

Navicent Health will continue its role as a teaching hospital maintaining its partnerships with the Mercer University School of Medicine, Middle Georgia State University, Wesleyan College, Central Georgia Technical College, Georgia College and State University.

Atrium is one of the nation's leading and most innovative healthcare organizations. Atrium is a not-for-profit providing care across North and South Carolina. Navicent Health felt that it was imperative to partner with a like-minded organization who shares our vision and values. Combining our organizations will allow us to reach more patients, families, teammates and partners now and for generations to come.

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Navicent Health Policies and Work Instructions

Med Ed Surgery Internal Guidelines

Dudley Benjamin Christie, III, MD, FACS
Assistant Professor of Surgery
Mercer University School of Medicine
General Surgery Program Director
Associate Director of Trauma
Medical Center Navicent Health

Message from the General Surgery Residency Program Director

The 2018–2019 academic year provided the largest graduating class that the department of Surgery has had to date, however this alone, is not why they will be recognized or remembered. This year's graduates demonstrated pure enthusiasm and magnetic spirits. They were excellent leaders, self-reliant, and they demonstrated a voracious appetite for self-improvement. These residents developed into surgeons, did it the right way, and will be fine additions to the anatomy of our tree of training.

The roots of our program run deep, are expansive and firmly anchor the trunk of our current faculty and staff. Sown and cultivated by legends in the annuals of surgery, Dr Will C. Sealy and Dr Martin L. Dalton, our tree of training, influence and mentorship now has generated graduates practicing in virtually every specialty, all over the United States and internationally.

Each graduating class is unique. They will have various personalities, backgrounds, and compositions of interests. While different in many ways, they will now, and forever, have a common career origin. With the exit of this year's graduating class, another strong branch sprouts from the departments tree of training as five new surgeons follow their callings and seek their own space and light in professional practice. We will miss them but will be pleased to see all that they can accomplish.

Row 1: Josh Ferenczy, Trine Engebretsen, Macram Ayoub, Alicia Register, Hany Atalah, Tyler Solomon, Eric Long, Alex Sapp
Row 2: Ravi Devalla, Obi Ekeledo, Carmen Lee, Allison Lord, Lindsey Bridges, Justin Vaughan, Shane Hill, Christopher Jean-Louis
Row 3: Matthew Barnes, Blake Bowden, Casey Hawes, Bill Wallace, Tim Nowack, Eric Forney, Tony Scott
Row 4: Andy Drahos, Hannah Nemec, Madison Lashley, Crystal Fancher, William Thompson, Brand Sheppard, Robert Parel, John Williams

Office of Graduate Medical Education

The Office of Graduate Medical Education (GME) is dedicated to support the human resource and administrative operations for GME programs and Residents at The Medical Center, Navicent Health. GME operates under the direction of Dr. Sandra Moore, Designated Institutional Official (DIO). The Designated Institutional Official ("DIO") for graduate medical education programs in collaboration with a Graduate Medical Education Committee (GMEC) oversees all ACGME accredited programs, has the authority and responsibility for the oversight and administration of the Medical Center's programs and responsibility for assuring compliance with ACGME Common, Specialty/Subspecialty-specific Program and Institutional Requirements. The DIO is responsible to assure the effective operation of a Graduate Medical Education Committee working collaboratively with an elected Committee Chairman. The DIO reports through the MCNH administrative structure to the Chief Medical Officer (CMO), Chief Operating Officer (COO), and Chief Executive Office (CEO). There are more than 900 residents in over 90 residency and fellowship programs.

GME Office Location and Contact Information:
3780 Eisenhower Parkway
Macon, GA 31206
phone: 478-633-1634
fax: 478-633-1578
http://intranet/medicaleducation/default.asp

Who to Contact in GME

Staff Member	Support Staff
Sandra Moore, M.D. Designated Institutional Official Moore.Sandra@Navicenthealth.org 478-633-1634	Ann Thaxton Director, GME Administration 478-633-1061 Thaxton.Ann@Navicenthealth.org Tim Prater GME Data Management and Compliance Specialist 478-633-7702 Prater.Timothy@Navicenthealth.org MaryAnn Paul Medical Education Secretary, GME 478-633-1634 Paul.Mary@Navicenthealth.org

2019-2020 Surgical Resident & Fellow Directory

GENERAL SURGERY RESIDENTS

Postgraduate Year V:	**Pager**	**Medical School**
Andrew Drahos	1169	Indiana University School of Medicine
Drahos.Andrew@navicenthealth.org		
Christopher Jean-Louis	2327	Univ of N TX College of Osteopathic Med
Jean-Louis.Christopher@navicenthealth.org		
Alexander Sapp	1172	Mercer University School of Medicine
Sapp.Alexander@navicenthealth.org		
Anthony Scott	1763	Mercer University School of Medicine
Scott.Anthony@navicentheatlh.org		

Postgraduate Year IV:	**Pager**	**Medical School**
Matthew Barnes	1525	University of South Alabama COM
Barnes.Matthew@navicenthealth.org		
Raviteja Devalla	1170	Trinity SOM - St. Vincent & Grenadines
Devalla.Raviteja@navicenthealth.org		
Hannah Nemec	1163	Virginia Commonwealth University SOM
Nemec.Hannah@navicenthealth.org		
Timothy Nowack	1171	MCG – Augusta
Nowack.Timothy@navicenthealth.org		
James Parker	2250	Trinity SOM - St. Vincent & Grenadines
Parker.James@navicenthealth.org		

Postgraduate Year III:	**Pager**	**Medical School**
Mallory "Blake" Bowden	3483	MCG - Augusta
Bowden.Mallory@navicenthealth.org		
Eric Forney	3371	University of Nebraska
Forney.Eric@navicenthealth.org		
Casey Hawes	1380	University of Mississippi
Hawes.Casey@navicenthealth.org		
Carmen Lee	1174	Mercer University School of Medicine
Lee.Carmen@navicenthealth.org		
William Wallace	2251	University of Oklahoma
Wallace.William@navicenthealth.org		

Postgraduate Year II:	**Pager**	**Medical School**
Lindsey Bridges	1168	Philadelphia College of Osteopathic Med
Bridges.Lindsey@navicenthealth.org		
Joshua Ferenczy	2332	Mercer University School of Medicine
Ferenczy.Joshua@navicenthealth.org		
Albert Kazi	2328	Ross University School of Medicine
Kazi.Albert@navicenthealth.org		
Allison Lord	2334	Mercer University School of Medicine
Lord.Allison@navicenthealth.org		
William "Tyler" Solomon	2336	Mercer University School of Medicine
Solomon.Tyler@navicenthealth.org		

Postgraduate Year I:	**Pager**	**Medical School**
Paul Cartwright	1517	Trinity School of Medicine
Cartwright.Paul@navicenthealth.org		
Allison Brown	1266	Mercer University School of Medicine
Brown.Allison@navicenthealth.org		
Cory Nonnemacher	1759	Florida State University College of Medicine
Nonnemacher.Cory@navicenthealth.org		
John Shillinglaw	2325	University of South Carolina SOM
Shillinglaw.John@navicenthealth.org		
Alexandra Thomson	1173	Mercer University School of Medicine
Thomson.Alexandra@navicenthealth.org		

PGY Level	Yearly Salary
1	$52,624
2	$55,120
3	$57,616
4	$60,112
5	$62,608
6	$65,104
7	$67,600

Resident Stipend Rates (2019-2020)

2019-2020 General Surgery Rotation Schedule

Rotation	7/1-8/4	8/5-9/8	9/9-10/13	10/14-11/17	11/18-12/22	12/23-1/5	1/6-2/9	2/10-3/15	3/16-4/19	4/20-5/24	5/25-6/30
GEN SURG / MA/WT/EL	Sapp	Scott	Sapp	Scott	Drahos		CJL	Drahos	CJL	Scott	Sapp
	Nowack	Parker	Barnes	Nemec	Forney		Nowack	Nemec	Nowack	Devalla	Parker
	Nonnemacher	Shillinglaw	Cauthen	Thompson	Cartwright		Shillinglaw	Thompson	Nonnemacher	Cartwright	Bowden
											Cauthen
GEN/BAR SURG / DV/RP	Parker	Sapp	CJL	Drahos	Scott		Devalla	Parker	Nemec	Barnes	Devalla
	Bowden	Hawes	Lee	Wallace	Nowack		Lee	Forney	Wallace	Bowden	Hawes
SURG/ONC / DB/AC/PD/MH	CJL	Drahos	Scott	CJL	Sapp		Parker	Barnes	Devalla	Nowack	Barnes
	Nemec	Nowack	Nemec	Parker	Devalla		Hawes	Lee	Forney	Hawes	Wallace
	Cartwright	Nonnemacher	Shillinglaw	Cauthen	Thompson		Solomon	Cartwright	Kazi	Bridges	Kazi
	Shillinglaw	Cauthen	Thompson	Cartwright	Nonnemacher		Thompson		Cauthen	Shillinglaw	Nonnemacher
DA/DBC/AJ	Devalla	Nemec	Nowack	Barnes	Parker		Sapp	Scott	Scott	CJL	Drahos
	Thompson	Cartwright	Nonnemacher	Shillinglaw	Cauthen		Ferenczy	Solomon	Bridges	Lord	Forney
PRIV	Drahos	Barnes	Devalla	Sapp	CJL		Scott	CJL	Drahos	Drahos	Nemec
	Wallace	Lee	Bowden	Lee	Bowden		Forney	Lord	Hawes	Wallace	Ferenczy
TRAUMA	Barnes	Devalla	Parker	Nowack	Nemec		Barnes	Devalla	Parker	Nemec	Nowack
	Kazi	Ferenczy	Solomon	Lord	Bridges		Cartwright	Cauthen	Thompson	Nonnemacher	Shillinglaw
	Cauthen	Thompson	Cartwright	Nonnemacher	Shillinglaw						
ICU	Ferenczy	Solomon	Lord	Bridges	Kazi		Bridges	Ferenczy	Solomon	Kazi	Lord
NIGHT FLOAT	Hawes	Wallace	Forney	Bowden	Lee		Lord	Kazi	Ferenczy	Solomon	Bridges
	Bridges	Lord	Ferenczy	Kazi	Solomon		Nonnemacher	Shillinglaw	Cartwright	Cauthen	Thompson
PED SURG	Forney	Forney	Hawes	Hawes	Wallace		Wallace	Bowden	Bowden	Lee	Lee
	Solomon	Kazi	Bridges	Ferenczy	Lord		Cauthen	Nonnemacher	Shillinglaw	Thompson	Cartwright
VASCULAR	Scott	CJL	Drahos	Devalla	Barnes		Drahos	Sapp	Sapp	Sapp	CJL
	Lee	Bowden	Wallace	Forney	Hawes		Nemec	Nowack	Barnes	Parker	Scott
TRANSPLANT							Bowden	Hawes	Lee	Forney	
								Wallace			
RESEARCH	Lord	Bridges								Ferenczy	Solomon
CORDELE			Kazi	Solomon	Ferenczy		Kazi	Bridges	Lord		

Educational Goals and Objectives for the
General Surgery Residency Program

The Core Competencies in General Surgery

The Accreditation Council for Graduate Medical Education (ACGME), including the Residency Review Committee for surgery, has adopted a set of general competencies for all physicians who complete higher training programs. These have been adapted for each specialty. Residents must become competent in the following six areas at the level expected of a surgical practitioner. Training programs must define the specific knowledge, skills, and attitudes required and provide the educational experience for residents to demonstrate:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Surgical residents must: demonstrate manual dexterity appropriate for their training level and be able to develop and execute patient care plans.

2. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Surgical residents are expected to critically evaluate and demonstrate knowledge of pertinent scientific information.

3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care. Surgical residents are expected to:

   a) critique personal practice outcomes.

   b) demonstrate a recognition of the importance of lifelong learning in surgical practice.

4. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals. Surgical residents are expected to:

   a) communicate effectively with other health care professionals.

   b) counsel and educate patients and families.

   c) effectively document practice activities.

5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Surgical residents are expected to:

   a) maintain high standards of ethical behavior.

   b) demonstrate a commitment to continuity of patient care.

   c) demonstrate sensitivity to age, gender and culture of patients and other health care professionals.

6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and response to the larger context and system of health care and effectively call on system resources to provide optimal care. Surgical residents are expected to:

   a) practice high quality, cost effective patient care.

   b) demonstrate a knowledge of risk-benefit analysis.

   c) demonstrate an understanding of the role of different specialists and other health care professionals in overall patient management.

The major educational goal of the General Surgery Residency Training Program in the Department of Surgery at the University of Louisville is to produce a board-certified surgeon capable of independently practicing general surgery of highest quality. On completion of the program, the surgeon should have a general knowledge, clinical judgment, the basic technical skills and personality attributes to establish rapport with patients and their families for the practice of general surgery, and be assessed as competent in the areas as outlined under the ACGME's 6 core competencies.

PGY-1, or surgical intern, is an entry level position to a 5-year surgical training program. A PGY-1 will perform the initial history and physical examination for patient encounters hospital wide, participate as a team member to each surgical service the PGY-1 rotates onto, provide clinical support to floor/ward patients, and be responsible for the timely creation of daily progress notes and discharge summaries. The PGY-1, in concert with more senior surgical residents, will see patients/consultations in the hospital, including the Emergency Center and affiliated clinics. The surgical intern will participate as a Trauma Team member on a rotational basis and respond to every trauma code while on this hospital service. Later in the academic year, the PGY-1 with spend one month in the Intensive Care Unit. The PGY-1 position with rotate through the predetermined surgical subspecialties as outlined in Department of Surgery Residency training curriculum. PGY-1's will perform no invasive procedures without the direct supervision of a senior resident (PGY-3 or above) or an attending surgeon. During the PGY-1 year, the intern will perform six of each of the following procedures under direct supervision: 1.) Arterial Line Insertion; 2.) Chest Tube Insertion; 3.) Central Venous Line Insertion; 4.) FAST Examination; 5.) Endo-tracheal Intubation; 6.) Pediatric/Adult Sedation; 7.) Bronchoscopy.

PGY 2 is resident is a second year position in a 5-year surgical training program. A PGY-2 resident will perform history and physical examinations for patient encounters hospital wide, participate as a team member to each surgical service the PGY-2 rotates onto, provide clinical support to floor/ward patients, and be responsible for the timely creation of daily progress notes and discharge summaries. The PGY-2, in concert with more senior surgical residents, will see patients/consultations in the hospital, including the Emergency Center and affiliated clinics. The PGY-2 position with rotate through the predetermined surgical subspecialties as outlined in Department of Surgery Residency training curriculum. During the PGY-2 term, the resident will have the option of spending one month on a Clinical Research rotation under the supervision of an assigned physician of the Mercer University School of Medicine or in a Rural Surgical rotation under the mentorship of Dr. Vince Culpepper of Crisp Regional Hospital in Cordele, Georgia. The PGY-2 will spend one month on the Transplant Surgery service at the Piedmont Hospital in Atlanta, Georgia. The PGY-2 may perform invasive procedures after six of each type of procedure (identified under PGY 1) has been correctly performed under the direct supervision by a senior resident or an attending surgeon.

PGY 3 is a mid-level position in a 5-year surgical training program. A PGY-3 will perform history and physical examinations for patient encounters hospital wide, participate as a team member to each surgical service the PGY-3 rotates onto, provide clinical support to floor/ward patients, and be responsible for the timely creation of daily progress notes and discharge summaries. The PGY-3, in concert with more senior surgical residents, will see patients/consultations in the hospital, including the Emergency Center and affiliated clinics. The PGY-3 position with rotate through the predetermined surgical subspecialties as outlined in Department of Surgery Residency training curriculum. The PGY-3 resident may perform invasive procedures without supervision and have gradually progressive surgical responsibilities. The PGY-3 resident is permitted to supervise the first and second year residents during patient encounters and invasive procedures. Traditionally, the PGY-3 resident will successfully complete the Advanced Trauma Operative Management course (ATOM).

PGY 4 is a chief-level position in a 5-year surgical training program. A PGY-4 will perform history and physical examinations for patient encounters hospital wide, participate as a team member to each surgical service the PGY-4 rotates onto, provide clinical support to floor/ward patients, and be responsible for the timely creation of daily progress notes and discharge summaries. The PGY-4, in concert with more junior surgical residents, will see patients/consultations in the hospital, including the Emergency Center and affiliated clinics. The PGY-4 position with rotate through the predetermined surgical subspecialties as outlined in Department of Surgery Residency training curriculum. The PGY-4 resident may perform invasive procedures without supervision and have gradually progressive surgical responsibilities. The PGY-4 resident is permitted to supervise the first and second year residents during patient encounters and invasive procedures. The PGY-4 will take chief call and serve as captain of the Trauma Team

and answer to every trauma code. Traditionally, the PGY-4 resident will successfully complete both the Fundamentals of Laparoscopic Surgery (FLS) and the Fundamentals of Endoscopic Surgery (FES) courses.

PGY 5 is a chief-level position in a 5-year surgical training program. A PGY-5 will perform history and physical examinations for patient encounters hospital wide, participate as a team member to each surgical service the PGY-5 rotates onto, provide clinical support to floor/ward patients, and be responsible for the timely creation of daily progress notes and discharge summaries.   The PGY-5, in concert with more junior surgical residents, will see patients/consultations in the hospital, including the Emergency Center and affiliated clinics. The PGY-5 position with rotate through the predetermined surgical subspecialties as outlined in Department of Surgery Residency training curriculum. The PGY-5 resident may perform invasive procedures without supervision and have gradually progressive surgical responsibilities. The PGY-5 resident is permitted to supervise the first and second year residents during patient encounters and invasive procedures. The PGY-5 will take chief call and serve as captain of the Trauma Team, answering to every trauma code. Each of the PGY-5 residents will serve as the Chief Administrative Resident for two to four months and as such administers the call schedule, any rotational changes, and assign cases to their respective surgical teams on the day prior to the expected operations. He/She is in charge of the Surgery Clinic and supervises the performance of junior residents and students in the Ambulatory Care Clinic. With a staff member present, the fifth year resident is permitted to do teaching cases with junior residents.

Optional Rural Surgical Experience – PGY 1-5: Christie/Parel Service
Monroe County Hospital
Forsyth, Georgia

Summary: Monroe County Hospital (MCH), located approximately thirty minutes north of Macon serves a vital role in patient care delivery in our region. As a hospital and long standing care provider for a great number of middle Georgia patients, MCH provides the opportunity for the resident to experience surgical and medical care delivery in a critical access hospital setting. The resident will attend surgical and endoscopic cases performed in the MCH, interact with physician and hospital staff and participate in the regional surgery clinic under the direct supervision of the credentialed surgical attending.

Goal: to provide experience in a rural/critical access hospital practice setting.

Knowledge: Familiarity with (a) Scope of practice of surgeons in rural practices (endoscopy, general surgery, emergency/urgency patient management); (b) Resources in critical access hospitals; (c) Relationships with providers in rural or critical access hospital settings (d) Referral criteria to tertiary hospitals; and (e) Professional and social relationships of surgeons in rural or critical access settings.

Skills: Skills appropriate for level in the essential areas of surgery, including (a) Upper and lower endoscopy; (b) basic laparoscopic (cholecystectomy, appendectomy) and open operations (bowel resection, hernia repair); and (c) evaluations of basic emergency and urgent surgical conditions.

Abilities: Skills in core competencies appropriate for level, including (a) Inpatient and outpatient management of surgical patients in critical access hospitals; (b) Consultation for referring physicians practicing in rural or critical access areas; and (c) Follow up of patients in rural or critical access areas.

Clinical Research Rotation – PGY 2 – one-month rotation

Rotation Goals: Encourage resident dedication to research, clinical investigations, project closure, Provision of a clear and transparent policy detailing expectations.

Rotation Objectives: Create a guided research plan, timeline, and goals with faculty mentorship to enhance the residents research efforts during their dedicated research rotation.

Rotation Expectations: The resident will be allowed to choose either a basic science or clinical pathway for their month of dedicated research.

If the basic science research pathway is chosen, the resident will create a project description and plan to be presented to the Chair of the Department of Surgery or Program Director for review. The goals and objectives of the basic science research pathway will be described. If the resident's research project description and plan is accepted, a research timeline will be developed where a mid-point assessment of progress by the Chair of the Department of Surgery or Program Director will be performed. The resident's research project meeting with the Chair or Program Director must be completed no later than one month prior to beginning the research rotation. The resident will select, or be directed to, a national or regional submission opportunity for presentation and publication. At completion of the basic science research month, the resident will have an end-of-rotation review with the Chair of the Department of Surgery or Program Director where rotational goals and objectives will be deemed as either satisfied or unsatisfied. If the rotation goals and objectives are deemed unsatisfied, the resident will be noted as insufficient in their program file for this rotation until the project description and plan has been completed. Failure to complete the project plan at the end of the five-year training period will result in the residents American Board of Surgery training verification form not being signed until this expectation has been met.

If the clinical research pathway is chosen, the resident will select a teaching faculty mentor and create a project description and plan to be presented to the Chair of the Department of Surgery or Program Director for review. The goals and objectives of the clinical research pathway will be described. If the residents research project description and plan is accepted, a research timeline will be developed where a mid-point assessment of progress by the Chair of the Department of Surgery or Program Director will be performed.   The resident's research project meeting with the Chair or Program Director must be completed no later than one month prior to beginning the research rotation. The resident will select, or be directed to, a national or regional submission opportunity for presentation and publication. At completion of the clinical research month, the resident will have an end-of-rotation review with the Chair of the Department of Surgery or Program Director where rotational goals and objectives will be deemed as either satisfied or unsatisfied. If the rotation goals and objectives are deemed unsatisfied, the resident will be noted as insufficient in their program file for this rotation until the project description and plan has been completed. Failure to complete the project plan at the end of the five-year training period will result in the residents American Board of Surgery training verification form not being signed until this expectation has been met.

Optional Rural Surgical Experience – PGY 2 – one-month rotation

Crisp Regional Hospital

Cordele, Georgia

Knowledge: Familiarity with (a) Scope of practice of surgeons in rural practices (endoscopy, trauma, emergencies); (b) Resources in critical access hospitals; (c) Relationships with providers in rural regions (d) Referral criteria to tertiary hospitals; and (e) Professional and social relationships of surgeons in rural areas.

Skills: Skills appropriate for level in the essential areas of surgery, including (a) upper and lower endoscopy; (b) basic laparoscopic (cholecystecomy, appendectomy) and open operations (bowel resection, trauma); and (c) evaluations of basic emergency conditions and trauma patients.

Abilities: Skills in core competencies appropriate for level, including (a) inpatient and outpatient management of surgical patients in critical access hospitals; (b) consultation for referring physicians practicing in rural areas; and (c) follow-up of patients in rural/sparsely populated areas.

Transplant Surgical Rotation – PGY 3 – one-month rotation

Piedmont Hospital

Atlanta, Georgia

Knowledge: Clinical evaluation of organ donors and recipients. Surgical immunology. Immunosuppression and pharmacological agents. Organ preservation. Histocompatibility and cross matching. Organ procurement. Transplant anatomy of the liver, kidney, and pancreas. Postoperative management including rejection. General surgical complications and conditions that arise in transplant patients.

Skills: Surgical techniques, pre- and postoperative management.

Elective Away Rotations

The Office of Graduate Medical Education will consider Away Rotations for Residents as approved by the Program Director as part of the educational training program. Advance planning is necessary for all the items that must be in place prior to an away rotation and residents should coordinate with the Program Director and Program Coordinator.

Resident Away Elective process:
- GME Resident Away Elective Rotation management system for U.S. Away Rotations: http://intranet/medicaleducation/files/GMEPP/PDF/New%20Format/Chapter%205/5.3%20Resident%20Away%20Electives.pdf
  - Program Coordinators submit PLA requests at least *90 days* in advance for In-State away rotations or at least *120 days* in advance for Out-of-State away rotations.
  - PLA (Program Letter of Agreement) drafted by sponsoring institution's residency program will be emailed to the receiving institution (participating site) for approval and signatures.
  - Residency Coordinator will enter all information on the Resident Away Electives Approval

Form and attach all required documents from the checklist (including PLA) and submit for final approval. The GME Resident Away Elective Rotation Form is to be approved by both the Program Director and DIO for GME before the resident staff makes any prior arrangements such as booking airline flights or make other financial commitments.

- o Professional Liability Coverage – upon approval the GME Away Elective Rotation Form is to be sent to the Insurance Administrative office located here at MCNH for approval (CPI letter) to ensure that insurance coverage is in place for the away rotation.
- o Residents will be guided by information to obtain the appropriate medical license, obtain appropriate immunizations, etc.

The GME away rotation management system is designed for resident staff to manage their rotations away from MCNH. The purpose of this site is to maintain a central repository of all approved rotation activities and to ensure resident staff members are prepared for any away rotations.

It is the responsibility of the Program Coordinator to submit a PLA Request (minimum of 90 days in advance for In-State/120 days for Out-of-State) for a contract to be established unless one is already in place. The GME checklist and PLA should be attached to the Resident Away Elective Approval Form.

Insurance administrative office will receive an email with a copy of the approved form attached requesting professional liability insurance coverage (CPI letter) for the away rotation. The approval letter (CPI letter) will indicate coverage is being provided for the away rotation.

Final review and approval of the GME Resident Away Elective Rotation Form will be generated by the DIO once the PLA is finalized. The Program Coordinator will receive notification of this approval.

Please advise resident staff members not to book airline flights or make other financial commitments related to away rotations until all items below are in place and confirmed. Please ensure that the resident staff member has appropriate medical licensure for the location of the rotation before the rotation begins.

ATOM, FLS, FES

Advanced Trauma Operative Management (ATOM) Course

The Advanced Trauma Operative Management (ATOM) course is an effective method of increasing surgical competence and confidence in the operative management of penetrating injuries to the chest and abdomen. https://www.facs.org/quality-programs/trauma/education/atom.

Objectives

- The student will explain and describe the proper operative technique for dealing with trauma injury.

- The student must identify traumatic injuries and develop a management plan in order to surgically repair the injuries.

- At the completion of the course, the student will be able to demonstrate the following:

    o Increased self-efficacy in the management of traumatic injuries

    o Increased knowledge in the management of penetrating injuries

    o Ability to successfully and safely perform all operative procedures presented in the course

Fundamentals of Laparoscopic Surgery (FLS) Program

The FLS Program has been mandated by the American Board of Surgery as a pre-requisite for eligibility for general surgical board qualifying exam.

The FLS Program is a comprehensive, educational module and assessment tool designed to teach the fundamental knowledge, clinical judgment and technical skills required in the performance of basic laparoscopic surgery. The educational module consists of a web-based multimedia presentation of didactic content and "watch & do" exercises that focus on manual skills training. The FLS assessment includes two components, a computer based-cognitive assessment and a performance-based manual skills assessment.

FLS Eligibility and Test Scheduling

Junior and senior surgical residents and fellows enrolled in an accredited program of surgical education are eligible to take the FLS test. The Onsite Testing is administered at Navicent Health in our simulation lab which is located on the first floor of the West Tower. The residency program coordinator will complete the didactic registration, order test vouchers and arrange to have an authorized FLS Test Proctor administer the computer based-cognitive and performance-based manual skills assessment.
https://www.flsprogram.org/index/fls-program-description/

Flexible Endoscopic Surgery (FES) Program

The Fundamentals of Endoscopic Surgery (FES) program is a test of knowledge and skills in flexible gastrointestinal (GI) endoscopy. FES is the flexible endoscopy equivalent of the Fundamentals of Laparoscopic Surgery (FLS) program. FES is meant to set a validated benchmark of understanding and skill in basic GI endoscopy.

There are two components to FES: web-based didactic materials and a two-part assessment made up of a multiple-choice cognitive exam and a hands-on skills test.

The assessment component is a 90-minute, 80 multiple-choice questioned exam administered via computer to document cognitive knowledge, plus a hands-on skills test documenting technical and psychomotor skills. Both the cognitive and skills assessment is taken during the same testing appointment in the presence of an authorized FES Test Proctor.

The American Board of Surgery (ABS) has recently announced a new requirement to ensure all ABS-certified general surgeons have completed a standard curriculum in the area of endoscopic techniques. The new requirement will apply to applicants for board certification in general surgery who complete their residency training in the 2017-2018 academic year or thereafter.

During their general surgery residency, applicants will be required to have completed the ABS Flexible Endoscopy Curriculum, available from the ABS website at www.absurgery.org.

The FEC is designed to provide general surgery residency programs with a milestone-based program for the teaching of endoscopic procedures over the five years of residency. One of the final milestones in the curriculum is successful completion of the FES program. Residents will be required to provide evidence of FES certification when applying for ABS certification. http://www.fesprogram.org/testing-information/.

A Year in the Life of a Residency Program

Note: key dates for GME items are in red below

July

- July 1 is the beginning of the academic year in all GME programs. It is the day the majority of new residents and fellows begin their training.
- Annual *ACGME ADS* update and *GME Track* updates of the resident census generally begins in the summer.
- Begin the process of answering questions about your Residency Program from 4th year medical students

August

- ERAS® opens mid-September. Install ERAS® Web-based on PCs of all staff who will be using it. Work with your IT person to ensure ERAS® is installed and operating properly.
- Submit match quotas to NRMP
- Complete GME Track and ACGME ADS updates for the new academic year

September

- Residency applications begin to arrive through ERAS®. It is helpful to download every day. Meet with your program director to determine process for screening applications.
- Prepare recruitment materials
- Assemble any other packets or materials to be distributed to residency candidates
- Make preparations for upcoming interview season
- Update all interview materials including Interview Evaluation Forms
- Begin to send out invitations to interview
- NRMP Registration – both PD and PC
- APE Report

October

- Determine interview date(s), if not already done. Notify faculty and appropriate personnel both administrative and clinical.
- Secure hotel reservations for all applicants.
- Medical student performance evaluations (MSPE) (formerly "Dean's Letters") are released October 1
- If your faculty uses ERAS® online for interviews, orient new faculty
- Begin to send out invitations to interview
- Coordinate with faculty in interview process by providing them with applicant information
- Coordinate scoring of applicants
- Plan and coordinate social activities for applicants – casual dinners
- Registration for in-training exam is usually in the fall, although this varies among specialties (invoice)
- Complete ACGME WebAds Surveys
- Schedule applicant lunches
- Assist during interview days by developing itineraries, greeting applicants, and providing an overview of the program
- Prepare for applicants to call to check their status updates and to find out if they will be offered interviews

- Beginning of interviewing of residency candidates

November
- Assist during interview days by developing itineraries, greeting applicants, and providing an overview of the program
- Coordinate with faculty in interview process by providing them with applicant information
- Coordinate scoring of applicants
- Send out email of regret to those applicants who have not been selected to interview

December
- Interviews continue
- Coordinate with faculty in interview process by providing them with applicant information
- Coordinate scoring of applicants
- Mid-year evaluations (semiannual)
- Continue emails of regret to those applicants who have not been selected to interview
- Assist during interview days by developing itineraries, greeting applicants, and providing an overview of the program
- Coordinate Milestone scoring of residents in ACGME

January
- Finish with interviews
- Coordinate "second look" visits from applicants
- Collect final scores and comments from interviewers and residents
- Continue emails of regret to applicants who have not been selected to interview
- Note deadline for NRMP match quota changes
- Begin submitting required appointment information for non-match applicants to the GME office. (March) (SOAP)

February
- Coordinate match list
- Enter match list on NRMP web site
- Register your programs for ERAS® for the following year
- Schedule Education Committee meetings or faculty meetings to systematically review your programs, make curriculum decisions for upcoming year and evaluate resident performance. This is an ACGME requirement and must be done at least annually.

March
- Match Day occurs in mid-March. Results are posted on the NRMP web site.
- *Submit required information regarding match applicants to the GME Office.*
- Prepare checklist of all tasks to complete for incoming and outgoing Resident Staff.
- Update web site, if necessary
- Coordinate Chiefs Retreat **(May)**
- Generate lists of residents for next academic year and distribute to appropriate personnel and departments

April

- Begin updating internal guidelines, program manual, etc.
- Secure venue for graduating residents' banquet two years in advance (June).
- *Notification will be sent from GME to Program Coordinators when Welcome Packets have been mailed to incoming residents. It is important for you to assist the GME Office in obtaining all items so your residents can begin training on time.*
- GME CERTIFICATE *data will be sent to programs for review late-April. Upon confirmation, certificates will be provided for signature rounding.*

May

- Prepare for departmental orientation (done annually before the academic year starts)
- You and the Program Director will receive periodic emails informing you of items needed for your incoming residents May/June. *It is important for you to assist the GME Office in obtaining these items so your Resident Staff can begin training on time.*
- Create new academic year in NEW INNOVATIONS and begin to enter rotation block.
- Plan events for graduating residents and fellows
- Order certificates and/or plaques for graduating residents and fellows
- Prepare and distribute annual evaluation forms of program and core faculty to residents
- Coordinate residents' semi-annual reviews for non-graduating residents

June

- GME certificates released to programs late June.
- Finalize Goals and Objectives, Policies and Procedures and other program documents for distribution to new residents
- Coordinate department orientation program for new residents
- Coordinate graduating residents' year-end evaluations meeting with Program Director
- Preparations for Chief Graduation ceremony
- ACGME end of the year Milestones report

Various

- Keep WebADS current with any change in the program and update at least annually.
- PROGRAM LETTER OF AGREEMENT *(PLA) must be renewed/re-signed every 5 years.*
- AWAY ROTATIONS *(domestic) require an Away Rotation Approval request from the resident. The coordinator will get the required documents and signatures within the appropriate time frame.* http://intranet/medicaleducation/files/GMEPP/PDF/New%20Format/Chapter%205/5.3%20Resident%20Away%20Electives.pdf
- Annual Mandatories - all residents are required to have an Annual health screen, Mask Fitting, PPD, and complete all online Care Learning modules assigned them.
- 360˚ Evaluations are sent out through New Innovations to directors located in specific areas and floors within the hospital.

Miscellaneous

Call Rooms

ACGME Institutional Requirement *II.F.3.b.* requires that "residents on call must be provided with adequate and appropriate sleeping quarters that are safe, quiet, and private." The GME Office is responsible for resident call rooms assigned to GME on the hospital space inventory. GME assigns the rooms to programs based on need and available space. GME provides the basic furnishings and should be contacted if there are problems with a call room. Each program should make sure that their residents know where their call room is located.

Napping and Transportation Options for Post-Call Residents

For post call residents call room space available on an as needed basis for residents who are too fatigued to safely return home. For transportation, the department will provide and/or reimburse the resident(s) for transportation to their place of dwelling via cab or Uber.

Computer Systems Access

The GME Office requests computer access for the following systems during the appointment process for all residents including off-cycle hires:

- Powerchart
- PowerWorks
- CPOE
- EMR (Electronic Medical Records)
- PACS (Imaging Radiology Tool)
- TraceMasterVue
- Xtend Paging
- New Innovations

If you have any questions, please contact Glenda Anderson at 478-633-1430.

It is not necessary to complete a "Systems Access Form" for new hires or terminating resident staff. GME office will be responsible for this process.

NPI Numbers

The Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information. The Centers for Medicare & Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers.

The new residents will set these up themselves (instructions provided in the New Hire Welcome Packet GME mails to incoming resident staff). You or the residents can look up their NPI numbers by searching the NPI registry website at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do.

Pager Assignment for all GME-appointed residents

Each department is responsible for assigning pager numbers for advancing and new residents. Each department will then provide this information to the Communications Office at The Medical Center, Navicent Health. Your department may require you to provide a list to additional groups.

Resident Pagers

- Pagers for residents stay within the same program, being reassigned from residents completing/leaving the program to residents starting the program. Residents are not able to keep the same pager if continuing at the Medical Center in another program or as faculty. As residents leaving the program check out, collect their pagers and distribute to your incoming residents according to the assignments you reported to the Communications Office.
- If additional pagers are needed for your residents, e-mail your request to Keith Fitts at Fitts.Keith@Navicenthealth.org. After approval and issue of the pager, you will receive an e-mail that the pager is ready for pickup at the Communications Office located on the ground level near the "B" elevators.

Georgia Medical License

The GME Office applies for temporary training permit licensure for all new surgery residents (as well as continuing residents). Verification of training permits are maintained in the GME Office. If verification of training permit is needed, please contact the GME Office (for GME appointed residents).

All surgery resident members who apply for MOONLIGHTING (internal or external) *must* have a full Georgia Medical License and provide a copy of their license with the application for moonlighting. The license exemption will not apply to moonlighting.

Vacation

Vacation time is awarded based on the appointment period instead of July-June. All residents are awarded 120 hours of vacation time at the beginning of the appointment period. Vacation must be used within the appointment period and will not carry over to the next appointment period.

Identification Badge

For the incoming residents who start in July (on-cycle), the GME Office will provide a list of all eligible residents to the Human Resource Office. All incoming residents are responsible for getting their badges from the Human Resource Office. For badge replacement cost go to http://intranet/cghspolicy/40000/40-006.pdf

Building Access

If any of your residents have issues with building access, please have them contact Hospital Police at 478-633-1490.

Liability Coverage for Residents

Residents paid through GME Cost Centers

The GME Office provides information to Risk Management regarding all new and continuing residents who have an appointment through GME. Those members who are paid through the GME cost centers are covered with no additional paperwork. Risk management sends a copy of the Certificate of Liability Coverage to GME which is maintained in the GME file and emailed to the residency coordinators.

New Resident Orientation

The GME office provides a new resident orientation before the beginning of each new academic year. New GME-appointed residents are expected to attend orientation. Some individual departments also have an internal orientation for new residents. New resident orientation will serve to welcome new residents, providing an overall introduction to the Medical Center GME and specific training and information.

New Innovations

New Innovations is the secure centralized internet database Residency Management System (RMS) which the GME office has purchased for use by all programs. Program coordinators are required to use this system to report and maintain all annual rotation information. Please note the "Academic Year" is defined as July 1 - June 30. Resident members can use New Innovations to enter their duty hours. The system has numerous additional modules and features which you are free to take advantage of in the maintenance of your program but are not required for all programs. These include, but are not limited to, duty hour entry and reports, evaluations, and reports, conference management, portfolio reviews, milestone tracking, and custom reporting.

New Innovations may be accessed at http://www.new-innov.com/pub/. For training and technical assistance, please contact Tim Prater in the GME Office at 478-633-7702 or contact New Innovations directly assistance at 330-899-9954. The functions and reports available in New Innovations are extremely helpful when preparing documentation for a site visit or internal review.

An individual program can use this residency management suite to assist with scheduling, evaluations, monitoring conference attendance, duty hours and general personnel tracking.

- The IRIS (INTERN AND RESIDENT INFORMATION SYSTEM) MODULE allows GME and finance personnel to collect and export IRIS information for Medicare Cost Reports.
- Prepare and track RRC or Internal Review documentation, dates and results.
- Maintain affiliation agreements with automatic renewal reminders.
- Easily gather information from across the institution and conduct reporting for all departments.
- Customize reporting to address specific requests and provide relevant information.
- Send institution wide evaluations out to any set of individuals.

- Demographic centralization and customization helps manage multiple aspects of medical personnel data.

More specific information regarding all that New Innovations offers can be found at the following link:
http://www.new-innov.com/pub/rms/main.aspx

Advancement

Advancing Current Resident Staff

The purpose of the GME Advancement Form is for the program to provide and approve the next appointment status or end of training information for each of their current Resident Staff in the next academic year.   The Administrative Manager in GME uses this information to prepare program certificates for Resident Staff completing their training, prepare reappointment agreements for those who will continue, and obtain exemption from medical licensure for continuing residents, plan for required personnel/payroll actions, and to prepare the fiscal budget for those salaries/benefits paid through GME cost centers.

All other advancement payroll actions will be processed thru GME as usual:

- Job code changes
- Salary changes
    - Remember off-cycle Resident Staff and those needing training extensions will need the July 1st salary increase before any advancement/termination actions are submitted
- Terminations
    - Effective date is the day after the last day of employment (i.e. appointment ends June 30th, termination will be effective July 1st)

Resident Staff Terminating and leaving MCNH

A PAR must be submitted to terminate Resident Staff from Payroll. These actions should also be submitted for processing by June 30th to allow for GME and HR processing.

Which form do I use?

GME is responsible for approving all resident staff pay forms and PAR actions because of the home department/center and/or job code. Please, make sure that you submit all Final Clearance forms to the GME office for final signature approval. GME also maintains copies of all pay forms submitted.

Exiting Process for Chiefs

Completion of Training Certificates

Certificates are generated according to the completed advancements. A draft of "ready to print" certificates will be sent to the Program Coordinator via email to check for spelling of names, degree suffix and dates of training. Once verified and initialed by both the Program Coordinator and Resident Staff member, an email will be sent to the GME office with a confirmation to print or make changes to the certificates. An e-mail will be sent to the Program Coordinator requesting pick up of the certificates. Certificates are released in early June unless an earlier date is requested in advance and approved by Dr. Moore.

Final Clearance Form

The GME Office will send an e-mail notifying the Program Coordinator of approaching exit dates for residents along with the final clearance form. As this data is important, it needs to be filled out completely and returned to the GME office. For any questions and/or issues regarding the exit process, contact MaryAnn Paul at 478-633-1634.

In the unusual circumstance where a member of the resident staff leaves prior to the completion of training and does not go through the normal check-out process, the coordinator may be asked to collect the following items: ID Badge, Pager, scrubs, and other items assigned by the department. These items should be returned to the appropriate departments. Please notify GME that the above items have been collected/returned.

Program Letters of Agreement (PLA)

The Program Letter of Agreement (formerly Memorandum of Understanding) is an ACGME requirement for resident/clinical fellow education at a participating site, which must be signed by the Program Director, the Signatory Authority at the Affiliate Institution and the DIO. The PLA addresses GME responsibilities between an individual accredited program and a site other than the sponsoring institution at which residents receive a required part of their education. This document, after it is signed, is in effect for a maximum of five years and must be renewed/resigned every five years with the affiliate institution so Resident Staff may continue to participate in this part of the training process. The PLA should be renewed sooner than 5 years if there is a change in PD, DIO, or affiliate institution official who originally signed the PLA or if there is a significant change to the rotation or to ACGME policy which affects the rotation.

When is a PLA Required?

- ACGME requires a PLA between the program and each site to which resident staff in that program are required to rotate.
- MCNH also requires a PLA between the program and each site to which resident staff elect to rotate (ELECTIVE AWAY ROTATIONS)

ACGME Common Program Requirements

ACGME approved revisions to Sections I-V: effective 2007, 2013, 2015, 2016
ACGME approved major revision of Section VI: February, 2017; effective: July 1, 2017

Common Program Requirements

Note: The term "resident" in this document refers to both specialty residents and subspecialty fellows. Once the Common Program Requirements are inserted into each set of specialty and subspecialty requirements, the terms "resident" and "fellow" will be used respectively.

Where applicable, text in italics describes the underlying philosophy of the requirements in that section. These philosophic statements are not program requirements and are therefore not citable.

Introduction

Int.A. Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. It is physically, emotionally, and intellectually demanding, and requires longitudinally-concentrated effort on the part of the resident.

The specialty education of physicians to practice independently is experiential, and necessarily occurs within the context of the health care delivery system. Developing the skills, knowledge, and attitudes leading to proficiency in all the domains of clinical competency requires the resident physician to assume personal responsibility for the care of individual patients. For the resident, the essential learning activity is interaction with patients under the guidance and supervision of faculty members who give value, context, and meaning to those interactions. As residents gain experience and demonstrate growth in their ability to care for patients, they assume roles that permit them to exercise those skills with greater independence. This concept--graded and progressive responsibility--is one of the core tenets of American graduate medical education. Supervision in the setting of graduate medical education has the goals of assuring the provision of safe and effective care to the individual patient; assuring each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishing a foundation for continued professional growth.

I. Institutions

I.A. Sponsoring Institution

One sponsoring institution must assume ultimate responsibility for the program, as described in the Institutional Requirements, and this responsibility extends to resident assignments at all participating sites. (Core)*

The sponsoring institution and the program must ensure that the program director has sufficient protected time and financial support for his or her educational and administrative responsibilities to the program. (Core)

I.B. Participating Sites

I.B.1. There must be a program letter of agreement (PLA) between the program and each participating site providing a required assignment. The PLA must be renewed at least every five years. (Core)

The PLA should:

I.B.1.a) identify the faculty who will assume both educational and supervisory responsibilities for residents; (Detail)

I.B.1.b) specify their responsibilities for teaching, supervision, and formal evaluation of residents, as specified later in this document; (Detail)

I.B.1.c) specify the duration and content of the educational experience; and, (Detail)

I.B.1.d) state the policies and procedures that will govern resident education during the assignment. (Detail)

I.B.2. The program director must submit any additions or deletions of participating sites routinely providing an educational experience, required for all residents, of one-month full time equivalent (FTE) or more through the Accreditation Council for Graduate Medical Education (ACGME) Accreditation Data System (ADS). (Core)

 [As further specified by the Review Committee]

II. Program Personnel and Resources

II.A. Program Director

II.A.1. There must be a single program director with authority and accountability for the operation of the program. The sponsoring institution's GMEC must approve a change in program director. (Core)

II.A.1.a) The program director must submit this change to the ACGME via the ADS. (Core)

[As further specified by the Review Committee]

II.A.2. The program director should continue in his or her position for a length of time adequate to maintain continuity of leadership and program stability. (Detail)

II.A.3. Qualifications of the program director must include:

II.A.3.a) requisite specialty expertise and documented educational and administrative experience acceptable to the Review Committee; (Core)

 II.A.3.b) current certification in the specialty by the American Board of _____, or specialty qualifications that are acceptable to the Review Committee; and, (Core)

II.A.3.c) current medical licensure and appropriate medical staff appointment. (Core)

 [As further specified by the Review Committee]

II.A.4. The program director must administer and maintain an educational environment conducive to educating the residents in each of the ACGME competency areas. (Core)

The program director must:

II.A.4.a) oversee and ensure the quality of didactic and clinical education in all sites that participate in the program; (Core)

II.A.4.b) approve a local director at each participating site who is accountable for resident education; (Core)

II.A.4.c) approve the selection of program faculty as appropriate; (Core)

II.A.4.d) evaluate program faculty; (Core)

II.A.4.e) approve the continued participation of program faculty based on evaluation; (Core)

II.A.4.f) monitor resident supervision at all participating sites; (Core)

II.A.4.g) prepare and submit all information required and requested by the ACGME. (Core)

II.A.4.g).(1) This includes but is not limited to the program application forms and annual program updates to the ADS, and ensure that the information submitted is accurate and complete. (Core)

II.A.4.h) ensure compliance with grievance and due process procedures as set forth in the Institutional Requirements and implemented by the sponsoring institution; (Detail)

II.A.4.i) provide verification of residency education for all residents, including those who leave the program prior to completion; (Detail)

II.A.4.j) implement policies and procedures consistent with the institutional and program requirements for resident duty hours and the working environment, including moonlighting, (Core)

and, to that end, must:

II.A.4.j).(1) distribute these policies and procedures to the residents and faculty; (Detail)

II.A.4.j).(2) monitor resident duty hours, according to sponsoring institutional policies, with a frequency sufficient to ensure compliance with ACGME requirements; (Core)

II.A.4.j).(3) adjust schedules as necessary to mitigate excessive service demands and/or fatigue; and, (Detail)

II.A.4.j).(4) if applicable, monitor the demands of at-home call and adjust schedules as necessary to mitigate excessive service demands and/or fatigue. (Detail)

II.A.4.k) monitor the need for and ensure the provision of back up support systems when patient care responsibilities are unusually difficult or prolonged; (Detail)

II.A.4.l) comply with the sponsoring institution's written policies and procedures, including those specified in the Institutional Requirements, for selection, evaluation and promotion of residents, disciplinary action, and supervision of residents; (Detail)

II.A.4.m) be familiar with and comply with ACGME and Review Committee policies and procedures as outlined in the ACGME Manual of Policies and Procedures; (Detail)

II.A.4.n) obtain review and approval of the sponsoring institution's GMEC/DIO before submitting information or requests to the ACGME, including: (Core)

II.A.4.n).(1) all applications for ACGME accreditation of new programs; (Detail)

II.A.4.n).(2) changes in resident complement; (Detail)

II.A.4.n).(3) major changes in program structure or length of training; (Detail)

II.A.4.n).(4) progress reports requested by the Review Committee; (Detail)

II.A.4.n).(5) requests for increases or any change to resident duty hours; (Detail)

II.A.4.n).(6) voluntary withdrawals of ACGME-accredited programs; (Detail)

II.A.4.n).(7) requests for appeal of an adverse action; and, (Detail)

II.A.4.n).(8) appeal presentations to a Board of Appeal or the ACGME. (Detail)

II.A.4.o) obtain DIO review and co-signature on all program application forms, as well as any correspondence or document submitted to the ACGME that addresses: (Detail)

II.A.4.o).(1) program citations, and/or, (Detail)

II.A.4.o).(2) request for changes in the program that would have significant impact, including financial, on the program or institution. (Detail)

[As further specified by the Review Committee]

II.B. Faculty

II.B.1. At each participating site, there must be a sufficient number of faculty with documented qualifications to instruct and supervise all residents at that location. (Core)

The faculty must:

II.B.1.a) devote sufficient time to the educational program to fulfill their supervisory and teaching responsibilities; and to demonstrate a strong interest in the education of residents; and, (Core)

II.B.1.b) administer and maintain an educational environment conducive to educating residents in each of the ACGME competency areas. (Core)

II.B.2. The physician faculty must have current certification in the specialty by the American Board of _____, or possess qualifications judged acceptable to the Review Committee. (Core)

[As further specified by the Review Committee]

II.B.3. The physician faculty must possess current medical licensure and appropriate medical staff appointment. (Core)

II.B.4. The nonphysician faculty must have appropriate qualifications in their field and hold appropriate institutional appointments. (Core)

II.B.5. The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following:

II.B.5.b).(1) peer-reviewed funding; (Detail)

II.B.5.b).(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b).(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b).(4) participation in national committees or educational organizations. (Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities. (Core)

[As further specified by the Review Committee]

II.C. Other Program Personnel

The institution and the program must jointly ensure the availability of all necessary professional, technical, and clerical personnel for the effective administration of the program. (Core)

[As further specified by the Review Committee]

II.D. Resources

The institution and the program must jointly ensure the availability of adequate resources for resident education, as defined in the specialty program requirements. (Core)

[As further specified by the Review Committee]

II.E. Medical Information Access

Residents must have ready access to specialty-specific and other appropriate reference material in print or electronic format. Electronic medical literature databases with search capabilities should be available. (Detail)

III. Resident Appointments

III.A. Eligibility Criteria

The program director must comply with the criteria for resident eligibility as specified in the Institutional Requirements. (Core)

III.A.1. Eligibility Requirements – Residency Programs

III.A.1.a) All prerequisite post-graduate clinical education required for initial entry or transfer into ACGME-accredited residency programs must be completed in ACGME-accredited residency programs, or in Royal College of Physicians and Surgeons of Canada (RCPSC)-accredited or College of Family Physicians of Canada (CFPC)-accredited residency programs located in Canada. Residency programs must receive verification of each applicant's level of competency in the required clinical field using ACGME or CanMEDS Milestones assessments from the prior training program. (Core)

III.A.1.b) A physician who has completed a residency program that was not accredited by ACGME, RCPSC, or CFPC may enter an ACGME-accredited residency program in the same specialty at the PGY-1 level and, at the discretion of the program director at the ACGME-accredited program may be advanced to the PGY-2 level based on ACGME Milestones assessments at the ACGME-accredited program. This provision applies only to entry into residency in those specialties for which an initial clinical year is not required for entry. (Core)

III.A.1.c) A Review Committee may grant the exception to the eligibility requirements specified in Section

III.A.2.b) for residency programs that require completion of a prerequisite residency program prior to admission. (Core)

III.A.1.d) Review Committees will grant no other exceptions to these eligibility requirements for residency education. (Core)

III.A.2. Eligibility Requirements – Fellowship Programs

All required clinical education for entry into ACGME-accredited fellowship programs must be completed in an ACGME-accredited residency program, or in an RCPSC-accredited or CFPC- accredited residency program located in Canada. (Core)

III.A.2.a) Fellowship programs must receive verification of each entering fellow's level of competency in the required field using ACGME or CanMEDS Milestones assessments from the core residency program. (Core)

III.A.2.b) Fellow Eligibility Exception

A Review Committee may grant the following exception to the fellowship eligibility requirements:

An ACGME-accredited fellowship program may accept an exceptionally qualified applicant**, who does not satisfy the eligibility requirements listed in Sections III.A.2. and III.A.2.a), but who does meet all of the following additional qualifications and conditions: (Core)

III.A.2.b).(1) Assessment by the program director and fellowship selection committee of the applicant's suitability to enter the program, based on prior training and review of the summative evaluations of training in the core specialty; and (Core)

III.A.2.b).(2) Review and approval of the applicant's exceptional qualifications by the GMEC or a subcommittee of the GMEC; and (Core)

III.A.2.b).(3) Satisfactory completion of the United States Medical Licensing Examination (USMLE) Steps 1, 2, and, if the applicant is eligible, 3, and; (Core)

III.A.2.b).(4) For an international graduate, verification of Educational Commission for Foreign Medical Graduates (ECFMG) certification; and, (Core)

III.A.2.b).(5) Applicants accepted by this exception must complete fellowship Milestones evaluation (for the purposes of establishment of baseline performance by the Clinical Competency Committee), conducted by the receiving fellowship program within six weeks of matriculation. This evaluation may be waived for an applicant who has completed an ACGME International-accredited residency based on the applicant's Milestones evaluation conducted at the conclusion of the residency program. (Core)

III.A.2.b).(5).(a) If the trainee does not meet the expected level of Milestones competency following entry into the fellowship program, the trainee must undergo a period of remediation, overseen by the Clinical Competency Committee and monitored by the GMEC or a subcommittee of the GMEC. This period of remediation must not count toward time in fellowship training. (Core)

** An exceptionally qualified applicant has (1) completed a non-ACGME-accredited residency program in the core specialty, and (2) demonstrated clinical excellence, in comparison to peers, throughout training. Additional evidence of exceptional qualifications is required, which may include one of the following: (a) participation in additional clinical or research training in the specialty or subspecialty; (b) demonstrated scholarship in the specialty or subspecialty; (c) demonstrated leadership during or after residency training; (d) completion of an ACGME-International-accredited residency program.

[Each Review Committee will decide no later than December 31, 2013 whether the exception specified above will be permitted. If the Review Committee will not allow this exception, the program requirements will include the following statement]:

III.A.2.c) The Review Committee for _____ does not allow exceptions to the Eligibility Requirements for

Fellowship Programs in Section III.A.2. (Core)

III.B. Number of Residents

The program's educational resources must be adequate to support the number of residents appointed to the program. (Core)

III.B.1. The program director may not appoint more residents than approved by the Review Committee, unless otherwise stated in the specialty-specific requirements. (Core)

[As further specified by the Review Committee]

III.C. Resident Transfers

III.C.1. Before accepting a resident who is transferring from another program, the program director must obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident. (Detail)

III.C.2. A program director must provide timely verification of residency education and summative performance evaluations for residents who may leave the program prior to completion. (Detail)

III.D. Appointment of Fellows and Other Learners

The presence of other learners (including, but not limited to, residents from other specialties, subspecialty fellows, PhD students, and nurse practitioners) in the program must not interfere with the appointed residents' education. (Core)

III.D.1. The program director must report the presence of other learners to the DIO and GMEC in accordance with sponsoring institution guidelines. (Detail)

[As further specified by the Review Committee]

IV. Educational Program

IV.A. The curriculum must contain the following educational components:

IV.A.1. Overall educational goals for the program, which the program must make available to residents and faculty; (Core)

IV.A.2. Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to residents and faculty at least annually, in either written or electronic form; (Core)

IV.A.3. Regularly scheduled didactic sessions; (Core)

IV.A.4. Delineation of resident responsibilities for patient care, progressive responsibility for patient management, and supervision of residents over the continuum of the program; and, (Core)

IV.A.5. ACGME Competencies

The program must integrate the following ACGME competencies into the curriculum: (Core)

IV.A.5.a) Patient Care and Procedural Skills

IV.A.5.a).(1) Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.a).(2) Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.b) Medical Knowledge

Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

[As further specified by the Review Committee]

IV.A.5.c) Practice-based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome)

Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome)

IV.A.5.c).(2) set learning and improvement goals; (Outcome)

IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome)

IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome)

IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome)

IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome)

IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

IV.A.5.c).(8) participate in the education of patients, families, students, residents and other health professionals. (Outcome)

[As further specified by the Review Committee]

IV.A.5.d) Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

Residents are expected to:

IV.A.5.d).(1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds; (Outcome)

IV.A.5.d).(2) communicate effectively with physicians, other health professionals, and health related agencies; (Outcome)

IV.A.5.d).(3) work effectively as a member or leader of a health care team or other professional group; (Outcome)

IV.A.5.d).(4) act in a consultative role to other physicians and health professionals; and, (Outcome)

IV.A.5.d).(5) maintain comprehensive, timely, and legible medical records, if applicable. (Outcome)

[As further specified by the Review Committee]

IV.A.5.e) Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles. (Outcome)

Residents are expected to demonstrate:

IV.A.5.e).(1) compassion, integrity, and respect for others; (Outcome)

IV.A.5.e).(2) responsiveness to patient needs that supersedes self-interest; (Outcome)

IV.A.5.e).(3) respect for patient privacy and autonomy; (Outcome)

IV.A.5.e).(4) accountability to patients, society and the profession; and, (Outcome)

IV.A.5.e).(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome)

[As further specified by the Review Committee]

IV.A.5.f) Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome)

Residents are expected to:

IV.A.5.f).(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty; (Outcome)

IV.A.5.f).(2) coordinate patient care within the health care system relevant to their clinical specialty; (Outcome)

IV.A.5.f).(3) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate; (Outcome)

IV.A.5.f).(4) advocate for quality patient care and optimal patient care systems; (Outcome)

IV.A.5.f).(5) work in inter professional teams to enhance patient safety and improve patient care quality; and, (Outcome)

IV.A.5.f).(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

[As further specified by the Review Committee]

IV.B. Residents' Scholarly Activities

IV.B.1. The curriculum must advance residents' knowledge of the basic principles of research, including how research is conducted, evaluated, explained to patients, and applied to patient care. (Core)

IV.B.2. Residents should participate in scholarly activity. (Core)

[As further specified by the Review Committee]

IV.B.3. The sponsoring institution and program should allocate adequate educational resources to facilitate resident involvement in scholarly activities. (Detail)

[As further specified by the Review Committee]

V. Evaluation

V.A. Resident Evaluation

V.A.1. The program director must appoint the Clinical Competency Committee. (Core)

V.A.1.a) At a minimum the Clinical Competency Committee must be composed of three members of the program faculty. (Core)

V.A.1.a).(1) The program director may appoint additional members of the Clinical Competency Committee.

V.A.1.a).(1).(a) These additional members must be physician faculty members from the same program or other programs, or other health professionals who have extensive contact and experience with the program's residents in patient care and other health care settings. (Core)

 V.A.1.a).(1).(b) Chief residents who have completed core residency programs in their specialty and are eligible for specialty board certification may be members of the Clinical Competency Committee. (Core)

V.A.1.b) There must be a written description of the responsibilities of the Clinical Competency Committee. (Core)

V.A.1.b).(1) The Clinical Competency Committee should:

V.A.1.b).(1).(a) review all resident evaluations semi-annually; (Core)

V.A.1.b).(1).(b) prepare and ensure the reporting of Milestones evaluations of each resident semi-annually to ACGME; and, (Core)

V.A.1.b).(1).(c) advise the program director regarding resident progress, including promotion, remediation, and dismissal. (Detail)

V.A.2. Formative Evaluation

V.A.2.a) The faculty must evaluate resident performance in a timely manner during each rotation or similar educational assignment, and document this evaluation at completion of the assignment. (Core)

V.A.2.b) The program must:

V.A.2.b).(1) provide objective assessments of competence in patient care and procedural skills, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice based on the specialty-specific Milestones; (Core)

V.A.2.b).(2) use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff); (Detail)

V.A.2.b).(3) document progressive resident performance improvement appropriate to educational level; and, (Core)

V.A.2.b).(4) provide each resident with documented semiannual evaluation of performance with feedback. (Core)

V.A.2.c) The evaluations of resident performance must be accessible for review by the resident, in accordance with institutional policy. (Detail)

V.A.3. Summative Evaluation

V.A.3.a) The specialty-specific Milestones must be used as one of the tools to ensure residents are able to practice core professional activities without supervision upon completion of the program. (Core)

V.A.3.b) The program director must provide a summative evaluation for each resident upon completion of the program. (Core)

This evaluation must:

V.A.3.b).(1) become part of the resident's permanent record maintained by the institution, and must be accessible for review by the resident in accordance with institutional policy; (Detail)

V.A.3.b).(2) document the resident's performance during the final period of education; and, (Detail)

V.A.3.b).(3) verify that the resident has demonstrated sufficient competence to enter practice without direct supervision. (Detail)

V.B. Faculty Evaluation

V.B.1. At least annually, the program must evaluate faculty performance as it relates to the educational program. (Core)

V.B.2. These evaluations should include a review of the faculty's clinical teaching abilities, commitment to the educational program, clinical knowledge, professionalism, and scholarly activities. (Detail)

V.B.3. This evaluation must include at least annual written confidential evaluations by the residents. (Detail)

V.C. Program Evaluation and Improvement

V.C.1. The program director must appoint the Program Evaluation Committee (PEC). (Core)

V.C.1.a) The Program Evaluation Committee:

V.C.1.a).(1) must be composed of at least two program faculty members and should include at least one resident; (Core)

V.C.1.a).(2) must have a written description of its responsibilities; and, (Core)

V.C.1.a).(3) should participate actively in:

V.C.1.a).(3).(a) planning, developing, implementing, and evaluating educational activities of the program; (Detail)

V.C.1.a).(3).(b) reviewing and making recommendations for revision of competency-based curriculum goals and objectives; (Detail)

V.C.1.a).(3).(c) addressing areas of non-compliance with ACGME standards; and, (Detail)

V.C.1.a).(3).(d) reviewing the program annually using evaluations of faculty, residents, and others, as specified below. (Detail)

V.C.2. The program, through the PEC, must document formal, systematic evaluation of the curriculum at least annually, and is responsible for rendering a written, annual program evaluation. (Core)

The program must monitor and track each of the following areas:

V.C.2.a) resident performance; (Core)

V.C.2.b) faculty development; (Core)

V.C.2.c) graduate performance, including performance of program graduates on the certification examination; (Core)

V.C.2.d) program quality; and, (Core)

V.C.2.d).(1) Residents and faculty must have the opportunity to evaluate the program confidentially and in writing at least annually, and (Detail)

V.C.2.d).(2) The program must use the results of residents' and faculty members' assessments of the program together with other program evaluation results to improve the program. (Detail)

V.C.2.e) progress on the previous year's action plan(s). (Core)

V.C.3. The PEC must prepare a written plan of action to document initiatives to improve performance in one or more of the areas listed in section V.C.2., as well as delineate how they will be measured and monitored. (Core)

V.C.3.a) The action plan should be reviewed and approved by the teaching faculty and documented in meeting minutes. (Detail)

VI. The Learning and Working Environment

Residency education must occur in the context of a learning and working environment that emphasizes the following principles:

☐ Excellence in the safety and quality of care rendered to patients by residents today

☐ *Excellence in the safety and quality of care rendered to patients by today's residents in their future practice*

⬜ Excellence in professionalism through faculty modeling of:

o *the effacement of self-interest in a humanistic environment that supports the professional development of physicians*

o *the joy of curiosity, problem-solving, intellectual rigor, and discovery*

⬜ *Commitment to the well-being of the students, residents, faculty members, and all members of the health care team*

VI.A. Patient Safety, Quality Improvement, Supervision, and Accountability

VI.A.1. Patient Safety and Quality Improvement

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures.

It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care. (Core)

 VI.A.1.a).(2) Education on Patient Safety

 Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. (Core)

VI.A.1.a).(3) Patient Safety Events

 Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; (Core)

 VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and, (Core)

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution's patient safety reports. (Core)

 VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions. (Core)

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families. (Core)

 VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated. (Detail)

 VI.A.1.b) Quality Improvement

 VI.A.1.b).(1) Education in Quality Improvement

A cohesive model of health care includes quality-related goals, tools, and techniques that are necessary in order for health care professionals to achieve quality improvement goals.

VI.A.1.b).(1).(a) Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities. (Core)

 VI.A.1.b).(2) Quality Metrics

 Access to data is essential to prioritizing activities for care improvement and evaluating success of improvement efforts.

VI.A.1.b).(2).(a) Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations. (Core)

VI.A.1.b).(3) Engagement in Quality Improvement Activities
Experiential learning is essential to developing the ability to identify and institute sustainable systems-based changes to improve patient care.

VI.A.1.b).(3).(a) Residents must have the opportunity to participate in interprofessional quality improvement activities. (Core)

VI.A.1.b).(3).(a).(i) This should include activities aimed at reducing health care disparities. (Detail)

VI.A.2. Supervision and Accountability

VI.A.2.a) Although the attending physician is ultimately responsible for the care of the patient, every physician shares in the responsibility and accountability for their efforts in the provision of care. Effective programs, in

partnership with their Sponsoring Institutions, define, widely communicate, and monitor a structured chain of responsibility and accountability as it relates to the supervision of all patient care.

Supervision in the setting of graduate medical education provides safe and effective care to patients; ensures each resident's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and establishes a foundation for continued professional growth.

VI.A.2.a).(1) Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care. (Core)

VI.A.2.a).(1).(a) This information must be available to residents, faculty members, other members of the health care team, and patients. (Core)

VI.A.2.a).(1).(b) Residents and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care. (Core)

VI.A.2.b) *Supervision may be exercised through a variety of methods. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow, or senior resident physician, either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.*

VI.A.2.b).(1) The program must demonstrate that the appropriate level of supervision in place for all residents is based on each resident's level of training and ability, as well as patient complexity and acuity. Supervision may be exercised through a variety of methods, as appropriate to the situation. (Core)
[The Review Committee may specify which activities require different levels of supervision.]

VI.A.2.c) Levels of Supervision

To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision: (Core)

VI.A.2.c).(1) Direct Supervision – the supervising physician is physically present with the resident and patient. (Core)

VI.A.2.c).(2) Indirect Supervision:

VI.A.2.c).(2).(a) with Direct Supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct Supervision. (Core)

VI.A.2.c).(2).(b) with Direct Supervision available – the supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision. (Core)

VI.A.2.c).(3) Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered. (Core)

VI.A.2.d) The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members. (Core)

VI.A.2.d).(1) The program director must evaluate each resident's abilities based on specific criteria, guided by the Milestones. (Core)

VI.A.2.d).(2) Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. (Core)

VI.A.2.d).(3) Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow. (Detail)

VI.A.2.e) Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s). (Core)

VI.A.2.e).(1) Each resident must know the limits of their scope of authority, and the circumstances under which the resident is permitted to act with conditional independence. (Outcome)

VI.A.2.e).(1).(a) Initially, PGY-1 residents must be supervised either directly, or indirectly with direct supervision immediately available. [Each Review Committee may describe the conditions and the achieved competencies under which PGY-1 residents progress to be supervised indirectly with direct supervision available.] (Core)

VI.A.2.f) Faculty supervision assignments must be of sufficient duration to assess the knowledge and skills of each resident and to delegate to the resident the appropriate level of patient care authority and responsibility. (Core)

VI.B. Professionalism

VI.B.1. Programs, in partnership with their Sponsoring Institutions, must educate residents and faculty members concerning the professional responsibilities of physicians, including their obligation to be appropriately rested and fit to provide the care required by their patients. (Core)

VI.B.2. The learning objectives of the program must:

VI.B.2.a) be accomplished through an appropriate blend of supervised patient care responsibilities, clinical teaching, and didactic educational events; (Core)

VI.B.2.b) be accomplished without excessive reliance on residents to fulfill non-physician obligations; and, (Core)

VI.B.2.c) ensure manageable patient care responsibilities. (Core)

[As further specified by the Review Committee]

VI.B.3. The program director, in partnership with the Sponsoring Institution, must provide a culture of professionalism that supports patient safety and personal responsibility. (Core)

VI.B.4. Residents and faculty members must demonstrate an understanding of their personal role in the:

VI.B.4.a) provision of patient- and family-centered care; (Outcome)

VI.B.4.b) safety and welfare of patients entrusted to their care, including the ability to report unsafe conditions and adverse events; (Outcome)

VI.B.4.c) assurance of their fitness for work, including: (Outcome)

VI.B.4.c).(1) management of their time before, during, and after clinical assignments; and, (Outcome)

VI.B.4.c).(2) recognition of impairment, including from illness, fatigue, and substance use, in themselves, their peers, and other members of the health care team. (Outcome)

VI.B.4.d) commitment to lifelong learning; (Outcome)

VI.B.4.e) monitoring of their patient care performance improvement indicators; and, (Outcome)

VI.B.4.f) accurate reporting of clinical and educational work hours, patient outcomes, and clinical experience data. (Outcome)

VI.B.5. All residents and faculty members must demonstrate responsiveness to patient needs that supersedes self-interest. This includes the recognition that under certain circumstances, the best interests of the patient may be served by transitioning that patient's care to another qualified and rested provider. (Outcome)

VI.B.6. Programs must provide a professional, respectful, and civil environment that is free from mistreatment, abuse, or coercion of students, residents, faculty, and staff. Programs, in partnership with their Sponsoring Institutions, should have a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns. (Core)

 VI.C. Well-Being

 In the current health care environment, residents and faculty members are at increased risk for burnout and depression. Psychological, emotional, and physical well-being are critical in the development of the competent, caring, and resilient physician. Self-care is an important component of professionalism; it is also a skill that must be learned and nurtured in the context of other aspects of residency training. Programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as they do to evaluate other aspects of resident competence.

VI.C.1. This responsibility must include:

VI.C.1.a) efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships; (Core)

VI.C.1.b) attention to scheduling, work intensity, and work compression that impacts resident well-being; (Core)

VI.C.1.c) evaluating workplace safety data and addressing the safety of residents and faculty members; (Core)

VI.C.1.d) policies and programs that encourage optimal resident and faculty member well-being; and, (Core)

VI.C.1.d).(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours. (Core)

VI.C.1.e) attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must: (Core)

VI.C.1.e).(1) encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence; (Core)

VI.C.1.e).(2) provide access to appropriate tools for self-screening; and, (Core)

VI.C.1.e).(3) provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week. (Core)

VI.C.2. There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work. (Core)

VI.D. Fatigue Mitigation

VI.D.1. Programs must:

VI.D.1.a) educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation; (Core)

VI.D.1.b) educate all faculty members and residents in alertness management and fatigue mitigation processes; and, (Core)

VI.D.1.c) encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning. (Detail)

VI.D.2. Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue. (Core)

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home. (Core)

VI.E. Clinical Responsibilities, Teamwork, and Transitions of Care

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services. (Core)

[Optimal clinical workload may be further specified by each Review Committee.]

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective inter professional teams that are appropriate to the delivery of care in the specialty and larger health system. (Core)

[Each Review Committee will define the elements that must be present in each specialty.]

VI.E.3. Transitions of Care

VI.E.3.a) Programs must design clinical assignments to optimize transitions in patient care, including their safety, frequency, and structure. (Core)

VI.E.3.b) Programs, in partnership with their Sponsoring Institutions, must ensure and monitor effective, structured hand-over processes to facilitate both continuity of care and patient safety. (Core)

VI.E.3.c) Programs must ensure that residents are competent in communicating with team members in the hand-over process. (Outcome)

VI.E.3.d) Programs and clinical sites must maintain and communicate schedules of attending physicians and residents currently responsible for care. (Core)

VI.E.3.e) Each program must ensure continuity of patient care, consistent with the program's policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue or illness, or family emergency. (Core)

VI.F. Clinical Experience and Education

 Programs, in partnership with their Sponsoring Institutions, must design an effective program structure that is configured to provide residents with educational and clinical experience opportunities, as well as reasonable opportunities for rest and personal activities.

VI.F.1. Maximum Hours of Clinical and Educational Work per Week

Clinical and educational work hours must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting. (Core)

VI.F.2. Mandatory Time Free of Clinical Work and Education

VI.F.2.a) The program must design an effective program structure that is configured to provide residents with educational opportunities, as well as reasonable opportunities for rest and personal well-being. (Core)

VI.F.2.b) Residents should have eight hours off between scheduled clinical work and education periods. (Detail)

VI.F.2.b).(1) There may be circumstances when residents choose to stay to care for their patients or return to the hospital with fewer than eight hours free of clinical experience and education. This must occur within the context of the 80-hour and the one-day-off-in-seven requirements. (Detail)

VI.F.2.c) Residents must have at least 14 hours free of clinical work and education after 24 hours of in-house call. (Core)

VI.F.2.d) Residents must be scheduled for a minimum of one day in seven free of clinical work and required education (when averaged over four weeks). At-home call cannot be assigned on these free days. (Core)

VI.F.3. Maximum Clinical Work and Education Period Length

VI.F.3.a) Clinical and educational work periods for residents must not exceed 24 hours of continuous scheduled clinical assignments. (Core)

VI.F.3.a).(1) Up to four hours of additional time may be used for activities related to patient safety, such as providing effective transitions of care, and/or resident education. (Core)

VI.F.3.a).(1).(a) Additional patient care responsibilities must not be assigned to a resident during this time. (Core)

VI.F.4. Clinical and Educational Work Hour Exceptions

VI.F.4.a) In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances:

VI.F.4.a).(1) to continue to provide care to a single severely ill or unstable patient; (Detail)

VI.F.4.a).(2) humanistic attention to the needs of a patient or family; or, (Detail)

VI.F.4.a).(3) to attend unique educational events. (Detail)

VI.F.4.b) These additional hours of care or education will be counted toward the 80-hour weekly limit. (Detail)

VI.F.4.c) A Review Committee may grant rotation-specific exceptions for up to 10 percent or a maximum of 88 clinical and educational work hours to individual programs based on a sound educational rationale.

VI.F.4.c).(1) In preparing a request for an exception, the program director must follow the clinical and educational work hour exception policy from the *ACGME Manual of Policies and Procedures*. (Core)

VI.F.4.c).(2) Prior to submitting the request to the Review Committee, the program director must obtain approval from the Sponsoring Institution's GMEC and DIO. (Core)

VI.F.5. Moonlighting

VI.F.5.a) Moonlighting must not interfere with the ability of the resident to achieve the goals and objectives of the educational program, and must not interfere with the resident's fitness for work nor compromise patient safety. (Core)

VI.F.5.b) Time spent by residents in internal and external moonlighting (as defined in the ACGME Glossary of Terms) must be counted toward the 80-hour maximum weekly limit. (Core)

VI.F.5.c) PGY-1 residents are not permitted to moonlight. (Core)

VI.F.6. In-House Night Float

 Night float must occur within the context of the 80-hour and one-day-off-in-seven requirements. (Core)

[The maximum number of consecutive weeks of night float, and maximum number of months of night float per year may be further specified by the Review Committee.]

VI.F.7. Maximum In-House On-Call Frequency

Residents must be scheduled for in-house call no more frequently than every third night (when averaged over a four-week period). (Core)

VI.F.8. At-Home Call

VI.F.8.a) Time spent on patient care activities by residents on at-home call must count toward the 80-hour maximum weekly limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one day in seven free of clinical work and education, when averaged over four weeks. (Core)

VI.F.8.a).(1) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. (Core)

VI.F.8.b) Residents are permitted to return to the hospital while on at-home call to provide direct care for new or established patients. These hours of inpatient patient care must be included in the 80-hour maximum weekly limit. (Detail)

*Core Requirements: Statements that define structure, resource, or process elements essential to every graduate medical educational program.

Detail Requirements: Statements that describe a specific structure, resource, or process, for achieving compliance with a Core Requirement. Programs and sponsoring institutions in substantial compliance with the Outcome Requirements may utilize alternative or innovative approaches to meet Core Requirements.

Outcome Requirements: Statements that specify expected measurable or observable attributes (knowledge, abilities, skills, or attitudes) of residents or fellows at key stages of their graduate medical education.

PolicyTech: Locating Published Documents by End Users

1. Log into PolicyTech (https://navicenthealth.policytech.com/) or Click PolicyTech on the Intranet home screen
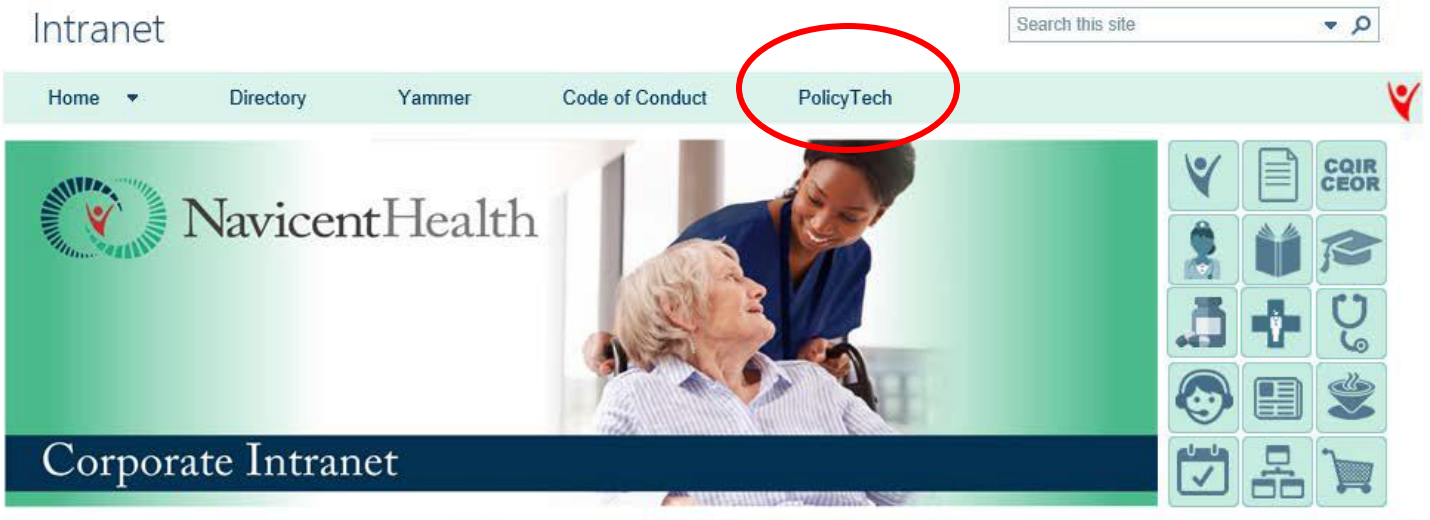
2. Click documents (left side of the screen); Then click Search (Search Box) or Browse (To search by Entity-Department)
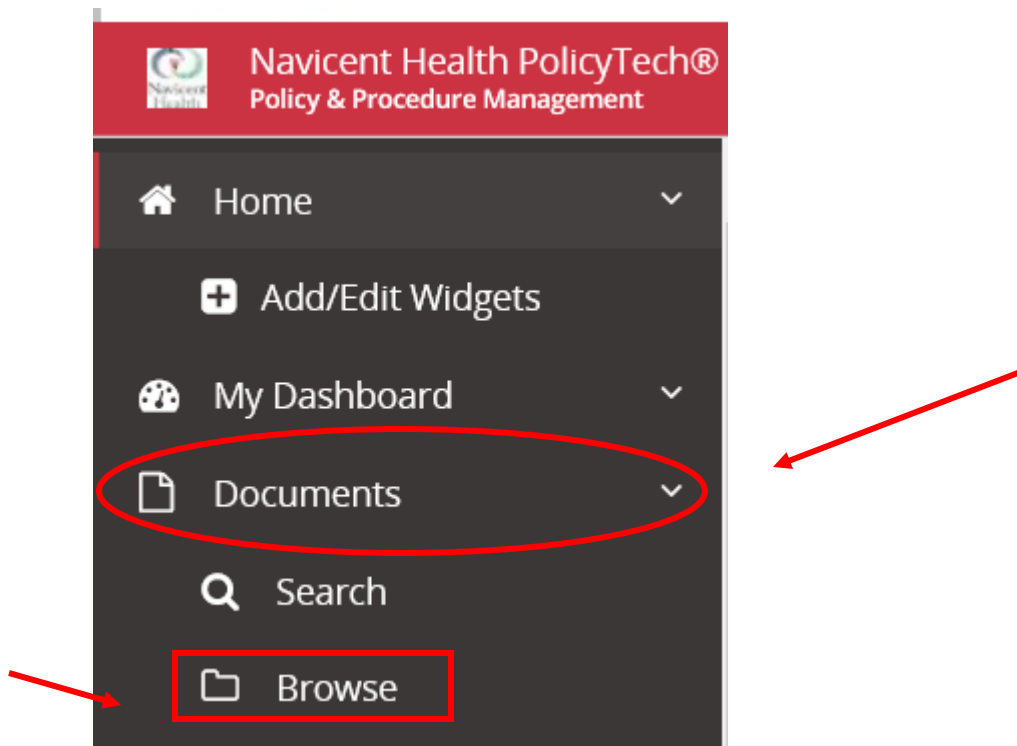
3. Access Browse and locate document type or an entity folder under all categories.
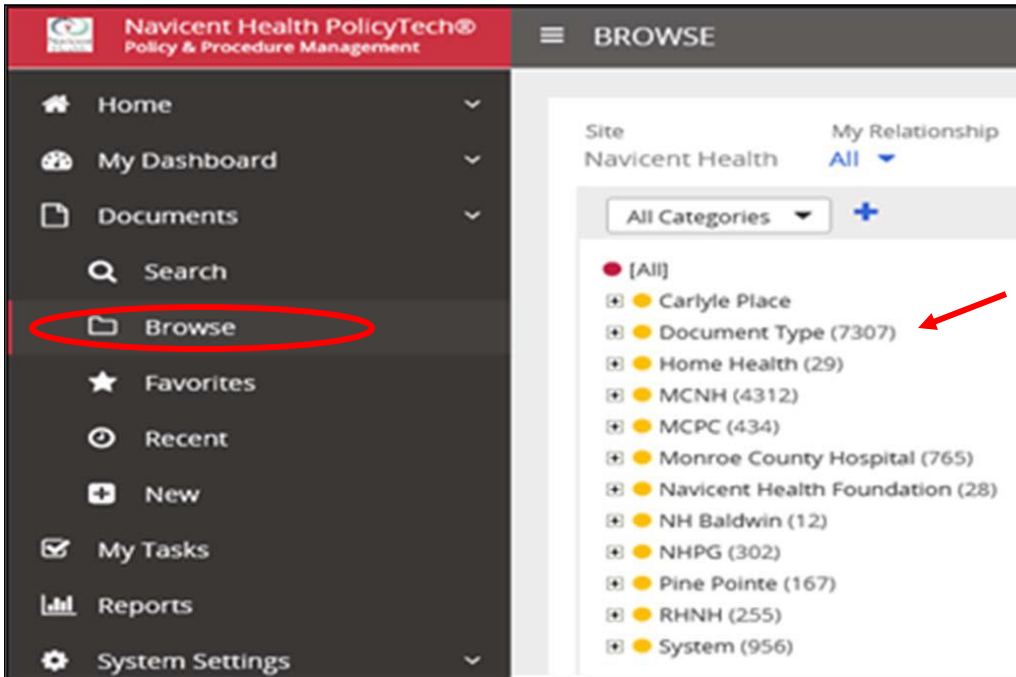
6. Click the plus sign beside document type or entity name
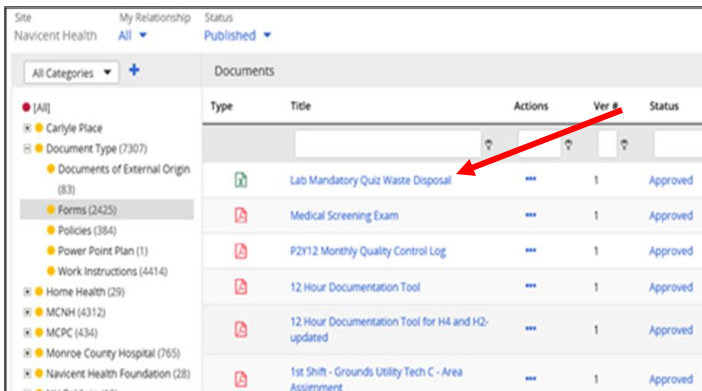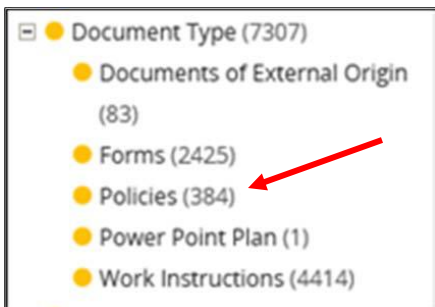
7. To refine the search under document type or dept. folder: Click the drop-down arrow by ABC (select the first number or letter of the desired document(s) title)
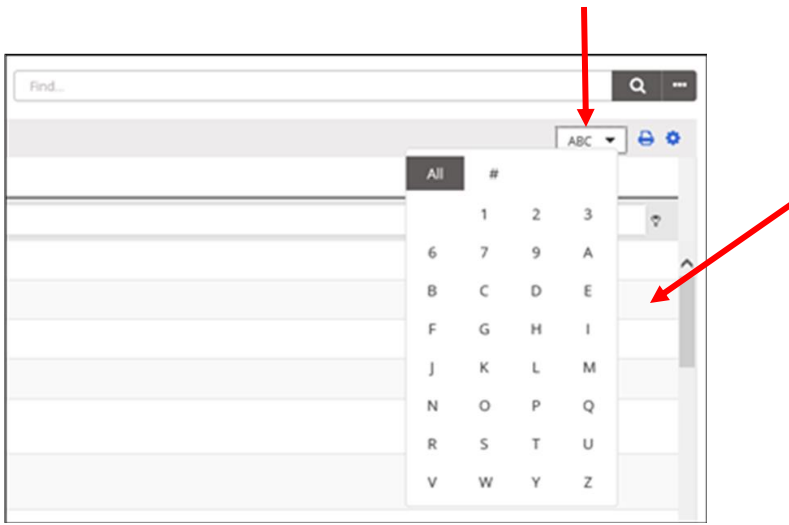
8. Locate and open the desired document by clicking its name

Internal Guidelines

General Surgery Attendings:
Back Row (Left to right): D. Benjamin Christie III, Dennis Ashley, Danny Vaughn, William Thompson
Front Row (left to right): Amy Christie, Eric Long, Macram Ayoub, Robert Parel

BACKGROUND:

The following guideline describes the process for the American Board of Surgery In-training Examination (ABSITE). All general surgery residents are required to take this exam. It is held annually during the exam window assigned by ABS.

Terms & Definitions	Description
ABSITE	American Board of Surgery In Training Exam
ACGME	Accreditation Council for Graduate Medical Education
ACS-FSC	American College of Surgeons, Fundamentals of Surgery Curriculum
SCORE	Surgical Council on Resident Education

GUIDELINE:

A. PGY -5

The PGY-5 resident must score at or above 30th percentile. If they are unable to meet this minimal standard, the resident may be placed on academic probation for the remainder of the PGY-5 year and subject to a guided learning plan, independent to the core curriculum, to be constructed with Department Chair and Program Director. The residents American Board of Surgery training verification form will not be signed until the guided learning plan is satisfactorily completed.

B. PGY 1-4 ABSITE Standards and Expectations

The PGY-1 resident will make at or above the 30th percentile on the ABSITE. If the resident fails to make at or above the 30th percentile, they will be notified of potential academic probation and subject to a guided learning plan, independent to the core curriculum, to be constructed with Department Chair and Program Director. If the residents PGY-1 ABSITE score is below 30th percentile and the resident fails to make at or above the 30th percentile on the PGY-2 examination, the resident will not be awarded a PGY-3 contract. If a resident scores below the 30th percentile on the ABSITE regardless of their PG-level, they will be notified of potential academic probation and subject to a guided learning plan independent to the core curriculum, to be constructed with Department Chair and Program Director. If a resident scores below the 30th percentile twice within their 5-year surgical training experience, they will be placed on formal academic probation. The resident's clinical and scholastic performance to date will be critically reviewed by the faculty, germane Department of Surgery Educational Committees, Program Director and Chair of the Department of Surgery where recommendations for promotion, remediation, or dismissal will be determined.

C. Med Ed Surgery PGY 1-5 Scholarly Activity Expectations

The resident will be expected to have generated a minimum of one publication during their 5-year training experience. The residents American Board of Surgery training verification form will not be signed until this expectation has been met.

D. Resident Academic Insufficiency Standards

All residents will be expected to make at or above the 30th percentile on the ABSITE. If the resident fails to make at or above the 30th percentile, they will be notified of their academic insufficiency status and subject to a guided learning plan, independent to the core curriculum, to be constructed with Department Chair and Program Director.

Med Ed Surgery Guideline:
ATLS, ACLS, and PALS Certification

BACKGROUND:

The following work instruction describes the ATLS, ACLS, and PALS certification requirements.

Terms & Definitions	Description
ACLS	Advanced Cardiac Life Support
ATLS	Advanced Trauma Life Support
PALS	Pediatric Advance Life Support

GUIDELINE:

All residents are required to take the necessary training and to become certified in ATLS, ACLS, and PALS before entering the residency program.

As ATLS certification expires after four years, residents will be required to recertify accordingly. ACLS and PALS certifications expire after two years. Residents are required to maintain certification. Both ACLS and PALS courses must be certified by the American Heart Association.

Senior residents are strongly encouraged to seek eligibility as ATLS instructors.

Medical Education Surgery NavicentHealth

Med Ed Surgery Guideline:
Approved Procedure List

BACKGROUND:

The following work instruction describes the process by which Interns obtain approval to perform invasive procedures.

Scope: General Surgery Residents

Terms & Definitions	Description
FAST	Focused Sonogram for Trauma Assessment
Interns	PGY-1
PGY	Post Graduate Year

GUIDELINE:

Interns will perform no invasive procedure without the direct supervision of a senior level resident (PGY-3, PGY-4 or PGY-5) or an attending surgeon. During the intern year, he/she will perform six of each of the following procedures under direct supervision: 1) Arterial Line; 2) Chest Tube Insertion; 3) Central Venous Line; 4) FAST Exam; 5) Endo-tracheal Intubation; 6) Pediatric/Adult Sedation; 7) Bronchoscopy.

During departmental orientation, each new resident is given six (6) Resident Procedure Cards indicating the name of the invasive procedure located at the top right-hand corner. The senior level resident/attending surgeon is required to sign and date the card as to when he/she directly supervised that particular invasive procedure. When the resident has acquired the six signatures for each procedure card, he/she is to turn them into the resident coordinator, who in turn will update the Approved Procedure list and have it posted online for easy access to all departments. These procedure cards are required to be completed by the end of their second year of training.

![Medical Education Surgery NavicentHealth]

Med Ed Surgery Guideline:
Approved Year of Training

BACKGROUND:

The following work instruction describes the training requirements and defines a "residency year".

Scope: General Surgery Residents

Terms & Definitions	Description
ABS	American Board of Surgery
ACGME	Accreditation Council for Graduate Medical Education
PGY	Post Graduate Year
RCPSC	Royal College of Physicians and Surgeons of Canada

GUIDELINE:

- A minimum of **5 years** of progressive residency education satisfactorily in a general surgery program accredited by the ACGME or RCPSC.

- Sixty months of progressive training at **no more than 3 residency programs**. If credit is granted for prior foreign training, it will count as one program.

- At least **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.

- A categorical **PGY-3 year** in an accredited general surgery residency program. Note that completing three years at PGY-1 and -2 levels does not permit promotion to PGY-4; a categorical PGY-3 year must be completed and verified by the ABS' resident roster. The only exception is in cases where 3 years' credit has been granted for prior foreign graduate training.

- 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.

- During all junior years (PGY 1-3), **no more than 6 months** assigned to non-clinical or non-surgical disciplines, and **no more than 12 months** allocated to any one surgical specialty other than general surgery.

- The final two residency years in the **same program**.

Med Ed Surgery Guideline:
Attire and Etiquette

BACKGROUND:

The following work instruction describes the attire and etiquette required.

Scope: General Surgery Residents

Terms & Definitions	Description
M&M	Morbidity and Mortality

GUIDELINE:

1. Always wear a white lab coat with the Navicent Health logo affixed when seeing patients. <u>Never leave the operating room in a scrub suit without a white lab coat</u>. <u>Never wear a dirty or blood-stained lab coat, scrub suit or shoe covers.</u>
2. Never see patients after leaving the operating room with blood or other body fluid stains on your shoe covers or scrubs.
3. When not in the operating room or preparing to go to the operating room, professional attire is preferable to a scrub suit.
4. When seeing patients, try to act as professional as possible. Use courtesy titles such as "Mr." or "Mrs." when addressing patients. Excessive familiarity is to be avoided.
5. Professional attire will be worn Tuesdays and Thursdays for attendance to M&M and Grand Rounds.
6. All out-patient clinics should be attended in professional attire as well.   The only exceptions are the Trauma Team, post-call residents, or those directly headed to or coming from the operating room.

Med Ed Surgery Guideline:
Away Rotation

BACKGROUND:

The following work instruction describes the away rotations.

SCOPE: General Surgery Residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
DIO	Designated Institutional Official
PGY	Post Graduate Year

GUIDELINE:

- No resident will be granted away rotation privileges if found to be deficient in any of the Department of Surgery competency based performance measures.
- No resident will be granted away rotation privileges if any clinical deficiencies exist in either faculty surgical skill evaluations, milestone trajectory reviews or faculty New Innovation evaluations.
- No resident will be granted away rotation privileges if any deficiencies exist in the resident's case log and operative experience recordings.
- No resident will be granted away rotation privileges if professional conduct or insubordination citations have been entered into their program file.
- No PGY-1, PGY-4, or PGY-5 will be granted away rotation privileges.
- No resident will be granted away rotation privileges if an ABSITE score of 30% or less has been achieved twice in their training experience.
- Away rotations for surgical experiences that are provided in our own institution will be strongly discouraged to be denied.
- Each resident with an away rotation request will submit a written statement detailing the away rotation institution name, location, specialty of interest, and a narrative that establishes the resident's goals and objectives by participating in the away rotation experience. The formal request and the narrative will be reviewed by the Program Director and the Chair of the Department of Surgery.
- The resident's composite body of work in their training to date will be evaluated and a decision rendered.
- The resident must provide a minimum of 1-year notice of intent to participate in an away rotation.
- No resident will rotate away twice within an academic year.
- Three away rotations are not permitted.

Med Ed Surgery Guideline:
Basic Science and Clinical Research

BACKGROUND:

The following work instruction describes the basic science and clinical research rotations.

SCOPE: General surgery Residents (PGY-2)

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
PGY	Post Graduate Year

GUIDELINE:

Basic Science Research Pathway: The resident (PGY-2) will create a project description and plan to be presented to the Chair of the Department of Surgery for review. The goals and objectives of the basic science research pathway will be described. If the resident's research project description and plan is accepted, a research timeline will be developed where a midpoint assessment of progress by the Chair of the Department of Surgery will be performed. The resident will select, or be directed to, a national or regional submission opportunity for presentation and publication. At completion of the basic science research month, the resident will have an end-of-rotation review with the Chair of the Department of Surgery where rotational goals and objectives will be deemed as either satisfied or unsatisfied. If the rotation goals and objectives are deemed unsatisfied, the resident will be noted as insufficient in their program file for this rotation until the project description and plan has been completed. Failure to complete the project plan at the end of the five-year training period will result in the residents American Board of Surgery training verification form not being signed until this expectation has been met.

Clinical Research Pathway: The resident (PGY-2) will select a teaching faculty mentor and create a project description and plan to be presented to the Chair of the Department of Surgery for review. The goals and objectives of the clinical research pathway will be described. If the resident's research project description and plan is accepted, a research timeline will be developed where a mid-point assessment of progress by the Chair of the Department of Surgery will be performed. The resident will select, or be directed to, a national or regional submission opportunity for presentation and publication. At completion of the clinical research month, the resident will have an end-of-rotation review with the Chair of the Department of Surgery where rotational goals and objectives will be deemed as either satisfied or unsatisfied. If the rotation goals and objectives are deemed unsatisfied, the resident will be noted as insufficient in their program file for this rotation until the project description and plan has been completed. Failure to complete the project plan at the end of the five-year training period will result in the resident's American Board of Surgery training verification form not being signed until this expectation has been met.

Med Ed Surgery Guideline:
Beepers and Other Electronic Devices

BACKGROUND:

The following work instruction describes the procedure for the use of beepers and other electronic devices.

SCOPE: General Surgery Residents

Terms & Definitions	Description
OR	Operating room

GUIDELINE:

- During conferences beepers and cell phones and IPads must be switched <u>to the silent mode</u>.
- When out of town or off call the Chief Residents should have the operator program their beeper to the Chief Resident who will be taking their calls.
- When in the O.R., place beepers on "in-house emergency only" status.

Med Ed Surgery Guideline:
Cases Performed

BACKGROUND:

The following work instruction clarifies the ability of general surgery residents to perform surgical procedures at other Macon hospitals.

SCOPE: General surgery residents

GUIDELINE:

Residents are not allowed to participate in surgical procedures at other Hospitals unless a formal agreement is in place. If clarification is needed on an individual case basis, contact the Chairman/Program Director. Currently, we have formal agreements with Crisp Regional Hospital, Monroe County Hospital, and Piedmont Hospital.

Med Ed Surgery Guideline:
Conscious Sedation Levels – Adult & Pediatric Credentialing Requirements

BACKGROUND:
The following work instruction describes the process by which general surgery residents obtain appropriate credentials required to manage both the adult and pediatric patient receiving sedation/analgesia.

SCOPE: The resident responsible for the treatment of the patient and/or administration of drugs for adult sedation/analgesia shall be trained and have the appropriate credentials to manage the patient receiving sedation/analgesia.

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ASA	American Society of Anesthesiologists
ATLS	Advanced Trauma Life Support
MCNH	Medical Center Navicent Health
MEC	Medical Executive Committee
PALS	Pediatric Advanced Life Support
PGY	Post Graduate Year

GUIDELINE:

<u>ADULTS</u>
The resident responsible for the treatment of the patient and/or administration of drugs for adult sedation/analgesia shall be trained and have the appropriate credentials to manage the patient receiving sedation/analgesia.

Credentialing for the administration of sedation/analgesia is granted through the MCNH Credentialing Committee, MEC, and MCNH Board.

This includes:
1. Training in the administration of pharmacologic agents and monitoring to achieve the desired level of sedation and maintain the patient at that desired level. This can be evidenced by:

    A. The resident possessing a current Georgia State Medical Licensure.

B. The performance of a sufficient number of procedures in the past year with good outcomes. (Initially 3 cases proctored by a surgery faculty member).

2. Training and experience in evaluation of patients prior to performance of sedation, i.e., Airway evaluation, assignment of ASA classification and documentation requirements. This can be evidenced by the successful completion of the online Sedation e-learning Database and Training / Education (SeDaTE) course found at http://mccg.sedationelearning.com/login.php. or adult conscious sedation session with a qualified instructor with an annual update.

3. The ability to rescue patients who unintentionally reach deep sedation levels. The ability to manage the patient's airway can be demonstrated by either:

    A. ACLS, ATLS, PALS certification or
    B. Demonstration of airway management skills via mannequin (ATLS).

4. A list of all residents approved to administer adult conscious sedation will be on the intranet under the Medical Affairs Department web page.

5. At the beginning of the intern year, it is the responsibility of the intern to register for the online sedation course found at http://mccg.sedationelearning.com/login.php and to renew their credentialing privileges every year.

"Re-credentialing" or the continued granting of these privileges will be based on the successful performance of sedation/analgesia with good outcomes, evaluated through ongoing monitoring by the Program Director.

PEDIATRICS

PGY-1, PGY-2, PGY-3, PGY-4 and PGY-5 residents may administer conscious sedation to children after satisfactory completion of the PALS course. Those residents approved for conscious sedation in children or adults are listed on the MCNH intranet.

Med Ed Surgery Guideline:
Department Teaching Conferences

BACKGROUND:

The following work instruction describes the criteria for teaching conference attendance.

SCOPE: General surgery residents

GUIDELINE:

Attendance to all Departmental Teaching Conferences is **MANDATORY.**

Med Ed Surgery Guideline:
Due Process

BACKGROUND:

The following work instruction describes the process of Due process (Discipline, Suspension, Dismissal)

SCOPE:

It is the policy of MCNH that all employees, to include medical residents, are expected to comply with the Medical Center's standards of behavior and performance, and that any noncompliance with these standards must be remedied. The Medical Center endorses the policy of progressive discipline described herein, which provides residents with notice of deficiencies and an opportunity to improve.

Conduct, which can result in progressive disciplinary action, includes, but is not limited to: unacceptable performance of duties, unacceptable personal conduct, and academic under achievement.

In addition, actions by a resident which are considered to be serious violations of MCNH rules and regulations or other actions of misconduct may result in immediate suspension or dismissal from the program.

At the time training begins, each resident is informed by the Program Director of the program objectives, standards, and criteria for advancement. The responsibility of monitoring and evaluating the performance of residents and for imposing disciplinary actions rests with the Director of the resident's training program.

Terms & Definitions	Description
MCNH	Medical Center Navicent Health
DIO	Designated Institutional Official

GUIDELINE:

1. Verbal Counseling: If the resident is not meeting the Medical Center's standards of behavior or performance, the Program Director or designee shall meet with the resident to clearly inform him/her of the nature of the problem, to determine why or how it occurred; and to provide assistance in identifying corrective action to prevent reoccurrence.

2. Written Warning (to Include Probation): This is the first formal step in the procedure that is normally taken when a second and/or serious violation of behavior or performance occurs. The Program Director or designee shall meet with the resident and inform him/her of the seriousness of the problem and issue a written warning (to include probation).

A written warning may include a requirement for extension of training. Residents who receive notice that their program may be extended for academic reasons must be notified 120 calendar days (with exception noted below) before the completion of the academic year. Such notification should state:
• Length of the extension or criteria to be satisfied (if length is not specified)
• Reasons for the extension supported by prior evaluations of performance, if needed
• specific deficits to be corrected
• criteria and evaluation procedures to be employed in determining satisfactory completion of the year for credit

The one exception to the 120-day time requirement for notification of the program extension shall be when major academic failure, occurring in the final two months of the academic year, may justify extension. In such cases, failure must be considered by faculty to overshadow satisfactory performance in the first ten months of the year.

3. Suspension: Serious violations of the Medical Center standards of behavior or performance or repetition of violations usually warrant suspension from duty without pay. Suspension in the progressive discipline process serves as a final warning to the resident to modify their behavior or face the consequence of possible dismissal. When the Program Director believes that a resident merits suspension from duty, he/she normally consults with the DIO prior to counseling the resident privately to inform them of the seriousness of the infraction or misconduct and the corrective action to be taken.

4. Dismissal: Residents will be given a written notice of intent not to renew the Agreement of Appointment no later than four months prior to the end of the current Agreement of Appointment. However, if the primary reason(s) for non-renewal occurs within the four months prior to the end of the Agreement of Appointment, residents will be provided as much written notice of intent not to renew as the circumstances will allow, prior to the end of the Agreement of Appointment. When in the judgment of the Program Director or an authorized designee, he/she determines that immediate action is necessary; a resident may be suspended pending further investigation. In either case, the resident may then invoke the residency program grievance procedure. The Program Director must first consult with the DIO before dismissal proceedings may begin.

Med Ed Surgery Guideline:
Grievance & Appeal Process

BACKGROUND:

The following work instruction describes the process by which a resident may appeal a written warning, suspension or notice of recommendation of dismissal.

SCOPE:

It is recognized that residents should be given the opportunity to appeal certain actions not to include performance evaluations and non-renewal of Agreement of Appointment, which may be imposed by the Program Director. Questions concerning performance of duties, personal conduct, or academic progress and achievement shall be discussed initially by the resident and the Director of their program.

Terms & Definitions	Description
CEO	Chief Executive Officer
DIO	Designated Institutional Officer
MCNH	Medical Center Navicent Health
MUSM	Mercer University School of Medicine

GUIDELINE:

Level I: If a resident receives a written warning and they disagree with the warning, the following appeal process may be followed:

Step 1 - Discussion between Resident and Program Director: All questions concerning the written warning shall be discussed initially by the resident and their Program Director within 5 days of receipt of the written warning. If the grievance cannot be resolved at this level, the resident may request a conference with the DIO for Graduate Medical Education.

Step 2 - Discussion Between Resident and DIO for Graduate Medical Education: The resident should submit to the DIO within 7 days of the Program Director's decision, a written request for a conference outlining the substance of their grievance. Upon receipt of this request, the DIO will arrange a conference with the resident. The DIO will notify the resident and the Program Director, in writing, of his decision.

Level II: If a resident receives a suspension or notice of recommendation of dismissal, the following appeal process may be followed:

Step 1 - Discussion Between Resident and Program Director: A resident that is suspended or receives a notice of recommended dismissal has 10 calendar days after receiving written notice

of such action to appeal the decision to the Program Director or his/her designee. Upon receipt

of the appeal, the Program Director or his/her designee will arrange to meet with the resident normally within 5 calendar days. The resident will be informed in writing of the decision regarding the appeal.

Step 2 - Discussion Between Resident and DIO: Same as Step 2 in Level I above except that the DIO's decision may be reviewed according to Step 3.

Step 3 - Hearing Before Hearing Committee or Hearing Officer: If the decision of the DIO is not deemed satisfactory, the resident may then request a hearing by filing a written request with the Chief Medical Officer within 7 days after receiving a copy of the decision of the DIO. Upon receiving the request for a hearing, the Chief Medical Officer will appoint a Hearing Committee or a Hearing Officer to conduct the hearing. If a Hearing Committee is appointed, the Chief Medical Officer will appoint a Chairperson for this Committee.

A hearing shall be held not less than 14 days or more than 28 calendar days from the date of the residents' request for a hearing. The Chairperson of the Hearing Committee or the Hearing Officer shall notify the resident of the date, time, and place of the hearing. The resident may meet with the Committee or Hearing Officer or may waiver the right. The resident has the right to present witnesses before the Hearing Committee or Hearing Officer.

At the conclusion of the hearing it will be the responsibility of the Chair of the Hearing Committee or the Hearing Officer to inform the Chief Medical Officer and resident, in writing, of the recommendations. This will normally be done within 7 calendar days following the hearing. If there is no appeal this decision is final.

Med Ed Surgery Guideline:
General Surgery Residency Academic Portfolio

BACKGROUND:

The following work instruction describes the General Surgery Residency academic portfolio guidelines.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education

GUIDELINE:

What is a Portfolio?

A portfolio is a collection of products prepared by the fellow that provides evidence of learning and achievement related to a learning plan. Each resident will have a portfolio, and will maintain entries into the portfolio. Physically it will be one three-ring binder with your name on the spine.

- **Learning Plan.** The 1999 ACGME Outcome Project required all residency programs to train residents in six general competencies to the level of that expected of a new practitioner. The six areas, also known as the "Six Competencies," include the areas of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. In turn, there are 28 specific skills (the "sub-competencies") that further define in operational terms the components underlying the six broader competencies.

- **Chronicling.** It will be a document that chronicles the development of your competencies in the six AGCME areas. It will include six dividers that correspond to each competency. You will provide documents that establish your experiences and developing competency in each area. Additional dividers have been added - Teaching Skills, Communication Skills, Operative Skills and Simulation Lab training.

- **Standardized Forms.** In an effort to make this a painless process and respectful of your time as possible, we have developed standardized forms, one page only, that you can fill out to place into the Portfolio. You're doing most of the work anyway. All you have to do is write things down in sufficient detail so that you create a meaningful document that can establish (1) that a particular competency was exercised, (2) what your role was in the encounter, (3) the issues involved, (4) how the encounter benefited the patient, (5) what you got out of the encounter, and (6) how your own competency was enhanced by the encounter. One page. Two or three sentences per item. That's all.

- **Why Document?** We have to document that you're applying specific knowledge, skills, and attitudes in your developing practice of surgery, and that you're getting better with more practice. It's directly analogous to keeping track of all of your cholecystectomies and saving the dictate operative reports. Then you start doing the same for your pancreatic resections. You have a paper trail that documents your developing surgical competency.

- Describe how I'm going to do this.

    1. Example One. You're presenting a complication at Death and Complications conference. In addition to preparing for your presentation and getting the films, you check Medline and get the latest Cochrane summary about prophylaxis against deep vein thrombosis. You make your presentation, and the case gets discussed. You fill out the appropriate form (Patient Safety and Medical Error), give a brief summary of the problem, narrative of events, your observation of how the system can be improved, notes on how various stakeholders responded to the error, and a summary of the discussion at the conference. You attach the abstract page only to the form. You punch three holes along the margin, and put in the Practice-Based Improvement section of your portfolio.
    2. Example Two. You have a difficult patient with a complicated problem. You do some reading using an internet search engine like Ovid. It's a pretty good article – you think it applies to your patient, and you use the results to guide what you do for the patient. You get the Practice-Based Learning form. You identify the specific clinical problem. You cite your article, and assign a level of evidence. You verify its validity, importance, and application to your patient based upon principles of evidence-based medicine that we covered in lecture, that you have a reference for, and for which there is a crib sheet on the reverse side of the form. You attach the front page of the article, punch three holes in the margin of both form and article, and stick it into the portfolio.
    3. Example Three. You attend a patient care conference for a complicated trauma case that is a discharge problem. The meeting includes nursing, rehab, OT, psych, etc. You grab a General Competency Worksheet. You check off the box next to "Patient Care." You look on the back and select one of the sub-competencies and write it down in the space provided ("develop and carry out patient management plans" would work, as would "work within a team"). In the space provided you give a summary of the situation (patient care conference), your role in the encounter (responsible physician), the issues that were discussed, how your participation affected the encounter, how the patient benefited from the meeting, the lessons you learned, and how your competency was enhanced. Three holes, it's in the Portfolio.

- **Difficulty**. I really think that it shouldn't take much more than five minutes, tops to fill one out. And you'd do most of your thinking about what to put into the narrative during the encounter, conference, meeting, whatever. I just ask that there's enough detail so that I know what happened, that you got something out of the experience, and that you're improving in that area. Also, we have to have sufficient documentation that some field representative from the Residency Review Committee will say, yes, these guys are covering competency education. And I can also see this as a sort of diary of your own experiences during your residency.

- **How many of these things do we have to do?** I'd like to have a minimum of one per competency each week, distributed more or less evenly among the six competencies. Every six months, your portfolio will be reviewed as to the number of entries you have completed. You can always do more. If anyone has a perceived deficiency in the development of an area, we could ask for more participation – and more documentation.

- **Reflective Statement.** We need a "reflective statement" to be included in the Portfolio as a kind of guide to the reader and a reminder to you of ultimately where you'd like to go in your training and career. No forms. Just a narrative titled "Reflective Statement" where you summarize your goals for the year, where you ultimately want to be in your training and education, and an honest assessment of where you are in each of the six competencies. No page limit, but enough for it to be meaningful as a guide to you for the year and a means by which you can judge the attainment of your objectives. One of these at the beginning of each year.

- **Patient Log.** You will need to document 50 patients on the patient log provided. This will need to be signed by both the Program Director and yourself. These will be used as part of your application for the

certification exam application. It is highly encouraged that you complete these as you perform throughout the year.

- Reasons. **It's the law, and we have to document your progress in each of the competencies.**

Med Ed Surgery Guideline:
GS Residency Administrative Portfolio

BACKGROUND:

The following work instruction describes the General Surgery Residents administrative portfolio guidelines.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ATLS	Advanced Trauma Life Support
CV	Curriculum Vitae
ERAS	Electronic Residency Application
FLS	Fundamentals of Laparoscopic Surgery
LOR	Letter of Recommendation
MCNH	Medical Center Navicent Health
PALS	Pediatric Advanced Life Support
PGY	Post Graduate Year
TB	Tuberculosis
USMLE	United States Medical Licensing Examination

GUIDELINE:

- **Administrative Portfolio:**
    - ❖ **Application.** ERAS application, LORs, Personal Statement
    - ❖ **Certifications.** ATLS, ACLS, PALS, FLS, Certificates (Intern/Graduation), Medical Diploma
    - ❖ **Licensure.** Georgia medical license
    - ❖ **Care Learning.** Transcripts
    - ❖ **Contract.** A copy of the signed contract
    - ❖ **Correspondence.** Copies of any correspondence between the resident and program
    - ❖ **Curriculum Vitae.** Copy of updated CV
    - ❖ **Evaluations.** Copies of Semi-Annual Resident Performance evaluations, Milestones
    - ❖ **Health/TB.** Copy of health certificate and TB testing results
    - ❖ **Incident Reports.** Copies of any incident reports
    - ❖ **In-Training Exams.** Copies of each PGY level In-training exam results
    - ❖ **Loan Deferments**. Copy of any loan deferments
    - ❖ **Meetings/Workshops**.

- ❖ **Miscellaneous**.
- ❖ **Mock Orals**. Copy of results
- ❖ **Moonlighting.** If approved by Program Director, a copy of the completed moonlighting form should be kept in the portfolio. Moonlighting must not interfere with the ability of the fellow to achieve the goals and objectives of the educational program. Time spent by fellows in Internal and External Moonlighting (as defined in the ACGME Glossary of Terms) must be counted towards the 80-hour Maximum Weekly Hour Limit.
- ❖ **Rotations.** Copies of approved away rotations
- ❖ **Societies/Organizations.** Copies of membership letters
- ❖ **Travel Expense.** Copies of all travel expense forms
- ❖ **USMLE Scores.** Copies of USMLE Step 1, 2, and 3 scores
- ❖ **Vacation/Meeting Requests.** Copies of all requests

Medical Education Surgery NavicentHealth

Med Ed Surgery Guideline:
Medical Record Documentation – Specific Internal Requirements

BACKGROUND:

The following work instruction describes the specific requirements for maintenance of medical records.

SCOPE: General surgery residents

Terms & Definitions	Description
H&P	History and Physical
OP	Operative
OR	Operating Room

GUIDELINE:

1. **Date and time every medical record entry** - orders, progress notes, etc. Use approved abbreviations only.

2. Progress notes need to be **completed the day of the encounter**.

3. No patient may be taken into the OR without an acceptable H&P on the chart. **Always dictate operative note within 24 hours.** Additionally, no patient may leave the recovery room without a written update on the chart.

4. **Always** dictate the discharge summary at or prior to time of discharge.

5. **Never** write an inflammatory, petulant, or foolish note on the patient's medical record. Criticism of a hospital employee or fellow resident is to be scrupulously avoided. "Offhand" remarks and comments are a frequent case of malpractice suits.

Med Ed Surgery Guideline:
Mock Orals

BACKGROUND:

The following work instruction describes the process by which mock oral exams are conducted.

SCOPE: 4th and 5th year general surgery residents

Terms & Definitions	Description
ABS	American Board of Surgery

GUIDELINE:

This is a component of the general surgery residency educational series. In order to give our residents the best experience and practice, the mock oral exams are set up similar to the real exam. The goal is to increase the passing percentage among residents by offering mock oral exams to residents who will sit for the ABS certifying exam.

Formal Mock Oral Exams are held for fourth and fifth year residents twice yearly.   These practice sessions are conducted by faculty and required components of curriculum. **Attendance is mandatory**.

Medical Education
Surgery *NavicentHealth*

Med Ed Surgery Guideline:
Night Float

BACKGROUND:
The following work instruction explains night float as it pertains to the 80-hour work week as mandated by ACGME.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
Chief Resident	Post Graduate Years 4 & 5
Intern	Post Graduate Year 1
Mid-level Resident	Post Graduate Years 2 & 3
PGY	Post Graduate Year

GUIDELINE:

- Night float begins each Sunday at 6:00 p.m. and ends at 7:00 a.m. Monday through Friday so their last weekly duty exit is on Friday at 7:00 a.m. Residents will have the rest of Friday, all day Saturday and Sunday until 6:00 p.m. free of all hospital duties.
- The on call team consists of three residents: one intern, one mid-level resident and one chief resident. The chief resident does not participate in the night float and he/she goes home six hours after 24 hours on call at 1:00 p.m. the following day. The interns and mid-level residents fully participate in the night float and follow the schedule described above.
- There are four interns, so each intern takes three months of night float each academic year.
- There are eight mid-level residents, so they take night float 1 to 2 months each per year.

Med Ed Surgery Guideline:
Operative Case Reporting

BACKGROUND:

The following work instruction describes the process for operative case reporting.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education

GUIDELINE:

Each resident will be responsible for data entry through the ACGME website of all operative, endoscopic and critical care cases. **Extreme accuracy and TIMELINESS is mandatory**. Cases should be entered and maintained on a weekly basis. All cases must be archived in the ACGME system at completion of rotation month or this becomes departmental insubordination.

Departmental Educational Coordinator will keep a record of the case totals for each resident. These figures will be posted on the board in the department and will be updated monthly. The goal is for each resident to place in the 50th percentile or higher for each category as compared to reported national averages.

Med Ed Surgery Guideline:
Promotion

BACKGROUND:

The following work instruction describes the process by which general surgery residents advance.

SCOPE: General surgery residents

Terms & Definitions	Description
ABSITE	American Board of Surgery In Training Exam
ACGME	Accreditation Council for Graduate Medical Education
AVP	Administrative Vice President
CCC	Clinical Competency Committee
DIO	Designated Institutional Officer
GME	Graduate Medical Education
MCNH	Medical Center Navicent Health
PGY	Post Graduate Year

GUIDELINE:

Each resident and fellow is evaluated annually by the CCC which consists of the Program Director, general surgery attendings and the chief residents. The final decision is based on personal knowledge of the resident's activities, ABSITE score, textbook quiz scores, oral presentations, conference participation, Basic Science Seminar presentation and record-keeping habits. Based on this information, one of the following recommendations is made:

1. Advancement with statement of exemplary performance.
2. Advancement with statement of deficiency to be improved.
3. Advancement with notification of one-year on academic watch and statement of deficiencies to be improved.
4. No advancement with one-year remediation with academic watch and discussion of alternative career choices.
5. Unsatisfactory performance and dismissal from program at the end of the current academic year.

The residents are scheduled to meet with the Chairman after the review by the Clinical Competency Committee. The Chairman takes this opportunity to discuss areas of exceptional performance, areas

for improvement and possible solutions to existing problems.

1. Promotion of Residents.

At the time training begins, each resident is informed by the Program Director of Program objectives, standards, and criteria for advancement. The responsibility for monitoring and evaluating the

performance of residents and for imposing disciplinary actions rests with the Program Director. Disciplinary decisions may be subject to review by the DIO for Graduate Medical Education and AVP for Medical Affairs, MCNH.

a. Monitoring of progress: Rotation Goals and Objectives.
Progress toward reaching goals and meeting objectives for each rotation is evaluated by attending surgeons on each service. Each attending rates each resident as to whether he or she reached goals and met objectives appropriate for his or her postgraduate level. These are reviewed by the Program Director. The Program Director receives input from attending staff through written evaluations, informal consultations, formal meetings with private surgical groups involved in residency programs, and the Education Committee of the Program. The Program Director then summarizes the various inputs into an overall evaluation of each resident's progress on a quarterly basis. The annual ABSITE examination and mock oral examinations provide additional assessments regarding the resident's progress in gaining proficiency in patient care and medical knowledge. Should areas of weakness or deficiencies be identified, the Program Director and resident discuss potential interventions, and make plans to address them. Milestones for progress are set, and a goal established for the next quarterly meeting.

b. Monitoring of progress: Core Competencies.
Residents undergo a number of evaluation methods to monitor their progress toward gaining proficiency in the six ACGME core competencies: record reviews, 360 global ratings involving attending, resident, and nurse evaluations; ABSITE examinations; oral examinations (PGY4 and -5); case logs; and patient surveys. Again the Program Director receives input from attending staff through the various sources listed above, and the Clinical Competency Committee. Each resident has a personal interview with the Program Director to review his or her progress toward proficiency in the core competency areas. As above, should areas of weakness or deficiencies be identified, the Program Director and resident will develop plans to address them and set goals that demonstrate progress in rectifying problem areas.

c. Promotion of residents.
Decisions for promotion are made on the basis of progress toward meeting rotation goals and objectives and proficiency in core competencies. Consistent achievement in the first three quarters of an academic year will lead to a decision by the Program Director in favor of promotion to the next postgraduate level.

Consistent professional growth over the course of the five-year program, reflected in the meeting rotation and Program goals and objectives, and achievement of proficiency in core competencies, will result in successful completion of the Residency Program in Surgery and thus eligibility to sit for Qualifying and Certifying Examinations of the American Board of Surgery.

d. Deficient performance
Residents, as MCNH employees, are expected to comply with the Medical Center's standards of behavior and performance. As surgical trainees, residents are expected to demonstrate satisfactory progress toward achieving Program goals and objectives. Thus noncompliance with either MCNH standards or Program academic and professional standards must be remedied. The Medical Center and Program endorses the policy of progressive discipline that provides residents with notice of deficiencies and an opportunity to improve. Progressive remedial and disciplinary action may result from failure to meet Program or rotation goals and objectives, remedial levels in core competencies, unacceptable performance of duties, unacceptable personal conduct, and academic under achievement.

Med Ed Surgery Guideline:
Publication, Presentation and Conference Attendance

BACKGROUND:

The following work instruction describes the publication, presentation and conference attendance objectives.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
PGY	Post Graduate Year

GUIDELINE:

1.   Publication.

A finished publication is expected at the completion of the research rotation and clinical research project. The publication must include:

 a. **Abstract:** a complete Abstract in the format of a standard surgical journal (i.e., introduction, materials and methods, findings, summary, and summary of all co-authors and contributions);

 b. **Introduction:** referenced, that clearly states the area investigated, the rationale for the present study, hypothesis and questions to be addressed;

 c. **Material and Methods:** with a complete summary that describes in standard detail all procedures performed, and the statistical analysis with statistics software used;

 d. **Results:** All results reported clearly, with appropriate figures, tables, statistical analyses, and completed legends pages;

 e. **Discussion:** A summary of findings, whether the hypotheses were supported, questions addressed, limitations of study, future questions, and relevance of work; and

 f. **References:** Listed in order of quotation, using standard abbreviations of journal articles. A completed draft of a research project **is required** before its presentation at any extramural meeting. In the event that presentation of a research project was made prior to completion of a draft manuscript, a first draft of the manuscript is required within three months of attendance. Failure to turn in a complete first draft will postpone all travel to conferences for all resident co-authors until the draft is submitted.

2.   Authorship.

A full-time attending surgeon will serve as senior author. He or she will determine authorship and order of co-authors in the manuscript. The following will be considerations in determining authorship:

 a. **Conception:** the resident that conceives of a project, question, or experiment and sets up the research plan, writes the proposal, grant application, and IRB approval forms;

 b. **Conduction:** the resident who first conducts the experiment and records the initial results;

 c. **Collaboration:** the resident who takes over the project, doing additional trials, refines and improves experimental techniques;

d.   **Collation and Analysis:** the resident who collates, analyzes the results, and does the statistical analysis; and

e.   **Communication:** the resident who constructs the figures and tables and writes the first draft of the publication.

Each resident co-authors must have one of the identified roles above to be considered to be included as a co-author. The senior author will make the final call as to inclusion in the roster of co-authors and order of priority.

3.   **Presentation.**

a.   **Presenter:** Only co-authors will be allowed to present the work at an extramural conference. This is absolutely necessary because questions will be asked that will require familiarity with the project, data, results, and interpretation. In general, the resident writing the first draft of the project (see Item **4e** above) will be best able to present the data. In the event that this resident cannot present the data, then one of the other co-authors may present the work. The senior author will decide whether the work may be presented, and which resident co-author will present the data.

b.   **Conference:** No foreign conferences will be approved. Acceptable national conferences will be the Surgical Forum of the American College of Surgeons, the Society of University Surgeons, the American Surgical Association, American Association for the Surgery of Trauma, the Society of Surgical Oncology, and the national meetings of major medical organizations such as the American Heart Association and the American Thoracic Society. All other conferences will be considered regional. Any meeting of the Southeastern Surgical Congress and meetings of other organizations not listed above located within acceptable driving distance are acceptable. Final approval will be with the Program Director.

c.   **Repeat presentations:** Projects will be presented only once. Repeated presentations of the same data are not acceptable.

d.   **Preparation:** Review of all presentations by the senior author is mandatory. Slides must mention the Medical Center of Central Georgia and the Mercer University School of Medicine. 'Joke' slides are not acceptable. An acknowledgement slide must be made at the end of the presentation, including the funding source for the research. Slides must be legible from the back of the room: black lettering on a white or light yellow background, white lettering on a black or dark blue background. A rehearsal presentation in near-final form must be made at least one month before the date of the conference.

4.   **Conference Attendance.**

Conference attendance is a privilege. Therefore, the resident or SCC fellow enjoying the privilege of conference attendance will have specific responsibilities upon his or her return.

a.   **Review of the session:** At the next research conference the presenter will review the feedback and questions he or she received at the session where his or her paper was given.

b.   **Conference review:** At the next appropriate grand rounds the conference attendee will present a detailed summary of the presentations that he or she attended, including handouts and notes. The number of presentations will be two or more per day at the conference, beginning on the first session attended to the last half-day.

c.   **Conduct:** Misconduct, public inebriation, absence for any full day from conference activities, or failure to provide either review above will be considered grounds to initiate disciplinary action.

Med Ed Surgery Guideline:
Resident Rotations

BACKGROUND:
The following work instruction describes the process by which general surgery residents rotate.

SCOPE: General surgery residents

GUIDELINE:

A. **Post-graduate Year One**
   General Surgery   six months
   Pediatric Surgery   one month
   Night Float-General Surgery   two months
   Trauma   three months

B. **Post-graduate Year Two**
   General Surgery   three months
   Research   two months
   Intensive Care Unit   three months
   Pediatric Surgery   one month
   Trauma Surgery   one month
   Night Float-General Surgery   two months

C. **Post-graduate Year Three**
   General Surgery   five months
   Transplant Surgery   one month
   Night Float-General Surgery   two months
   Pediatric Surgery   three months
   Thoracic/Vascular Surgery   one month

D. **Post-graduate Year Four**
   General Surgery   seven months
   Thoracic/Vascular Surgery   two months
   Trauma Surgery   three months

E. **Post-graduate Year Five (Chief Year)**
   General Surgery   nine months
   Thoracic/Vascular Surgery   three months

Med Ed Surgery Guideline:
Robotics

BACKGROUND:

The following work instruction describes the process by which training and criteria for performing robotic operations.

SCOPE: General surgery residents

Terms & Definitions	Description
PGY	Post Graduate Year

GUIDELINE:

Residents that anticipate performing robotic operations after residency will have the opportunity to gain additional console experience, with the goal of being able to operate independently on the robot at the completion of residency. Residents who choose to pursue this opportunity will have additional training requirements, as outlined below. Trainees who meet these requirements and are deemed competent on the console by at least two robotic surgeons, will be provided with a letter at the completion of their residency documenting their experience and competency. While all hospitals will have different requirements regarding surgical readiness, documentation of adequate robotic training in residency generally replaces on site clinical training with Intuitive Surgical.

REQUIREMENTS:

The following requirements are to be completed by all residents sequentially during their residency. Additional information about the requirements follows.

1. Complete online robotic training at www.davincisurgerycommunity.com
2. Attend a Saturday workshop for introduction to docking, instrument exchange, simulator, and console training.
3. Bedside assistant in 5 robotic cases, with responsibility for docking, instrument exchange, and assisting.*
4. Complete 6 designated modules on the simulator with a score of 90% or greater.
5. Console surgeon for minimum 5 cases.

*Residents currently in their 3rd, 4th, or 5th year who have completed simulator training can log themselves both as bedside assistant and console surgeon if they docked the robot and inserted the instruments, and operated from the console in the same case.

Residents who desire a letter documenting their experience and competency at the time of graduation need to meet the following additional requirements:

1. Completion of additional more advanced modules on the simulator with a score of 90% or greater
2. Console surgeon for minimum of 30 cases
3. Minimum of 5 cases as console surgeon must include a post case review with the attending surgeon. Must be deemed as competent on the console for these five cases. All cases should not be performed with the same attending, and must be performed during the final year of residency.

ACTIVITIES BY POST GRADUATE YEAR:

1. PGY-1
   a. Complete online training
   b. Attend a Saturday course
   c. Observer or bedside assistant for robotic cases
   d. Practice on the simulator
2. PGY-2
   a. Review online training and/or attend a Saturday course if needed for review
   b. Observer or bedside assistant for robotic cases
   c. Complete all required modules on the simulator
   d. Perform uncomplicated cholecystectomies
3. PGY-3
   a. Review online training and/or attend a Saturday course if needed for review
   b. Continue practice on the simulator
   c. Perform robotic cholecystectomies
   d. Perform robotic ventral hernia repairs and inguinal hernia repairs
4. PGY-4
   a. Review online training and/or attend a Saturday course if needed for review
   b. Continue practice on the simulator
   c. Perform robotic cholecystectomies
   d. Perform portions of the mobilization in segmental colectomies
5. PGY-5
   a. Review online training and/or attend a Saturday course if needed for review
   b. Complete advanced modules on the simulator
   c. Assist junior residents in robotic cholecystectomies and ventral hernias
   d. Perform segmental colectomies, rectopexies, gastric resections and adrenalectomies
   e. Have the attending surgeon evaluate at least 5 cases to assess skills and competency

Instructions for Online Robotics Training:

Completing the pre-requisite Preparation & System Training for the da Vinci Si Surgical System will yield a more productive experience in that you will have already covered the basics and have a working knowledge of the Robotic System prior to hands-on experience.

Below is a step-by-step outline of the procedure modules & evaluation process:

1. Go to www.davincisurgerycommunity.com. You will need to establish an account and password.
2. From the left menu, select "Training" -> "Surgeons" -> "Online Training Courses"
3. We have a da Vinci Si system. You are to do the following modules. Make sure you are doing them on the Si system, not the S system. We DO have SmartPedal technology.
   a. "da Vinci Si System Overview"

   b. "Docking"
   c. "Advanced Surgeon Console Controls"
   d. "Safety Features"
   e. "Assessment" (Save and Print your Assessment Certificate)
 4. Turn in your assessment certificate to Resident Coordinator.

You may want to spend some time exploring the website. You will find links to papers about robotic surgery, as well as videos of common robotic operations.

Med Ed Surgery Guideline:
Role of PGY Levels

BACKGROUND:

The following work instruction describes the roles of each PGY level in the general surgery residency program.

SCOPE: The Surgery Residency is a five-year program as required for certification by the American Board of Surgery. The program has four categorical residents at each level. The levels are as follows: PGY-1 (Intern Year), PGY-2, PGY-3, PGY-4, and PGY-5 (Chief).

Terms & Definitions	Description
ACLS	Advanced Cardiac Life Support
AHC	Anderson Health Clinic
FAST	Focused Sonogram for Trauma Assessment
PALS	Pediatric Advanced Life Support
PGY	Post Graduate Year

GUIDELINE:

- **INTERN YEAR (PGY-1)**
  Interns will perform no invasive procedure without the direct supervision of a senior resident (PGY-3 or higher) or an attending surgeon. During the intern year, he/she will perform six of each of the following procedures under direct supervision: 1) Arterial Line; 2) Chest Tube Insertion; 3) Central Venous Line; 4) FAST Exam; 5) Endo-tracheal Intubation; 6) Pediatric/Adult Sedation; 7) Bronchoscopy.

  The Intern will do History & Physicals, dictate the Discharge Summary and attend to ward work on the surgical services. During this year, he/she will rotate through the surgical subspecialties. The intern will be a member of the Trauma Team and, when on call, will answer every trauma code. The intern in concert with more senior residents will see consults in the hospital, including the Emergency Center. There should be no conscious sedation procedures performed by interns.

- **PGY-2**
  PGY-2 residents may perform invasive procedures once six of each type has been correctly performed under direct supervision by a senior resident or attending surgeon. The PGY-2 residents will see consults in the emergency room and, when on call, will be a member of the Trauma Team. During the second year of training, each resident will spend one month on a Clinical

Research rotation, one month on an Approved Away Rotation (Cordele), and one month on the Transplant Service at the Piedmont Hospital in Atlanta, Georgia. Adult moderate conscious sedation may be performed unsupervised by PGY-2, PGY-3, PGY-4, and PGY-5 residents after completing the designated number of proctored cases (3) with the attending surgeon present. Documentation of these proctored cases will be kept in each residents file.

- **PGY-3**
  PGY-3 residents may perform invasive procedures without supervision and will have gradually progressive surgical responsibilities. The third year residents will supervise the first and second year residents doing invasive procedures. Traditionally, the PGY-3 resident will successfully complete the Advanced Trauma Operative Management course (ATOM).

- **PGY-4**
  PGY-4 residents act as chief residents because we have four fourth year residents and four fifth year residents and the RRC for Surgery requires that residents take call no more than every third night. Therefore, both PGY-4 and PGY-5 residents take chief call and when on call are captains of the Trauma Team and answer every trauma code. Also, only PGY-4 and PGY-5 residents are permitted to perform pediatric moderate sedation. They will have already completed at least three unsupervised proctored cases by an attending surgery faculty or private practice surgeon and completed PALS training before performing any unsupervised pediatric moderate sedation. Traditionally, the PGY-4 resident will successfully complete both the Fundamentals of Laparoscopic Surgery (FLS) and the Fundamentals of Endoscopic Surgery (FES) courses.

- **PGY-5**
  During the fifth year, each of the four residents serves a Chief Administrative Resident for four months and as such administers the Call Schedule as well as any rotation changes. The fifth year resident also assigns surgery cases for the residents on the day prior to the operating room schedule. He/She is in charge of the Surgery Clinic and supervises the performance of residents and students in the Anderson Health Center on Tuesday and Thursday. With a staff member present, but not scrubbed, the fifth year resident is permitted to do "teaching assistant cases" with junior residents.

Med Ed Surgery Guideline:
Time Off

BACKGROUND:

The following work instruction describes the criteria for time off for vacation, sick leave, and interviews.

SCOPE: General surgery residents

Terms & Definitions	Description
ACGME	Accreditation Council for Graduate Medical Education
EIB	Extended Illness Benefit
PGY	Post Graduate Year

GUIDELINE:

Vacation: Fifteen days of vacation per year services allowed as authorized by the Program Director or his/her designee. Vacation time *does not* accumulate from year to year. Vacation *cannot* be taken during June, July, and January unless approved by Program Director.

Sick Leave: Sick leave is taken out of your vacation time. Extended illnesses are covered under the standard Extended Illness Benefit (EIB) allowances.

Interviews: Both PGY 4s and PGY 5s will have 5 days each year for interviews for job or fellowship opportunities. Days not used during the PGY 4 year cannot roll over to the PGY 5 year. Interview days must be authorized by the Program Director or his/her designee. Interview days CANNOT be used for vacation or meeting experience.